PROBLEMATIZING REFUGEE CLAIMANT HEALTHCARE: CRITICAL POLICY ANALYSIS OF THE INTERIM FEDERAL HEALTH PROGRAM AMENDMENTS OF 2012.

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Abstract

This thesis is a critical policy analysis of the 2012 Interim Federal Health Program amendments. It examines how and why refugee claimants in Canada remain unable to enact their universal right to access healthcare. It is specifically concerned with the underlying meanings contained within Canadian refugee healthcare policy and considers how such policies construct the "problem" of refugee healthcare. Using the critical discourse analysis methodology of Carol Bacchi, it traces the genealogy of the 2012 amendments and their place within policy history. It reveals the power struggles and political conflicts that have shaped the discursive conditions for the development and operationalization of Canada's unique policy. This work paves the way to alternatively represent the "problem" of refugee claimants' access to healthcare and more humanely approach it through policy. It concludes that a rights-based approach, driven by an adoption of international human rights conventions into law, is needed to address refugee claimants' access to healthcare.

General Summary

This thesis examines the health care coverage provided to people claiming refugee status to see why they remain without a right to access healthcare. It is specifically concerned with the history of one government policy – the Interim Federal Health Policy -- and considers how this policy may have created the problem. It examines the history of this policy and seeks to understand how history and politics shaped this policy. It shows how the policies have created a particular image of what a refugee claimant is like, an image that makes it seem like refugees are cheaters and putting an unfair burden on the health care system. The critique I present paves the way to think of the "problem" of healthcare access by refugee claimants differently by concluding that adopting international rights into law is needed to improve refugee claimants' access to healthcare.

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List of Abbreviations

CARL	Canadian Association for Refugee Lawyers
CBC	Canadian Broadcasting Corporation
CDRC	Canadian Doctors for Refugee Care
DCO	Designated Country of Origin
DHA	Discourse Historical Analysis
GAR	Government Assisted Refugee
ICESCR	International Covenant on Economic, Social and Cultural Rights
IFHP	Interim Federal Health Program
IOM	International Organization for Migration
IRB	Immigration and Refugee Board of Canada
IRCC	Immigration, Refugee and Citizenship Canada
IRPA	Immigration and Refugee Protection Act
NHS	National Health Service
PDT	Political Discourse Theory
PSR	Privately Sponsored Refugees
RPA	Rhetorical Political Analysis
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
WPR	What's the Problem Represented to be?

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Chapter 1: Introduction

Refugee claimants in Canada are unable to enact their universal right to access healthcare. They are provided temporary access through the Interim Federal Health Program (IFHP); however, that program does not guarantee the right to access healthcare. Without a legal framework requiring health professionals to treat beneficiaries of the IFHP, refugee claimants have faced barriers to accessing medical treatment. This thesis is a critical policy analysis that seeks to understand how and why asylum seekers in Canada remain without a guaranteed right to access healthcare.

1.1 Brief introduction to the policy

The IFHP was initiated following the Second World War as a temporary charitable humanitarian relief program to cover the medical expenses of displaced persons who migrated to Canada for employment (Toussaint v. Canada, 2010, para 29). Starting in 1946, the Department of Labour paid hospital and medical expenses for specific migrant groups (see Table 1). The department responsible for these migrants' successful settlement felt such aid was needed as these groups could not pay or give acceptable assurance for payment of medical services (Dhand & Diab, 2015; Government of Canada,1946; Toussaint v. Canada, 2010, para 33). Between 1949 and 1952, medical coverage was broadened by the Deputy Minister of Immigration to include medical, dental, hospitalization, and any expenses incidental for nearly all immigrants that lacked financial resources and had become suddenly ill after being admitted but before arrival at their final place of employment (Dhand & Diab, 2015; Government of Canada, 1949; Government of Canada, 1952; Toussaint v Canada, 2010, para 34;). By 1957, authority for the program transferred from the Department of Citizenship and Immigration to the Department of National Health and Welfare under Immigration Medical Services (Dhand & Diab, 2015;

Government of Canada, 1957; Toussaint v. Canada, 2010, paragraph 36;). During the subsequent decades, the immigrant medical services program began to narrow in scope regarding who was covered. The program shifted and limited its coverage from migrants unable to cover medical expenses to persons needing state protection following the country-wide adoption of public healthcare under the Canada Health Act in 1985 (Canadian Doctors for Refugee Care v Canada, 2014; Dhand & Diab, 2015; Toussaint v Canada, 2011). By the mid-1990s, responsibility for the program transferred from the Department of National Health and Welfare to the Department of Canadian Employment and Immigration, a precursor to Immigration, Refugees, and Citizenship Canada (CDRC v Canada, 2014, para 39).

Shortly following this transfer of responsibility, the program increasingly faced scrutiny, starting with the 1997 Auditor General report, which critiqued the program for being too open to abuse by refugee claimants (Kelly and Trebilcock, 2010). In response to a subsequent 2009 Auditor General report which echoed the same critique in 1997, a series of policy reforms were introduced between 2010 and 2012 intended to resolve the "abuse of the refugee system by people who come from countries generally considered safe" (Government of Canada, 2012a, para 2-3). In 2012, amendments were adopted that severely limited insurance benefits for refugee claimants and added additional administrative burdens for health professionals providing treatment to such claimants (Barnes, 2012; Canadian Hospital Association, 2012; Eggerston 2013). Government opponents of the federal program argued that barriers preventing access to treatment were necessary to protect the publicly funded healthcare institution (Government of Canada, 2012a, para 9). Proponents of the program argued that the Interim Federal Health Program was a small cost compared to the billions spent nationally and provided a positive

national image of Canada's charitable humanitarian traditions for a relatively small price (Harris & Zuberi, 2015; Villegas & Blower, 2019).

Following much public debate and a series of federal court challenges to the amendments between 2012 and 2016, the newly elected Liberal government reinstated medical coverage to refugee claimants[1] in early 2016 (Canadian Broadcasting Corporation, 2016). However, critics like Paperny (2021), Somos (2021), Stevenson (2021), as well as others, have highlighted issues that persist. They argue that federal health insurance coverage is contingent upon the status of one's claim for refugee protection (Somos, 2021). A coverage gap persists for refugee claimants due to the Interim Federal Health Program operating as a federal health insurance program outside a provincial healthcare system (Paperny, 2021; Stevenson, 2021). Such gaps have created a lack of targeted healthcare resources to combat the COVID-19 pandemic within refugee groups (Campbell-Scherer et al., 2021; Globalanna, 2021; Maltceva, 2021). Reflecting upon the reinstatement of funding and medical coverage in 2016, as well as the gaps in law guaranteeing refugees access to healthcare, policy experts like Beatson (2016) note that systemic barriers persist due to the lack of any "serious attempt to elevate the status of asylum seekers within Canadian society on a permanent level"(p.130).

Table 1: Refugee Health Policy Changes Since 1946

July 23, 1946, Order in Council PC 1946-3112	Implemented medical coverage for approx. 4,000 Polish armed forces resettled following WWII (Government of Canada,1946; Toussaint v. Canada, 2011, para 33; Dhand & Diab, 2015)
August 4, 1949, Order in Council PC 1949-41/3888	Authorized the Department of Citizenship and Immigration to cover hospital expenses for immigrants who lacked financial resources prior to reaching their destination. (Government of Canada, 1949; Toussaint v. Canada, 2011, para 34; Dhand & Diab, 2015)

[1] I will more carefully define the difference between categories of refugees in Section 2.1, but here it is important to know that refugee claimants are legally distinct from refugees as they are individuals seeking refugee protection from a state but have yet to have their claim accepted/rejected.

Table 1: Continued

June 6, 1952, Order in Council PC 1949-4/3263	Extended coverage to include medical, dental, hospital for indigent immigrants and immigrants awaiting to start work placements (Government of Canada, 1952; Toussaint v. Canada, 2011, para 35; Dhand & Diab, 2015)
June 20, 1957, Order in Council PC 1957-11/848	Department of National Health and Welfare (DNHW) under the Immigration Medical Services branch assumed authority for medical coverage for any person who is under the "jurisdiction" of immigration and "for whom Immigration authorities feel responsible." (Government of Canada, 1952; Toussaint v. Canada, 2011, para 36; Dhand & Diab, 2015)
1976 Immigration Act	Formally recognized Refugees as a distinct immigration class. (Government of Canada, 1976)
1985 Canada Health Act	Permanent residents and other economic migrants became eligible for health care coverage under this "Act." Immigration Medical Services branch limited coverage to specific classes of vulnerable and indigent migrants (Toussaint v Canada, 2011, Dhand & Diab, 2015; CDRC v Canada, 2014).
1993 Memorandum of Understanding Signed	DNHW transfers programs to the Canada Employment and Immigration Commission (CEIC is now Immigration Refugee and Citizenship Canada). CEIC begins delivering medical expenses coverage under the Interim Federal Health Program (CDRC v Canada, 2014, para 39).
1995 and 1996 Quebec and Ontario end coverage.	Ontario and Quebec ceased providing coverage to refugee claimants instigating change at federal level whereby refugee claimant coverage was now provided by IFHP (Dhand & Diab 2015, p 357)
1996 IFHP narrows eligibility	CEIC (now IRCC) narrowed IFHP application to refugees, refugee claimants, and other humanitarian classes eliminating health coverage for newly arrived indigent immigrants (CDRC, 2014, para 41).
1997 Auditor General Report	The Auditor General's audit of the refugee system critiqued the refugee system as being "slow and open to abuse" (Bauder, 2011, p.52).
1999 IFHP extends scope of coverage	Victims of human trafficking and applicants seeking Pre-Removal Risk Assessments were now covered. (Dhand & Diab, 2015, p. 358)
2001 Immigration and Refugee Protection Act	Passed in Nov 2001, the new act allowed for the deportation and indefinite detention of foreign nationals and linked immigration and refugee elements to national security.
2009 Auditor General Report	Highlighted a refugee protection system overburdened by rejected or withdrawn refugee claims, sparking debates on immigration reform (Government of Canada, 2009).
2010 Bill C-11 "Balanced Refugee Reform Act"	Introduced designate countries of origin (DCO) as not "normally" producing of refugees subject to faster processing to deter "abuse" of the refugee system by claimants from listed countries (Government of Canada, 2012a, para 2-3)
2010 Toussaint v Canada and IFHP review	The judge ruled that the government was not obligated to provide undocumented migrants with healthcare through the IFHP. The ruling triggered a review of the IFHP. (Toussaint v. Canada, 2010; CDRC v Canada, 2014, para 53)
2012 Bill C-31 "Protecting Canada's Immigration System Act"	Introduced a multitiered refugee protection system with asylum seekers being subject to different privileges based upon their country of origin and mode of arrival (Government of Canada, 2012d)
2012 *Order Respecting the Interim Federal Health Program*	The resulting review trigged by Toussaint v Canada and tied to Bill C-11 and Bill C-31, the government introduced tiered health coverage levels within the IFHP based upon refugee status, country of origin, and mode of arrival (Government of Canada, 2012e)

Table 1: Continued

2013 CDRC vs Canada	Canadian Association of Refugee Lawyers (CARL) and Canadian Doctors for Refugee Care (CDRC) launch an application for judicial review of the 2012 Order in Council, arguing that the reforms breach the Canadian Charter of Rights and Freedoms and international agreements (CDRC v Canada, 2014).
2014 CRDC vs Canada Ruling and the Temporary IFHP	Judge Mactavish ruled that the government must restore the IFHP to pre-2012 coverage. The federal government filed an appeal and implemented a temporary IFHP coverage scheme that increased complexity (Ruiz-Casares et al., 2016)
2016 Restoration of pre-2012 IFHP	The newly elected Liberal government dropped the appeal and restored the IFHP (CBC, 2016)

1.2 Thesis objective and organization

This thesis examines the history of the Interim Federal Health Program to understand how and why refugee claimants[2] in Canada remain without a guaranteed right to access healthcare. I use the qualitative policy analysis method of Carol Bacchi (2009), an approach that asks, "What's the Problem Represented to be" (WPR). I critically examine the historical, political, and cultural discursive practices that have shaped the *problem*[3] of refugee healthcare by highlighting the underlying presumptions about how the *problem* of refugee claimant healthcare is represented. I scrutinize how these presumptions have come about in Canadian immigration history. I interrogate what has been silenced within the refugee healthcare problem and what effects this has had on refugee claimants. I dissect how has the *problem* of refugee healthcare been produced, distributed, defended, and rejected within and following the 2012 amendments. Finally, I present an alternative representation of the refugee healthcare *problem* and how it may be approached through policy.

[2] As noted above I will more carefully define the difference between categories of refugees in Section 2.1, but here it is important to know that refugee claimants are legally distinct from refugees as they are individuals seeking refugee protection from a state but have yet to have their claim accepted/rejected.

[3] The key terms problem and problem representation in this thesis are italicized to emphasise their usage as methodological terms. This distinction of the terms from their everyday usage is important. It draws attention to how the problem indicated is not objectively a "problem," but rather is something constructed as a problem by policy makers, which I am scrutinizing.

In Chapter 2, I review the literature related to refugees/asylum seekers[4] as it relates to how they are defined and the legal status of refugees and asylum seekers. Asylum seekers' and refugees' rights and the barriers to healthcare. The health status of asylum seekers and refugees. The asylum seeker and refugee health experience in Canada. Lastly, I discuss Canadian refugee health policy in the context of the 2012 amendments and identify gaps in the scholarly understanding of the factors that contributed to the 2012 amendments. In Chapter 3, I explain my research methodology in relation to the field of policy analysis. Next, I explain my research method, WPR analysis, which is utilized to identify, deconstruct, and interrogate how a specific policy *problem* came into existence, starting with policy proposals. This explanation of the WPR method is followed by an outline of my data collection methods, how I conducted my analysis, and the limitations of this approach. In Chapter 4, I present my analysis of the 2012 policy amendments to identify how the *problem* of refugee healthcare is represented within select policy texts. Chapter 5 interrogates the underlying presuppositions and assumptions within the identified *problem representations*. Chapter 6 is where I establish how the *problem representations* have a history, singling out specific points in time when critical decisions were made that took policies on refugee healthcare in a particular direction. Chapter 7 follows this genealogical analysis by scrutinizing the constraints, limitations, and inadequacies with how the *problem* of refugee healthcare is being represented. Here, I critique the representation by presenting examples of how the *problem* has been thought about differently in the United Kingdom and the United States. Chapter 8 follows the identification of what has been left unproblematic in the *problem representations*. I delve into the effects (discursive, subjectification, and lived) produced by the *problem representation*, considering the long-term

[4] The distinction between refugees, asylum seekers, and other types of migrants will be explained in Section 2.1. Here, I use refugees/asylum seeks for simplicity, in advance of that more indepth discussion.

implications of the policy interventions. In Chapter 9, I analyze how the *problem representations* have been promoted, disseminated, and defended and how they have been disrupted and replaced. Lastly, in Chapter 10, I discuss my key findings, explore the limitations of this study, and conclude the thesis by arguing that a rights-based approach driven by a human rights policy discourse is needed to reshape, contest, and address the policy *problem* of refugee claimants' access to healthcare.

Chapter 2: Literature Review

Chapter 1 introduced the *problem* of how policy in Canada prevents refugee claimants from being able to enact their universal right to access healthcare, which is the subject of my critical analysis. To fully understand the *problem* of access to healthcare, we require a fuller description of what "refugee claimants" means to differentiate them from other kinds of migrants, which is the task of this chapter. Starting broad and narrowing the focus progressively, I start the chapter by differentiating the types of migrant groups and explaining how they are distinguished differently and sometimes inconsistently in the literature. Following the migrant definitions, I present the international legal framework that broadly utilizes the term "refugee," and then I detail the differences between "asylum seeker," "refugee claimant," and "refugee." I provide an overview of existing international laws and the global rights and barriers to healthcare access that asylum seekers and refugees face. I discuss how systemic barriers to accessing healthcare affect the health outcomes of asylum seekers and refugees. I then narrow the focus to the Canadian context, exploring the use of the term "refugee claimants" and how they as a migration category differ from asylum seekers in Canada's refugee protection system. I present the similarities and differences in the experiences of refugee claimants compared to refugees in Canada in terms of access to healthcare. In addition, I provide a brief overview of the history of the 2012 Canadian refugee health policy amendments, which, for a nearly four-year period, introduced the most significant number of reforms to the health services and healthcare that refugee claimants could access since 1957. Lastly, I highlight existing research on refugee claimants' access to healthcare and identify the gaps in knowledge that inspired this thesis.

2.1 Defining terminology and the legal status of refugees and asylum seekers

In this section, I will describe how researchers delineate migrant groups in different ways. I will explain how some researchers use multiple narrow categories; others use broad definitions that encompass several subcategories of migrants who face very different legal hurdles. I will also explain how and why I use the most common terms.

Generally speaking (and this will be further explicated below), anyone crossing a border between countries is a migrant (International Organization for Migration, 2022). Those without documentation are undocumented migrants who do not possess the necessary permissions or documents required to cross a national border and enter a country with the intention of remaining (York University, 2022). There are various reasons why people become undocumented migrants, and the category delineates further into illegal migrants and asylum seekers (York University, 2022). Illegal migrants are persons who do not have what the state considers a legitimate reason to enter a country or who have entered the country in a manner that violates the immigration laws of that country (Taylor, 2007). The other group of undocumented migrants, asylum seekers, are individuals escaping harm they have experienced in their country of nationality or residence by seeking refuge and protection within another country (IOM, 2022). Asylum seekers often do not possess documentation or do not have the necessary permissions to enter a country; thus, they fall within the category of undocumented migrants and are supposed not to be considered illegal migrants under international law (Parliament of Australia, 2011). A state that is a signatory to international law (specifically, the *1951 United Nations Convention and Protocol Relating to the Status of Refugee* and the *1967 Protocol*) is required to accept and rule upon the case of each *asylum seeker* to determine if they have a legitimate claim for refuge and protection (United Nations High Commissioner for Refugees, 2016). While a case is pending

determination, a person may still be considered an asylum seeker (known as a refugee claimant in the case of Canada -- an exceptional label discussed and clarified in section 2.4 of this chapter). If a state determines that such an asylum seeker/refugee claimant's case is valid. In that case, they become what is known as a refugee, a legal category that affords such a person specific rights, protections, and entitlements to care. The final term to consider is internally displaced persons who flee harm but have not crossed a border to seek protection within another state (IOM, 2022). Within academic literature, confusion about the terminologies can occur because asylum seekers, refugee claimants, and refugees are often not distinguished from each other despite being distinct legal categories of migration (CBC, 2019; Parliament of Australia, 2011). Such lack of distinction is complicated by the unique use of the term refugee claimant within Canadian literature (York University, 2022). The term refugee claimant is utilized within Canadian law to categorize an individual who has made a claim to be recognized as a refugee, thus distinguishing them from *asylum seekers* who are in a state of fleeing persecution to seek refugee status but have yet to make a claim.

Globally, undocumented migrants (which include illegal migrants and asylum seekers/refugee claimants) are constructed as a human rights and citizenship challenge that almost every nation faces. However, international law (specifically, the *1951 United Nations Convention and Protocol Relating to the Status of Refugee and the 1967 Protocol*) exists to help identify persons that require refugee protection (United Nations, 2010). According to the United Nations High Commissioner for Refugees, as of 2021, an estimated 82.4 million people worldwide have been forced to leave their homes (UN, 2021a). The largest group of these persons, estimated at 48 million, do not cross borders and are known as internally displaced people (UN, 2021b). Internally displaced people are those who have been forced from their

homes but have not crossed a border to find safety. The second-largest group, at 26.4 million, is refugees (UN, 2021b). Refugees are individuals who have crossed borders and are legally recognized as requiring state protection. Lastly, at 4.1 million, the smallest group are asylum seekers who cross state borders seeking protection but have not been awarded refugee status for various reasons (UN, 2021b). Broadly, asylum seekers and refugees are stateless persons without nationality who lack access to fundamental human rights, including employment, freedom of movement, education, and healthcare (UNHCR, 2021a; UNHCR, 2021b). The United Nations *Convention and Protocol Relating to the Status of Refugees* (will be referred to as the Convention) is the international legal framework by which persons requiring protection are defined and afforded rights as refugees. The UN Convention defines a refugee as someone who, "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, unwilling to return to it" (UN, 2010, Article 1, Section A, Paragraph 2). The UN Convention defines refugees and broadly outlines the rights of those seeking refuge and protection (such as asylum seekers). Those seeking refuge and awarded refugee protection are legally protected within the Convention through non-discrimination, non-penalization, and non-refoulement (forbids a country to return asylum seekers to a country where they would face persecution). In addition, the Convention outlines minimum standards for their treatment by a host state and compels the host state to extend the rights and privileges that citizens enjoy to refugees.

2.2 Asylum seekers' and refugees' rights to healthcare

The interpretation of the Convention varies from state to state. Some states apply the Convention only to those awarded refugee status, while others extend some rights and privileges to asylum seekers awaiting the determination of their claim for refugee protection (UNHCR, 2017). As a result, each nation has dealt differently with who is entitled to rights and what those rights mean regarding access to publicly accessible services like healthcare[5].

An asylum seekers' healthcare access varies because of ambiguity with the word "refugee" in the Convention. In the Convention, healthcare is addressed under Article 23, which asserts that "the Contracting States shall accord to refugees lawfully staying in their territory the same treatment with respect to public relief and assistance as is accorded to their nationals" (UN, 2010). The specific mention of "refugee" in Article 23 with no mention of the term asylum seeker has led some countries to adopt different laws to address this gap and remove ambiguity over whether the Convention was referring only to refugees or to refugees and asylum seekers. For example, the European Union has dealt with the issue of an asylum seeker's right to healthcare in its *Reception Condition Directive*, Article 19, Section 1, which affirms that member states "shall ensure that applicants receive necessary healthcare which shall include, at least, emergency care, and essential treatment of illness and of serious mental disorders" (EU, 2013). The *Reception Condition Directive* is coupled with Article 35 of the *European Union Charter of Fundamental Rights*, which states, "everyone has the right of access to preventive healthcare and right to benefit from medical treatment under the conditions established by national laws and practices" (EU, 2000). The broader term "everyone" in the *EU Charter of Fundamental Rights*

[5] It is not my intention to describe all the ways that nations have dealt with the issue of asylum seekers' right to healthcare (or more broadly a migrant's right), but rather to explain that variation exists by giving examples of how this issue has been dealt with in particular laws.

clarifies that member states are not supposed to deny healthcare and medical treatment access to anyone, citizen or non-citizen, including all categories of migrants. For nations outside of the European Union, it could be argued that all migrants (including asylum seekers) have rights guaranteed within the United Nations *Universal Declaration of Human Rights*, Article 25. The Declaration affirms everyone "has the right to a standard of living adequate for the health and well-being of himself and his family…" which includes healthcare in the event of sickness (U.N., 1948). Another international law that guarantees a right to healthcare for all migrants (including asylum seekers) is the United Nations *International Covenant on Economic, Social and Cultural Rights* (ICESCR), Article 12, Section 1. The *Covenant* affirms the "… right of everyone to the enjoyment of the highest attainable standard of physical and mental health…" (UN, 1966). However, only some nations have ratified these international human rights treaties like the Declaration and ICESCR. Many countries, including Canada, have not included and implemented these treaties within their domestic law (OHCHR, 2021; OHRC, n.d). As a result, healthcare entitlements for migrants, specifically asylum seekers, have significantly varied between countries, with full access to healthcare beyond emergency care only available in a few countries (OECD, 2018).

2.3 Asylum seekers' and refugees' barriers to healthcare

There are numerous barriers to accessing services for both asylum seekers and refugees. In practice, arrival in a country that provides asylum seekers and refugees with healthcare does not necessarily mean an immediate improvement in one's health status. The barriers for asylum seekers and refugees depend upon one's legal status. Asylum seekers, in particular, can face additional burdens if they do not fall under refugee protection laws until the state has resolved their claim for refugee status. As a result, the laws between countries are different and can result

in a difference in the experience of accessing healthcare and medical treatment. In addition, within any given nation, there is the possibility of inequality in the availability and accessibility of healthcare between citizens and non-citizens. A person's migration status can compound these barriers to the availability and accessibility of health services for non-citizens like asylum seekers and refugees (Chiarenza et al., 2019; Chuah et al., 2018). The persisting inequality of access means that asylum seekers, in particular, often face administrative and procedural barriers to accessing healthcare and medical treatment without a clear migration status or legal status. However, in countries whereby access to healthcare by all persons, regardless of their migration status, is a right under the law, other barriers can also prevent the utilization of medical services. These barriers include affordability, whereby an inability to pay for medical consultation can inhibit asylum seekers and refugees from seeking treatment in countries where they do not have access to government-sponsored health insurance (Hadgkiss & Renzaho, 2014; Koponen et al., 2014; Spike et al., 2011).

Differences in language and culture between health providers and patients can impede healthcare utilization by asylum seekers and refugees. To overcome the barriers to healthcare utilization, there is a need for translators and cultural interpreters to reduce misunderstandings by health professionals and bridge the gap between health providers and their patients regarding beliefs and traditions (Asgary & Segar, 2011; Bischoff & Denhaerynck, 2010; Chiarenza et al., 2019; Chuah et al., 2018; Szajna and Ward, 2015). Cultural and linguistic barriers which impede healthcare utilization by asylum seekers and refugees can be compounded by other factors, such as a lack of continuity of care. Asylum seekers and refugee patients often cannot present at clinics with reliable health information, face issues with long wait times, and lack access to comprehensive care beyond emergency and acute care (Asgary & Segar, 2011; Chiarenza et al.,

2019; Hadgkiss & Renzaho, 2014; O'Donnell et al., 2007). Asylum seekers and refugees also may lack knowledge of their entitlements and the available services, often preventing them from accessing healthcare or utilizing services. Limited knowledge regarding entitlements of public services is usually due to health service information not being in an easily accessible medium tailored for non-nationals. (Asgary & Segar, 2011; Chuah et al. 2018; Grant et al., 2015; Hadgkiss & Renzaho, 2014; Lee et al., 2013). In countries that provide access to healthcare, there is often insufficient support or availability of specialized services for refugees and asylum seekers. Specialized services that tend to be lacking include psychological support to help those with traumatic experiences and much-needed culturally appropriate sexual/reproductive health services to address knowledge gaps, foster trust, and improve maternal outcomes (Chiarenza et al., 2019; Lebano et al., 2020; Sudbury & Robinson, 2016).

Asylum seekers and refugee patients can also face stigma and discrimination when seeking medical services from health providers. In seeking treatment, health providers may deny or offer poor-quality care based on a person's race or immigration status (Hadgkiss & Renzaho, 2014). For asylum seekers, who often do not have a clear migration status within a host country, they may fear that their lack of documentation or funds to pay for treatment could increase their risk of deportation or detention (Chiarenza et al., 2019; Hadgkiss & Renzaho, 2014). Such fears can contribute to asylum seekers not trusting health providers to keep their identity and presence in the country confidential (Asgary & Segar, 201; Hadgkiss & Renzaho, 2014; O'Donnell et al., 2007; O'Donnell et al., 2008). These negative experiences can impede individuals from seeking the medical treatment they need (Asgary & Segar, 2011; Hadgkiss & Renzaho, 2014; O'Donnell et al., 2007; O'Donnell et al., 2008;). Systemic barriers to healthcare that vary between countries

have led refugees and asylum seekers to delay treatment, resulting in deterioration of health and a likelihood of poor treatment outcomes the longer they wait (Chuah et al., 2018).

2.4 Health status of asylum seekers and refugees and the factors that contribute

Asylum seekers and refugees generally have poor health status compared to a host country's general population, and various factors contribute to this poor health status. A study conducted in Spain by Serre-Delcor and colleagues (2018) found that post-traumatic stress disorder (PTSD) is ten times more frequently diagnosed among refugees and asylum seekers than in the general population of their country of arrival. In addition to PTSD, asylum seekers and refugees in other European countries, such as Germany and Italy, have been found to have higher rates of depression, traumatization, anxiety, psychosis, paranoia, self-harm, sleep problems, and somatic complaints than the general population. Asylum seekers are three times more likely than the general population to seek help for a mental health problem (Kleinert et al., 2019; Lebano et al., 2020; Serre-Delcor et al., 2018). Research conducted by Kleinert and colleagues (2019) in Germany found that many asylum seekers and refugees are poorly vaccinated, leading to high rates of preventable diseases. In systematic reviews conducted by German and Italian researchers, other common ailments were identified, including respiratory infections, intestinal infections, sexually transmitted infections, skin infections, and parasitic infections (Hadgkiss & Renzaho et al., 2014; Russo et al., 2016). Due to their limited access to healthcare and treatment, asylum seekers and refugees are more likely to have non-communicable diseases exacerbated by legal, financial, and personal insecurity (Hadgkiss & Renzaho et al., 2014; Russo et al., 2016). Common non-communicable conditions, as documented in a study conducted in Spain, include respiratory problems, cardiovascular disease,

mental health or drug dependence, neurological problems, diabetes, dental, eye, and renal problems (Serre-Delcor et al., 2018).

Health status is further compounded by whether an individual is an asylum seeker or a refugee. Typically, asylum seekers are relatively more vulnerable than refugees (Hadgkiss & Renzo, 2014). They often move frequently and stay in unsafe locations without necessities such as food, medicine, and shelter, increasing their risk of infection (Hadgkiss & Renzo, 2014). In addition, asylum seekers' migration status is unclear in the countries they arrive or transit through, limiting their ability to access various services (Hadgkiss & Renzo, 2014). As a result, according to two German studies conducted by Hadgkiss & Renzo (2014) and Klienert and colleagues (2019), asylum seekers are more frequently diagnosed under all categories of the International Classification of Diseases (ICD)-10 than refugees. In other words, with such a high prevalence of illness, asylum seekers' health status is poor compared to the refugees requiring a greater need for medical treatment. According to Hadgkiss and Renzo, even when asylum seekers can access services in countries like the United Kingdom, Australia, and Switzerland, they are documented to have nearly double the rate of primary care attendance compared to the general population (Hadgkiss & Renzo, 2014). Such high rates of primary care attendance have been linked to the hardships of the migration process, which can harm an asylum seeker's health (Klienert et al., 2019).

A study conducted in Malaysia identified these three distinct migration phases that asylum seekers can face. During the pre-departure phase, health problems are due to exposure to violence, inadequate nutrition, psychological trauma, poor access to healthcare due to physical barriers, persecution/discrimination, and poverty. In the travel phase, where a person undertakes precarious and dangerous routes to flee, individuals may experience inadequate nutrition, poor

shelter/sanitation/hygiene, interpersonal violence, psychological trauma, and no access to medical care for a long time leading to high morbidity and mortality. Lastly, in the arrival phase, where the pre-departure and travel phases have often led to unfavourable outcomes, individuals may experience infections, non-communicable diseases, and psychological disorders (Chuah et al., 2018). In addition, asylum seekers, unlike refugees, are not likely to have the increased security afforded by a clear legal migration status, which many refugees have in various countries that entitles them to services and public relief. The model presented in the Malaysian study is one possible model that could also explain some of the differences that have been identified previously between asylum seekers and refugees. Studies in Spain and Germany have determined that an asylum seeker's hardship experience may be more extended than a refugee's. The result is that asylum seekers are more vulnerable to illness than refugees or other migrant groups (Hadgkiss & Renzaho, 2014; Kleinart et al., 2019; Serre-Delcor et al., 2018).

Asylum seekers and refugee women and children are more likely to have poor health status when compared to their adult male counterparts. Asylum seeker women are documented in the Netherlands and Switzerland to have a complex range of gynecological and obstetrical issues that could lead to severe acute maternal morbidity (Goosen et al., 2009). In addition, these asylum-seeking women are more likely than the general population to have experienced sexual assault leading to higher rates of unwanted pregnancies and induced abortions (Goosen et al., 2009; Kurth et al., 2010). Children are another group among asylum seekers and refugees in Europe documented to have a higher prevalence of ill health due to viral/bacterial/parasitic infections, malnutrition, and poor mental health due to insecurity, trafficking, violence, and sexual exploitation (Lebano et al., 2020; Pavlopoulou et al., 2017).

Lastly, in Europe and South Asia, the health status of all asylum seekers is documented to be aggravated by several migration factors, such as their confinement in detention centers upon arrival (Chuah et al., 2018; Lebano et al., 2020). Confinement in a detention center can mean exposure to cold or heat, overcrowding, malnourishment, high stress, the spread of infectious diseases, and a lack of access to medical care (Chuah et al., 2018; Lebano et al., 2020). These factors are likely to result in a deterioration of the health status of asylum seekers and increase the need for medical treatment the longer asylum seekers are held in detention facilities.

2.5 The asylum seeker and refugee rights and health experience in Canada

In 2019, Canada received 58,378 new claims for refugee protection by asylum seekers. When added to previous claims still pending refugee status determination, the total number of asylum seekers at the end of 2019 was 87,270 (Government of Canada, 2021). In the same year, Canada resettled 9,951 Government Assisted Refugees (GAR) and 19,143 Privately Sponsored Refugees (PSR) (Government of Canada, 2021). It is important to note that GARs are persons who are outside Canada but recognized as Convention refugees and who receive financial and other support from the Government of Canada or the Province of Quebec for one year upon arriving in Canada. Whereas PSRs are persons who are outside Canada but recognized as Convention refugees and who received financial and other support from a group of volunteers for one year upon arriving in Canada. In Canada, the number of asylum seekers who arrive to claim refugee protection is often greater than the number of refugees resettled from abroad (Government of Canada, 2021). Legally, both asylum seekers and refugees within Canada are under the responsibility of Immigration, Refugee and Citizenship Canada (IRCC). The Immigration and Refugee Protection Act (IRPA) outlines their rights and protections. The IRPA

governs all matters relating to immigration and border security. The IRPA also broadly defines a refugee and the rights and protections they may receive within the country.

While refugees' rights and privileges are clearly defined, asylum seekers, by contrast, do not have such precision regarding their status in Canada. Like many other countries, asylum seekers must claim refuge and protection when they arrive in Canada. The claim is then evaluated and decided upon by immigration officials. This responsibility falls to the Immigration and Refugee Board (IRB) in Canada's case (Gagnon, 2002). Once asylum seekers have claimed refugee protection, they become known as *refugee claimants*[6] in Canada until immigration officials make a final decision[7] (Gagnon, 2002). This period between making a claim and the final decision is precarious for refugee claimants. They have limits on their entitlements to public and private services and resources (Tuck et al., 2019). In contrast, GARs and PSR refugees receive housing, income support, and dedicated settlement support within the community (Tuck et al., 2019). Refugee claimants may apply for a work or study permit but are not entitled to receive the same assistance as GARs and PSRs (Tuck et al., 2019). However, all three groups – GAR, PSR, and refugee claimants -- are provided temporary health coverage through the Interim Federal Health Program (Tuck et al., 2019).

As mentioned briefly in Chapter 1, the IFHP's origins can be traced to the period following the Second World War, when the program was initiated as a temporary charitable humanitarian relief program for economic migrants from Europe to Canada. In 1946, the Department of Labour paid hospital and medical expenses for specific migrant groups. The

[6] As mentioned in section 2.1, *refugee claimant* is a term that may not be used in other states, where even after making a claim an asylum seeker may still be defined as an asylum seeker until their case as been resolved.
[7] For the remainder of this thesis I will use the term *asylum seeker* to denote someone who has yet to claim refugee protection and the term *refugee claimant* to denote someone who has made a claim for refugee protection but awaits the government's decision regarding their case.

Department accepted that such an aide was needed as these groups could not pay or give acceptable assurance for payment of medical services (Dhand & Diab, 2015; Government of Canada,1946; Toussaint v. Canada, 2010, para 33). Between 1949 and 1952, authorization was broadened by the Deputy Minister of Immigration. Medical, dental, hospital and any incidental expenses were included under this expanded authorization for nearly all immigrants who lacked financial resources when a person had become suddenly ill, but only after being admitted to Canada and before arriving at their final place of employment (Dhand & Diab, 2015; Government of Canada, 1949; Government of Canada, 1952; Toussaint v Canada, 2010, para 34). Following the movement of many Hungarian refugees into Canada in 1956, discretionary *Order in Council* PC, 157-11/848 was introduced, which transferred authority for the program from the Department of Citizenship and Immigration to the Department of National Health and Welfare under the Immigration Medical Services branch (Dhand & Diab, 2015; Government of Canada, 1957; Toussaint v. Canada, 2010, paragraph 36). During the subsequent decades, the Immigrant Medical Services program began to narrow in scope regarding who was covered. The program shifted and limited its coverage from migrants unable to cover medical expenses to persons in need of protection (such as refugees and asylum seekers) following the adoption of public healthcare under the Canada Health Act in 1985 (Dhand & Diab, 2015; Toussaint v Canada, 2010). By the mid-1990s, responsibility for the program was transferred back from the Department of National Health and Welfare to the Department of Canadian Employment and Immigration (precursor to Immigration, Refugees, and Citizenship Canada). After this responsibility transfer, the program was renamed the Interim Federal Health Program (Dhand & Diab, 2015). The IFHP remains under the discretion of IRCC officials without parliamentary oversight.

The IFHP is the government's latest incarnation (since the 1990s) of the Immigration Medical Services program. It provides access to Canada's healthcare system and provides healthcare insurance for protected persons (refugees), refugee claimants, and other humanitarian groups (designated by the minister) (Dhand and Diab, 2015). However, the IFHP is meant to be temporary and fill a gap for refugees until they can receive provincial welfare relief and, for refugee claimants, until their case has been decided (Toussaint v. Canada, 2010). The program is limited to essential health services for treating and preventing severe medical conditions, urgent dental and vision care, and services from allied healthcare practitioners such as psychologists, which are subject to pre-approval. Coverage of prescription medication, assistive devices, medical supplies, and equipment is also subject to plan formularies and maximum dollar limits (Canada, 2021b). In essence, the insurance coverage the program provides is similar to what individuals on provincial/territorial public relief programs receive. Government-assisted and privately sponsored refugees are enrolled in the program upon their arrival in Canada with the help of publicly funded settlement support services (Dhand and Diab, 2015).

Asylum seekers must first take several steps before receiving access to the IFHP. First, an asylum seeker must claim refugee protection. Second, an asylum seeker must wait to receive a notification on their eligibility to claim refugee protection. Third, once they have received their eligibility notice, they become a refugee claimant. Fourth, refugee claimants must apply for the program independently and have their eligibility assessed, which depends upon a demonstrated lack of funds evaluated by an immigration official. As a result, the financial assessment only occurs after a claim for refugee protection has been made. Unlike government-assisted refugees and privately sponsored refugees, refugee claimants face variable uncertainty. The time between

these steps varies the length of time that a person who has claimed refugee protection has no health insurance (Gagnon, 2002; Somos, 2021).

Coverage by the IFHP does not mean easy access for beneficiaries; individual experiences vary, depending upon several factors. According to a review by Patil et al. (2015) and a subsequent review by Hansen et al. (2016), relatively few studies have researched refugees' and refugee claimants' health and healthcare needs in Canada compared to other populations. The research indicates systemic barriers to healthcare access by IFHP recipients due to an informal two-tiered healthcare system (Edge and Newbold, 2013). According to Campbell and colleagues (2014), this informal two-tiered health system consists of a system for citizens and one system for immigrants (including refugees, asylum seekers, refugee claimants, economic migrants and others). For immigrants, the healthcare system lacks resources and services due to many provinces not believing it is their responsibility to widely fund tailored services like translation which is crucial in treatment (Campbell et al., 2014; McKeary & Newbold, 2010). The lack of services for immigrants is compounded by a lack of training and knowledge among health providers regarding the social/cultural complexities of care for these populations (Campbell et al., 2014; McKeary & Newbold, 2010).

These problems are compounded for IFHP recipients as they bring complex health needs, linguistic challenges, and a complex insurance scheme (outside provincial/territorial healthcare systems). Other problems accessing healthcare for IFHP beneficiaries include a lack of appropriate information about accessing services, their insurance eligibility, and what medications are available (Campbell et al., 2014; Gagnon, 2002; McKeary & Newbold, 2010). Studies by Newbold and Colleagues conducted with refugees, refugee claimants and health service providers have documented an “unwillingness” by health services providers to provide

healthcare services to those covered by the IFHP (Edge & Newbold, 2013; McKeary & Newbold, 2010; Newbold & McKeary, 2018). The reported lack of unwillingness is due to several factors. The IFHP operates within a bureaucracy that delays payment to health service providers as expense claims are made to the federal government instead of provincial/territorial healthcare programs (Gagnon, 2002; McKeary & Newbold, 2010). Many of these expense claims require pre-approval for services and procedures, and the compensation is often lower than what is paid under provincial/territorial healthcare plans (Gagnon, 2002; McKeary & Newbold, 2010). As a result, the IFHP has been confusing and burdensome for both patients and providers (Campbell et al., 2014; Gagnon, 2002; McKeary & Newbold, 2010). A research study and review conducted by Chase and colleagues (2017) documented the persistent discrepancies in service, differences between provincial /territorial and federal insurance coverage, and the complexities of care have led the researchers to report discrimination by clinic and hospital staff and health professionals towards those with IFHP coverage. These systemic barriers affect the health status of IFHP beneficiaries and long-term health outcomes (Chase et al., 2017).

The healthcare system's systemic barriers manifest in a lack of continuity of care for IFHP recipients (Edge & Newbold, 2013). The lack of continuity of care is due to a high turnover frequency among health service providers (Edge & Newbold, 2013). As mentioned, many health providers are reluctant to accept patients without provincial/territorial health insurance as they are unfamiliar with the federal insurance plan and its operation (Gagnon, 2002; McKeary & Newbold, 2010). What often occurs amongst IFHP recipients is an increased utilization of walk-in clinics and emergency departments and an experience of disjointed care and record-keeping (Edge & Newbold, 2013). In their literature review, Edge and Newbold (2013) found that these negative experiences of disjointed care can result in IFHP recipients

being discouraged from seeking health and medical services. These findings were supported by Chase and colleagues (2017) in their research with refugee claimants in Montreal. That study found that refugee claimants' experience of accessing healthcare was inconsistent over time and often varied from person to person. Such experience was attributed to the variable understanding of what services patients were eligible for under the IFHP. This inconsistency was due to incorrect information being spread amongst IFHP recipients and the incorrect information received from health providers. Health providers were often found to be unwilling to learn about or navigate the IFHP. For refugee claimants, the uncertainty about their entitlements for healthcare coverage often resulted in disengagement and abandonment of help-seeking efforts and an unwillingness to self-advocate regarding their entitlements. Lastly, in a study by Tuck and colleagues (2019), the healthcare needs of refugees (including refugee claimants) remain unmet at a higher rate than the general population and other immigrant groups, such as permanent residents. For refugee claimants specifically, these unmet needs are coupled with additional stressors. These stressors include precarious immigration status, lack of income security, psychological distress due to financial/legal insecurity, feelings of social exclusion, and a lack of support, leading to greater gaps in obtaining treatment for illness and disease (Chase et al. 2017). The result is a negative impact on health that can lead to mental health problems and a decline in physical health over time in Canada (Maximova & Krahn, 2010; Newbold & McKeary, 2018).

2.6 The 2012 Canadian refugee healthcare policy amendments

In 2012, the federal government introduced an array of immigration policy reforms. The policy reforms were promoted as necessary to make the refugee system "faster and fairer" by protecting it from illegitimate refugee claims (Government of Canada, 2012c). The goal was to protect Canada's welfare system, save tax dollars, and actively prevent successful claims by what

the government believed were bogus refugee claimants (Government of Canada, 2012c). Crucial to these policy changes was the *Protecting Canada's Immigration System Act* of 2012*,* which introduced a multi-tiered refugee protection system with various refugee claimant statuses for asylum seekers who arrived and claimed refugee protection. As a result, asylum seekers were subject to different treatment based on their country of origin and mode of arrival in Canada (Government of Canada, 2012d). The federal government repealed the 1957 *Order in Council* PC 157-11/848, the basis for the IFHP. It replaced the 1957 *Order in Council* on June 30, 2012, with the *Order Respecting the Interim Federal Health Program.* The IFHP amendments and budgetary cuts developed under the assertion that such actions were necessary to save taxpayers millions of dollars and protect healthcare for Canadians (Government of Canada, 2012e). This new *Order* limited refugee claimants' coverage and access to healthcare. Coverage and access depended upon a claimant's status within the multi-tiered refugee protection system (Dhand & Diab, 2015). The amended IFHP targeted asylum seekers from countries designated as safe and thus judged unlikely to produce genuine refugee protection claims (Dhand & Diab, 2015). These Designated Country of Origin (DCO) refugee claimants were no longer entitled to healthcare coverage for primary care services or medications (Dhand & Diab, 2015). IFHP coverage following 2012 varied depending on whether a refugee claimant was designated as *genuine*, from a *designated country of origin*, had withdrawn/abandoned their claim, or immigration officials found their claim unfounded (Dhand & Diab, 2015; Government of Canada, 2012e). The result was a health insurance policy offering increasing coverage levels based on an immigration official's judgement on how *genuine* a refugee claim is.

Opposition to the IFHP reform was swift and persistent (Harris & Zuberi, 2015). An unprecedented level of direct activism and advocacy came from groups that worked directly with

asylum seekers, refugee claimants and refugees. Doctors, allied health professionals, lawyers, and settlement service providers participated in direct and indirect activism (Harris & Zuberi, 2015). In response to the opposition by professionals such as doctors and lawyers, the public gained a greater awareness of the amendments and what they meant for them and the healthcare system. On one side was the federal government, and on the other was a coalition of allied providers who served the refugee community. Within academic institutions, studies began to document the costs and impact of the IFHP reforms on service providers and various groups of refugees and refugee claimants across the country (Barnes, 2012; Campbell et al., 2014; Evans et al., 2014, Harris & Zuberi, 2015; Jackson 2014; Marwah 2014; Ruiz-Casares et al. 2016). Among select provincial governments, services and health insurance were temporarily expanded to provide temporary relief to refugee claimants to close the gap left by the amended IFHP. At the same time, these same provincial governments pressured the federal government to repeal the policy changes to the IFHP. These provincial governments argued that the gaps created by the amended IFHP had created a financial burden upon hospitals and other centers of care that could not recover medical expenses due to the reformed insurance scheme (Evans et al., 2014).

Meanwhile, on February 25, 2013, a charter challenge was launched by the Canadian Doctors for Refugee Care and the Canadian Association for Refugee Lawyers within the Federal Court of Canada (Harris & Zuberi, 2015). Despite these two advocacy groups winning the case in 2014, the government resisted the court's ruling to reinstate the pre-2012 IFHP. Instead, in November 2014, the government pursued an appeal and implementation of an even more complicated IFHP insurance compensation formula. The temporary IFHP of 2014 added additional categories of coverage for refugee claimant recipients depending upon their status, further complicating access to health services and eligibility for reimbursement. It was not until

the election of a new federal government at the end of 2015 that the government dropped the appeal. By April 1, 2016, the IFHP was reinstated to the pre-2012 level (Antonipillai et al., 2017).

2.7 Scholarly critiques of the 2012 interim federal health program amendments

The 2012 Interim Federal Reforms, and their effects, led to the rise of vocal opposition and led to research on refugee health policy with a greater frequency than in the decades prior (Harris & Zuberi, 2015). In previous work, I examined the discourses and the power relations between citizens and non-citizens that contributed to the social construction of the *bogus refugee* that informed the 2012 IFHP amendments (Olsen et al., 2014). Harris & Zuberi (2015) chose to unpack the problematic rhetoric and discourses present between 2012 and 2015 that ultimately framed the debate surrounding refugee health policy reform. Some researchers utilized post-structuralist, constructivist, and critical theory to uncover the discursive, subjective, and lived effects of the IFHP amendments. For example, Connoy (2018, 2020) uses the concept of irregularity (i.e., not having a secure legal status in a country) to explain how presence within social space is problematized in everyday healthcare places, resulting in IFHP recipients being denied access to services regardless of their actual coverage. Beatson (2016) alternatively utilized frame theory to analyze the debate between supporters and opponents of the 2012 amendments, concluding that framing asylum seekers as either "bogus" or "victims" obscured any arguments about substantial and guaranteed access to healthcare. Villegas & Blower (2019) employed boundary work to examine "deservingness frames" to understand how social exclusion operated within different categories of non-citizenship during the policy amendment period.

Several studies focused on the amendments themselves within the immigration policy landscape. First, Dhand & Diab (2015) examined the court case brought by Canadian Doctors for

Refugee Care and the Canadian Association for Refugee Lawyers against the federal government, questioning whether the IFHP amendments violated Canadian law. They concluded that facets in the case present a compelling reason for Canada to meet international obligations regarding a positive duty to provide healthcare to refugees (including asylum seekers). Second, Sheridan and Shankardass (2015) evaluated governance structures and processes at the federal level and concluded that the IFHP amendments were a failure in policy decision-making due to the non-incorporation of evidence-based knowledge when defining the policy problem within a policy development stage. Third, Chen (2017) examined how positioning precarious-status migrants like refugee claimants relative to other migrant groups within the immigration policy have resulted in their insecurity and limited right to healthcare as guaranteed by international law. Fourth, Holtzer and colleagues (2017) examined how policy concepts could be utilized to evaluate controversial policy decisions like the IFHP amendments. Lastly, Antonipillai and colleagues (2018) compared the temporary 2014 IFHP reforms to the original 2012 amendments. They concluded that Canada's refugee policies have transformed from providing humanitarian relief to embracing "other" policies and excluding refugees from fundamental rights.

Each of these studies lacked a connection with the historical factors that shaped the problem of refugee healthcare in Canada. The 2012 amendments are a beginning point for these researchers in terms of a dramatic shift in Canada's approach to addressing the problem of refugee healthcare. What is missing is the connection between the IFHP, its roots in immigration policy, and an analysis of how the IFHP amendments emerged out of the intersection of political, historical, and cultural interests to create the problem of refugee healthcare.

2.8 Rationale for the study

This thesis aims to reflect upon the 2012 amendments concerning the prior decades of policy development to understand how and why refugee claimants in Canada remain without a guaranteed right to access healthcare. This critique of the policy problems contained in the 2012 amendments and their place within policy history uncovers the power struggles and political conflicts that shape the discursive conditions for the development and operationalization of public policy. Such critique challenges policy which prevents refugee claimants from being able to enact their universal right to access healthcare in Canada and paves the way to alternatively represent the problem of refugee healthcare and how it may be approached through policy.

2.9 Chapter summary

This chapter introduced the commonly used terms such as refugee, refugee claimant, and asylum seeker and explained how they are used inconsistently in the research literature. I explain that the United Nations Convention is the basis for how asylum seekers are legally differentiated from refugees. I discussed how the lack of a UN Convention status means that asylum seekers are subject to different healthcare entitlements between different countries. Even with entitlements in place, asylum seekers and refugees still have multiple barriers to accessing medical treatment. I delineated how, internationally, the health status of asylum seekers and refugees varies and is dependent upon various factors such as migration experience and legal status. I then narrowed the focus to the Canadian system and introduced the distinction between asylum seekers and refugee claimants in Canada. I outlined the history of the IFHP and discussed how the nature of Canada's publicly funded healthcare system creates an informal two-tiered system, one for citizens and one for immigrants. I reviewed the literature that presents evidence that IFHP recipients experience systemic barriers in accessing healthcare. Lastly, I introduced the

2012 IFHP amendments. I discussed the opposition to the amendments by professionals working with refugee claimants and presented the available scholarly critiques. I concluded that existing studies lack a critical examination of the historical factors that shaped the *problem* of refugee healthcare and led to the 2012 amendments. I argue that such a critical examination is needed to challenge policy which prevents refugee claimants from being able to enact their universal right to access healthcare in Canada and paves the way to alternatively represent the *problem* and how it may be approached differently through policy. This thesis aims to analyze how and why refugee claimants in Canada remain without a guaranteed right to access healthcare and how the policy *problem*[8] of refugee claimant healthcare emerged out of the intersection of political, historical, and cultural interests.

In the next chapter, I explain my research methodology in policy analysis. I am specifically concerned with the underlying meanings contained within refugee healthcare policy and how such policies construct the *problem* of refugee healthcare. I explain my use of interpretive and critical discourse analysis to interrogate and interpret the policies I examine. I introduce the method I employ, Bacchi's (2009) "What is the Problem Represented to be?" (WPR). I explain how the WPR method examines how a policy *problem* has been questioned, analyzed, classified and regulated across specific times and circumstances to make visible the politics that operate to shape the reality and patterns of deep-seated ways of thinking about a *problem*. I discuss how I collected my data for my analysis, walk the reader through a WPR approach to data, present the

[8] The key terms *problem* and *problem representation* in this thesis are italicized here to emphasise their usage as methodological terms within this thesis. This distinction of the terms from their everyday usage is important. It draws attention to how the problem indicated is not objectively a "problem," but rather is something constructed as a problem by policy makers, which I am scrutinizing. However these terms will not be italicized further from this point on for reasons of readability.

limitations of my approach to the research topic, and provide an outline of the subsequent chapters of my analysis.

Chapter 3: Methodology

This chapter outlines the methodology I utilize to examine this problem. First, I provide a broad explanation of my approach to policy analysis, an approach that is concerned with social discourse and its role in the construction of policy. This approach lets us see how policies result from the power relations between stakeholders who inform the policy's creation, adoption, and interpretation. I detail how my approach utilizes both interpretative and critical approaches to policy analysis. I also introduce how I use discourse analysis to interrogate and interpret policy. I present the analysis method I employ, Bacchi's (2009) *What's the Problem Represented to be?* (WPR). I explain how the WPR method examines a policy as a problem that is questioned, analyzed, classified, and regulated across circumstances. The approach to analysis within the WPR method seeks to make visible the politics that operate to shape the ways of thinking about the problem under consideration. I explain the specific steps I used for my data collection within the WPR method, and I conclude the chapter by discussing the limitations of my research method and what this means for my study.

3.1 Research Methodology

The examination of policy formation and its adoption falls within the research field of policy analysis. Policy analysis is an evolving multidisciplinary inquiry that aims to create, critique, and transfer policy-relevant information. Policy analysis has three main traditions: traditionalist, interpretive, and critical (Dunn, 2015). The traditionalist approach sees policy as an instrument of problem-solving, the interpretive approach focuses on the meanings around and context of the problem under consideration, and the critical approach sees policy as a method of social control.

The dominant tradition is the traditionalist or rationalist approach, which draws upon quantitative social science methods, theories, and "substantial" findings to solve practical problems (Dunn, 2015). The traditionalist views policy analysis as a tool to provide objective and value-free solutions to problems that benefit the general population and act as a stage to legitimize policy (Blackmore & Lauder, 2015; Goodwin, 2011).

By contrast, the interpretive approach utilizes qualitative methods that focus on language meaning within policy text. According to Yanow "Interpretivism" presupposes that we live in a social world characterized by multiple interpretations(1999). Policy within the interpretive approach is the manifestation of the motives of stakeholders who participate in policy construction and application (Yanow, 1999). Interpretivism argues a policy is never free of the interpretations and representations of the policymakers. According to Interpretivists, a policy is also subject to the different interpretations made by a reader based upon their social class and power in relation to other groups (Ball, 1993). However, although a policy reader can have an individualistic and independent narration of the problem contained within a policy, the reader is hindered from offering an alternative solution to that problem. This inability to offer an alternative solution is due to the reader being constrained by the framework of interpretation and representation that the policymaker has established. Within the interpretative approach, the constraints upon alternative solutions within the policy-setting demonstrate the inequality of power relations between groups (Blackmore & Lauder, 2005).

The third main tradition within policy analysis is the critical approach. The critical approach critiques the dominant rationalist tradition of policy neutrality, objectivity, and generalization. Instead, critical policy analysts utilizing qualitative methods argue from a social control perspective that policy is a tool the government uses to exert influence and control over

some aspects of social life. Such policy tools result from negotiating and contesting interests amongst stakeholders within unequal power relations (Blackmore & Lauder, 2005). Research interests within the critical approach lie in these unequal power relations that increase inequalities between social classes, genders, and ethnicities. According to critical analysts, the government is just one party amongst multiple stakeholders whose interests lie in pursuing their political agenda. The critical approach interrogates the interest of the government and stakeholders and their role in the formation of policy (Dunn, 2015).

The interpretative and critical policy analysis approaches commonly interrogate and interpret policy using discourse analysis. When interpretive and critical approaches rely on Foucauldian (Foucault & Rabinow, 2010) discourse theory, a policy is the product of socially constructed meanings and knowledge. According to Foucauldian discourse theory, constructed meanings and knowledge subject actors to an interconnected web of power relations between individuals. The interconnected web of power relations determines what can be said and thought and where and with what authority a person can speak (Ball, 1993). The way people communicate about things and social organization helps shape how we think and are knowledgeable at any point in time and is known as discourse. Such discourse contributes to predetermining outcomes within the policy context. Discourse analysis, especially critical discourse analysis, questions the discursive assumptions of policy to understand the meaning and knowledge logic behind a policy to highlight important thoughts or perspectives not considered within a policy framework (Fairclough, 2001). In this way, discourse analysis interrogates the constructions of meaning and knowledge to provide insight into how a discourse was adopted and produced (Ball, 1993; Goodwin, 2011). This interrogation allows for considering alternative frameworks for a policy problem because a policy is no longer a solution developed to address a

specific problem. Instead, within the discursive analysis approach, the policy creates the problem the policy addresses. The construction of a policy discourse involves various actors with unequal power relations whose self-interests negotiate, influence, and compete against each other for relevance (Goodwin, 2011). Each actor with a diverse and unique social, political, and economic perspective affects the framing of a policy problem and the solution proposed within the policy. The problem presented in a policy is no longer considered value-free within discourse analysis.

Interpretive and critical approaches are in contrast to the dominant traditionalist approach to policy development, where a policy problem is seen as objective and value-free. In traditionalist approaches, the normative space limits debate by enforcing the impression that the best solution is within a policy proposal (Bacchi, 1999). Discourse analysis within interpretative and critical traditions, however, shifts analysis away from accepting a given policy problem as value-free toward analyzing the problem as a representation of policy discourses with the goal of questioning and challenging the underlying assumptions that support it (Bacchi, 1999; Bacchi, 2009; Goodwin, 2011).

For this thesis, a critical interpretive discourse analysis is an appropriate approach, as it allows for the challenge and contestation of discourse within a policy. Foucault and his discourse analysis approach (Foucault & Rabinow, 2010) fall within the poststructuralist movement (described below), which encourages researchers to challenge accepted "truths" and "knowledge." The Foucauldian discourse analysis approach focuses on understanding the production of meaning and analyzing what discourses underpin policy. The objective is to challenge the naturalness with which policy depicts a problem. In many ways, it is like constructionist approaches, which view knowledge as actively made by people. Foucault's *Theory of Discourse* (Foucault, 1972), Laclau and Mouffe's *Theory of Discourse and Hegemony*

(Laclau & Mouffe, 1985), and Faircloughs *Critical Discourse Analysis* (Fairclough, 1995) share the same view of language as the medium to produce meaning in discourse. Each analysis positions actors within unequal power relations who construct and change the social and political landscape (Phillips & Jorgensen, 2002). However, differences exist between poststructuralists and constructionists, especially in their underlying theoretical foundations, aims, and methods. Despite these differences, they share the same premises for an analysis. Knowledge is a product of discourse and should be suspect and interrogated (Ball, 1993). Knowledge is bound by language, which imposes limits on thoughts, speeches, and the consideration of other possibilities. The meaning derived from knowledge in a discourse comes not only from language but historical and cultural perspectives, institutional practices, and power relations between social actors, which are shaped discursively through the production and ownership of knowledge (Phillips & Jorgensen, 2002). Government policy is like discourse; it shapes the social world into dichotomies of problems and solutions and is reinforced through policy frameworks that construct concepts, categories, distinctions, and subject positions. The knowledge created within these policy frameworks in turn produces knowledge that provides legitimacy for normative government statements, judgements, and truth claims which has led some researchers like Goodwin (2011) to describe policy as discourse.

Researchers like Graham (2005) claim that historically clarity has been lacking in turning discourse theory and analysis into a method that can be used systematically on policy and that discourse theory contains no suggestions for a method. According to Graham (2005), the lack of systematic methods was due to some practitioners within the social constructionist movement suggesting that adopting a prescribed method would constrain thoughts and the generation of alternative perspectives. However, the growth of interest in discourse analysis in the policy field

led to the development of various methods. Glynos and colleagues (2009) describe three methodological techniques for studying discourse. Political Discourse Theory (PDT), Rhetorical Political Analysis (RPA), and Discourse Historical Analysis (DHA), which is a type of Critical Discourse Analysis. PDT stems from the work of Laclau and Mouffe (1985) and takes a logics approach to capturing the purpose, rules, and ontological presuppositions of a policy by assuming the objects of study are constructed and not a natural phenomenon (Glynos et al., 2009). PDT lacks an analysis of the historical underpinnings of the problem identified in the policy. Alternatively, RPA focuses specifically on describing the nature and character of rhetoric to analyze the "intersubjective", "dynamic formation" and "reformation" of arguments and the elements of which they are composed (Glynos et al. 2009). However, while it does examine the historical "genealogies" of "common sense" meanings, it is concerned with understanding to reduce argumentation rather than exposing or critiquing these meanings (Finlayson, 2007). Lastly, DHA is a type of Critical Discourse Analysis (Fairclough, 1995) developed in response to the critique of the latter's lack of interest in the influence of social structures on the discursive structures that are identified in the text the researcher analyzes. DHA draws attention to this interaction and how discourse is conceptualized historically. Rather than just explaining, DHA engages in critique to discover contradictions, paradoxes and dilemmas in the text or discourse (Glynos et al., 2009). The drawback of DHA is that there is no iron rule by which texts are selected or data is gathered or steps on how to engage texts once selected (Glynos et al. 2009). Each of the three listed approaches' drawbacks would result in an analysis of the problem of refugee claimant healthcare that does not meet this thesis's goals.

Carol Bacchi's (2009) *What is the Problem Represented to be?* or WPR approach is an alternative to the three approaches described above. Bacchi's method resolves many of the

limitations present in the PDT, RPA, and DHA methods as it concerns itself with problematizing a policy problem through discursively analyzing and critiquing its historical underpinnings, exposing and critiquing the "common sense" discursive meanings in policy, and providing a systemic deductive approach to breaking down a policy problem.

3.2 Positionality statement

Bacchi (2009) encourages researchers to engage in self-reflexivity. She notes that we are all located within historically and culturally entrenched forms of knowledge, and we need to subject our ways of thinking to the same critical scrutiny to which we subject our object of study (p.19). Her WPR method dictates that a seventh step in the discourse analysis should involve a robust and introspective account of this self-reflexivity. Before presenting the findings, and in this spirit of self-reflexivity, I acknowledge my position as an educated white Canadian who has never directly experienced the realities of seeking asylum and protection within Canada or any other nation that offers refugee protection. My earliest ancestors arrived in 1773 on the ship Hector from Scotland and settled in the town of Pictou, Nova Scotia. Many of them became farmers, and their descendants have entered a variety of skilled and unskilled professions, with hardships that do not compare to the experience of having to flee one's home and country.

It was during my undergraduate years that I first began volunteering with settlement organizations. That experience working with newcomers, including refugees and other migrant groups, has shaped my passion for social justice with respect to those who have been "othered." I witnessed the difficulties some experienced in accessing public services, specifically healthcare. I heard stories from friends and those I assisted about their challenging experiences and frustration with the lack of available avenues to voice their experiences to decision-makers. Their stories shaped my thinking and inspired my interest in activism. In particular, during those early

days of activism, I learned that government-sponsored and privately sponsored refugees have some form of government support among the various types of refugees. In contrast, such support is lacking for those seeking refugee status, such as refugee claimants.

By June 2012, following the completion of my undergraduate degree, broad federal policy changes to the immigration system had exacerbated problems with access to healthcare insurance for refugee claimants, who already had fewer supports than refugees. Various health and service professionals, community members who had personal connections to refugees, and volunteer resettlement workers – including me – became politically active. We protested what we saw as an abandonment of already marginalized individuals and the construction of a narrative that refugee claimants are cheaters who are putting an unfair burden on the healthcare system. The more I read, learned and participated in civic action against the federal policy changes, the more I became upset and motivated to learn about Canada's provision of healthcare to refugee claimants.

My experience with refugees and my past activism inevitably influenced the path I chose and shaped the direction that this thesis (and my graduate program in general) has taken. I am drawn to and shaped by the work of scholars who seek to confront the assumed naturalness of social, historical and ideological forces and structures that produce knowledge and constrain it. Indeed, this approach and its emphasis on understanding context drew me to Carol Bacchi's method.

In researching the topic of refugee claimant healthcare, I made decisions that have undoubtedly impacted my analysis. Within the project of a Master's thesis, the objective is to show that a candidate can work in a scholarly manner and is acquainted with the key issues by researching, analyzing, and drafting an extensive scholarly paper; the objective is not to produce

an exhaustive analysis. Thus, I had to make decisions about the scope of my topic, which contextual information to emphasize, and which to de-emphasize.

First, the topic of refugee claimants' access to healthcare could be vast. Many of the laws, policies, and regulations that impact refugee claimants also impact other resettled peoples, such as economic and family class migrants. However, I was specifically interested in critiquing the 2012 immigration policy reforms to the IFHP, and those reforms specifically targeted refugee claimants. The IFHP reforms did not directly affect government-assisted or privately sponsored refugees. However, the policy itself, along with other related policies, did affect these other groups. In order to narrow down to the IFHP reforms and their implications for the construction of refugee claimants, I also had to explicate this broader policy context briefly. That ongoing movement between drawing briefly on the broader context to explain the situation and keeping my gaze narrowly on the thesis topic of the IFHP reforms and refugee claimants was tricky to navigate. Eventually, I settled on a model of concentric circles of macro, meso and micro as a way to keep my focus narrow while also attending to the broader context. I no doubt left out contextual features that were important; perhaps didn't always do justice to the fulsomeness of the focus on the IFHP reforms.

A related decision along the way that impacted my analysis is that I left some aspects of policy unexamined. My Foucauldian archaeology of the policy events leading up to the 2012 policy reforms could have been much more robust – but I chose to limit the history to those events that most obviously shaped the IFHP amendments. Some contextual facts and history -- for example, much of the history that preceded the earliest adoption of the IFHP and much of the broader immigration history (e.g., the Chinese Immigration Act and other prejudicial policies) were explicitly excluded by me. These no doubt also shaped the development of the IFHP and

the construction of refugee claimants but would have made for too long of an analysis for this Master's thesis. I intentionally kept the scope of my inquiry narrowly focused on the IFHP history and its intersection with refugee claimants. In addition, the broader experiences of refugees and refugee claimants, in general, were also excluded, as I wanted to keep the emphasis as much as possible narrowed on the IFHP.

A third decision is that I did not introduce an analysis of the policy relative to critical race theory. As much as this topic lends itself to such a lens, and a critical race perspective would no doubt have made for a much more sophisticated analysis, doing so would have dramatically expanded the analysis to a scope that would be more appropriate for a doctorate dissertation where a broader demonstration of theoretical understanding and application is necessary.

Finally, as I reflect on my own positionality in relation to my subject matter, I wonder about my intentional use of the concept of the "bogus refugee" to critique the harmful way that the concept has been used in Canadian policy-making. The term "bogus" was used explicitly by the federal government (as will be discussed in later chapters) in press statements to de-legitimize refugee claimants to the public and support the reforms by emphasizing the idea that these individuals are morally problematic. The term "bogus" is a powerful and harmful symbol. It reduces the complexity of the experience of fleeing persecution and seeking asylum to a binary of legitimate and illegitimate and is used to justify restrictive policy amendments that target specific groups of individuals (a point that will become clearer in the analysis). In reflecting on the decision to highlight this term, I have considered whether my use of the term "bogus" might inadvertently perpetuate terminology that connotes refugee claimants as immoral. Ultimately, I stand by my intentional use of the term as a device for reinforcing that I am explicitly

challenging the harmful way that refugee claimants have been imagined and managed in government policy.

I acknowledge that this thesis would have been different if I had had a different life experience. My own personal positioning has shaped the assumptions and pre-suppositions I identified in my analysis. I came into this thesis with the assumption that there is a problem with refugee claimants' access to healthcare, that this problem is socially constructed, and that this particular construction of the problem has adverse social effects on refugee claimants.

3.3 Research method

To analyze how the policy problem of refugee claimant healthcare emerged out of the intersection of political, historical, and cultural interests, I have turned to a method that has been increasingly deployed within policy analysis by researchers, scholars, and students. Bacchi (2009) has developed a valuable framework for analyzing the discursive aspects of policy and policy problems. In her book *Analyzing Policy: What is the Problem Represented to be?* (WPR) she proposes a set of questions (presented later in this chapter) to guide analysis. WPR method draws upon four interrelated intellectual traditions: social construction theory, poststructuralism, feminist body theory, and governmentality studies (Bacchi & Goodwin, 2016; Goodwin, 2012).

The WPR method is a perfect fit for my thesis aim and subject matter. As an analytical tool, WPR facilitates the critical interrogation of public policies, commonly accepted categories, and other governing practices and techniques. WPR provides a way to think about how people are governed, how governing takes place, how people are produced as governed subjects within governing practices, and how there are implications for those governed. Falling between interpretative and critical approaches to policy analysis, WPR analyzes policy not from a problem-solving perspective common to traditionalist approaches but as a problem questioning

perspective found within Foucauldian post-structural theory. Bacchi presumes that within policy, "some problem representations benefit the members of some groups at the expense of others" (Bacchi, 2009, p.44). By taking the side of those who are harmed, the goal is to challenge a problem representation that has deleterious effects, with the aim not to find the "real problem" and the "right solution" but to interrogate how these *problem representations* have come about and how they have shaped the adopted policy solutions (Bacchi, 2012a, pp. 21-24). WPR analysis goes beyond the governance problems to embrace a broader conceptualization of politics that includes struggles around difference and identity where gender, sexuality, ethnicity, and race are problematized daily (Mottier, 2001, p.332).

Bacchi's WPR method revolves around her notion of problem representation, which is not to be confused with the term "problematization," even though the meaning is the same for her (2009, p.xii, xv). Problem representation refers to the problem contained in any policy or rule that appears explicitly or implicitly. Foucault, in his work, defined problematization as not meaning a representation of a pre-existing object. Instead, the representations are not imitations of an objective reality, but rather they are the result of practices through which a particular policy problem is constituted as real or existing; alternatively stated, policy problem representations are socially constructed forms of knowledge or discourse (Shapiro, 1988). In addition, *problem representations* are also productive as they affect "what is done or not done and how people live their lives" (Bacchi 2012b, p.22). Thus, the analysis within WPR falls upon problem-questioning instead of problem-solving. The WPR method challenges a researcher to reconstruct a problematization from a policy and its proposals. To examine a problem representation, a researcher must uncover what Foucault called "the unexamined ways of thinking" contained within a policy proposal(s) (Shapiro, 1988). The WPR method directs a researcher to examine a

problem representation and question whether it is indeed a problem or just the product of discourses that have constructed it as a problem. WPR analysis starts with policy and its proposals, questions their underlying premises, situates them within history, and examines their implications (Bacchi and Goodwin, 2016, p. 16) The point of WPR analysis is not to look for or find the one correct response to an issue, but rather -- to follow Foucault's particular method of analysis -- "thinking problem-matically," and to examine how the policy problem has been questioned, analyzed, classified and regulated across specific times and circumstances (Bacchi, 2018).

By identifying, reconstructing, and interrogating policy problematizations, the underlying goal of WPR analysis is to make visible the politics involved in the policy practices behind problem representations (Bacchi 2012b; Bacchi and Goodwin 2016). WPR takes a more holistic and expansive understanding of politics that extends beyond political institutions and parties, including the heterogeneous strategic relations and practices that shape us and how we live (Bacchi and Goodwin 2016, p.16). As mentioned above, the WPR approach has an agenda, which presumes that some problem representations benefit some groups at the expense of others. The goal is to intervene by challenging those problem representations that have harmful effects and suggest that issues could be thought about in a manner that avoids some of these effects. However, Bacchi notes, "there is no presumption that patterns of harm and benefit are predictable and even in their distribution" (Bacchi 2009, p. 44).

Bacchi's WPR analytical method has three fundamental premises: first, problem representations can be exposed by examining a policy proposal or a policy solution. The process of exposure occurs by understanding that a policy proposal indicates that something needs to change. This change suggests that policymakers believe something is problematic, hence what

the problem is represented as. Second, analysis needs to start from the proposal or proposed solutions, such as policies, and not from the stated problem. Working backward lets us see how problems result from proposals or proposed solutions. Third, problems are not separate from the policy proposals that address them. The problem representation is implicit within a policy proposal. There is no need to go beyond the policy to find these problem representations (Bacchi & Goodwin, 2016).

WPR offers benefits to policy analysts and researchers. Although uncovering problem representations from examining a proposal might at first appear to be a truism, it has excellent potential for questioning policies or other political phenomena. Breaking down governing practices over problematizations with critical scrutiny is where the value of the WPR approach lies. WPR can uncover the problem representations within policy, examine their effects, and demonstrate how policy problems and their associated categories of objects and subjects are made and, therefore, can be unmade (Bacchi 2009; Bacchi & Goodwin 2016). WPR draws attention to the tensions and contradictions within problem representations by highlighting their limitations and inadequacies in representing a problem (Bacchi, 2009). WPR is well suited for studying continuity and change in policy discourse. It compares the development of deep-seated premises across time and space on which statements of problems and solutions rest and tracks their journey (Bacchi, 2009). However, it also facilitates identifying the particular combination of practices and relations that gave a problem its shape in a specific context, which indicates that as practices change, they can produce contrasting problematizations (Bacchi and Goodwin, 2016, p. 22-3).

It is essential to point out what the WPR approach is not. First, WPR is not interested in studying linguistic structures and styles, which is more common in constructivist discourse

analysis approaches. The material or text selected for examination is only a starting point within an analysis. Bacchi argues that texts or materials related to policy act as "levers" to open a reflection upon the forms of governing, its associated affects, as well as how a particular way of constituting a problem occurs (Bacchi & Goodwin, 2016, p. 18). Unlike traditionalist or rationalist policy analysis approaches, WPR does not involve a strict conventional form of policy evaluation. Such rigid traditional forms of policy evaluation concern themselves with the performance of policy implementation by measuring the gaps between a policy promise and its achievements (Bacchi 2009: xiv). Lastly, WPR is not concerned with how people represent an issue through a policy recommendation or competing interpretations common to Critical Discourse Analysis projects within interpretative approaches. Instead, Bacchi argues that "problem representations are the implied 'problems' in policy proposals – how a problem is characterized and conceptualized within a policy proposal or some other text" (2018). Thus, to gain access to a problem representation, the WPR begins with the proposals for change contained *within* governing texts, making it possible to grasp what is implicitly rendered as problematic and how these problems originate within governing practices. It is unnecessary to look outside a policy or other selected text to seek a starting point for analysis, as governing takes place through these problem representations that shape the reality and the patterns of deep-seated "ways of thinking" about a problem.

3.4 Data assembly

The central data sources for this thesis are the Government of Canada policy documents that focus on the Interim Federal Health Care Program (IFHP) and refugee claimants[9]. My selection

[9] In this thesis, the term "refugee claimants" refers to asylum seekers who have arrived in Canada and have made a claim for refugee protection to the government of Canada but are still awaiting a final decision regarding that claim. This was discussed in detail in Chapter Two.

of refugee claimant healthcare policy documents was delimited by the following criteria, which began wide and increasingly narrowed with each step: I started with a general literature review of scholarly work related to the IFHP. I utilized the Memorial University Libraries OneSearch to search all documents associated with the key search terms: Refugee, Healthcare, and Interim Federal Health Program. This broad search included all peer-reviewed journal articles published after April 30, 2012[10], related to the IFHP and refugee claimants within Canada. This request produced 330 peer-reviewed articles.

Out of these, I selected only papers discussing refugee claimants and the IFHP. This smaller pool of documents was then further reduced as I set aside documents tangentially related to healthcare or general immigration policy due to the lack of specific applicability to the Interim Federal Health Program or refugee claimants. Examples include articles that researched or discussed healthcare access by economic or family class immigrants where the term IFHP or refugee claimant may be present but is not the focus of the research or the discussion. The result was a list of 28 articles.

I scanned these articles for mentions of policies, regulations, or reports on the Interim Federal Health Program and Refugee Claimants. These articles repeatedly mention five key government policies: "Order Respecting the Interim Federal Health Program, 2012" (Government of Canada, 2012e); "Balanced Refugee Reform Act" (Government of Canada, 2010); "Order in Council P.C. 157-11/848 of June 20, 1957" (Government of Canada, 1957); "Protecting Canada's Immigration System Act" (Government of Canada, 2012d); and "Immigration and Refugee Protection Act of Canada" (Government of Canada, 2001).

[10] April 30, 2012 was when the government of Canada announced the Interim Federal Health Program amendments.

I retrieved digital copies and searched for any related policy document relevant to refugee claimant healthcare. Since these laws and policies were not policy proposals, I turned to the Government of Canada website to look for proposals, statements, or other documents related to the laws and policies that explained the problem the laws and policies were trying to address. I limited this search to a period between 2010 (two years before the IFHP Amendments were announced) and 2016 (the year that the IFHP Amendments were reversed), searching the Immigration, Refugees, and Citizenship Canada website (Government of Canada, 2018a); the Justice Laws website (Government of Canada, 2018b) and utilizing the search bar on the general Government of Canada website (Government of Canada, 2018c). This search yielded 11 backgrounder press release statements from the communications branch of Immigration, Refugees, and Citizenship Canada. The press release statements detailed the significance, proposed purpose, and goal of the proposed amendments and provided additional context to the policy amendments.

The 11 backgrounder press releases I identified became the basis for my analysis of the problem addressed by the IFHP. They are rich sources of information to analyze the problematizations, objectifications, subjectifications and the governmentalities related to refugee claimants and the IFHP. The documents serve as the starting point for my inquiry, as they contain references to the IFHP amendments and other broader immigration reforms. The press release statements inform the construction of how the term refugee claimant was defined and provide insight into what the problem of refugee claimants' access to healthcare was understood to be, as well as how the problem was to be addressed by the proposed policy reforms.

3.5 Method of analysis

A policy encompasses texts, political decisions, programs, processes, and discourses. Therefore, a critical policy analysis involves these texts, procedures, judgments, statements, speeches, interviews, and other data and, in some cases, the interactions between institutional actors (Goodwin, 2011). Bacchi's WPR approach starts with selecting a policy "text," a broad-based document that provides context and can be open to interpretation and debate. However, deciding what to analyze is the interpretative act of the researcher, in which the "policy analyst is embroiled in a process of marking off and marking out territory for analysis" (Goodwin 2011, p. 168). For Bacchi (2009), selecting a policy text for analysis is a subjective exercise reflecting the analyst's interest and intent. The WPR approach examines established policy documents such as legislation, judicial decisions, bills, speeches, institutional records, media statements, records and reports, organizational files, budgets, program contracts, research reports, and statistical data. However, it is not limited to these texts, as what matters is that the policy materials are prescriptive – "that it can be understood, possibly in a loose sense, as a form of proposal and a guide to conduct" (Bacchi & Goodwin, p. 18). In other words, the texts that the researcher chooses to examine and analyze should be those that reveal what the policy is proposing to change and why this change is believed necessary during policy development. Such texts will identify the intended target for change and will contain information to reveal what the problem is represented to be.

Knowledge about selected text(s) context is essential for applying the WPR approach. Specifically, a researcher must draw upon history, theory, research studies, commentary and other secondary sources. Context is necessary, as problem representations tend to be lodged or

nested[11] within other problem representations[12]. It is essential to recognize the analytical process's interpretative dimension and acknowledge contesting positions within a document when they are apparent.

The WPR approach assists in the analytical task of "making politics visible." It begins by approaching policy with skepticism towards the "full range of things commonly associated with policy," these being the policy itself, the knowledge which supports the policy and its proposals, and the conventional forms of policy analysis that concern themselves with problematizing the solutions and not the problems (Bacchi & Goodwin 2016, p.3). This section seeks to explain the analysis process undertaken in greater detail for the reader and provide a foundation upon which they may approach the following chapter. Key to the WPR process is its seven questions to be addressed in the analysis, which can be considered as steps in the analysis process (See Table 2).

[11] These nested policies contain tensions and contradictions, as there is seldom a singular voice behind them (Bacchi 2009, p. 20).

[12] Alternatively, problem representations may exist in a silo or outside a genealogy of policy interventions – this is the case for those that fall within a "problem" concept like "alcoholism" or "racism" or any distinctive doctrine, theory, system, or practice (Bacchi 2009, p 20).

Table 2: WPR steps in the analytic process

Question 1: What is the problem (for example: "crime," "climate change," "age discrimination," "alcohol and drug abuse," "etc.") represented to be in a specific policy or policies?
Question 2: What deep-seated presumptions or assumptions underlie this representation of the "problem"?
Question 3: How has this representation of the "problem" come about?
Question 4: What is left unproblematic in this problem representation? Where are the silences? Can the "problem" be conceptualized differently?
Question 5: What effects (discursive, subjectification, lived) are produced by this representation of the "problem"?
Question 6: How and where has this representation of the "problem" been produced, disseminated and defended? How has it been and/or how can it be disrupted and replaced?
Step 7: Apply this list of questions to your own problem representations.

Adapted from the WPR chart on the website: https://carolbacchi.com/about/ accessed November 27, 2022. WPR Chart on the website listed was adapted from: C. Bacchi and S. Goodwin (2016) Poststructural Policy Analysis: A Guide to Practice. New York: Palgrave Macmillan, p. 20.

3.5.1 Q1: What is the problem represented to be in a specific policy or policies?

Question 1 starts the analysis and is the first step in identifying and clarifying the problem representation within a specific policy or proposal. I worked backward from a policy or proposal document to identify a problem representation to see what is problematized by making explicit what is assumed as problematic in the text. An example of the process works as follows: a decision-making body has proposed to do something; that proposal indicates that they think something needs to change; that need for change assumes that something is problematic and, therefore, assumes what the problem is represented to be. Floret (2019), in their thesis on the *United Nations New Urban Agenda*, elaborates on this logic of the process for identifying a

problem representation[13]. Floret describes the logic of the operation of the identification of the problematization as including: “what the document proposes to do about something; what is proposed as needing to change or needing to be done; therefore, what is assumed to be problematic and, by extension, what the problem is represented to be” (Floret, 2019, p 64).

Not all problem representations are explicit in policy texts; therefore, I started from stated solutions to investigate their implicit representation of the problem. In these cases, related statements and policy documents are also examined – as they can provide insight into governing rationales. In addition, as mentioned earlier, it is possible that more than one problem representation may be contained within a policy text "because problem representations tend to lodge or nest one within the other," possibly requiring the researcher to ask the question more than once (Bacchi & Goodwin 2016, p.23). It is also possible that problem representations can be hierarchical, with several problem representations deriving from one dominant one. It is up to the researcher to select a starting point, which will depend on their goals, objectives, and political priorities. In this step, I answered question 1 by scanning the 11 backgrounder press release statements for language that contained a core proposal regarding the need for policy reform and amendments related to refugee claimants and their access to healthcare. With the core proposal(s) identified, I utilized Floret’s (2019) method that corresponds to step 1 of the WPR approach[14], to work backwards from this core proposal to identify the problem representation(s).

For step 1, key proposals need to be identified and analyzed from policy texts. However, not all problem representations are explicit in policy texts; in these cases, related statements and

[13] It should be noted that Floret is in fact combining Bacchi’s WPR approach (2009) with the approach offered by Glynos and Howarth (2007); but for the purposes of my illustration here, the points Floret makes remain valid within my approach, which uses WPR alone.

[14] My rationale for using Floret’s more detailed approach, rather than Bacchi’s general approach to Step 1 of the WPR method, will be explicated in Chapter 4.

policy documents are examined as they can provide insight into government practices or the mentality of government. For this thesis, I identified 11 backgrounder press release statements that provide insight into policies related to immigration reforms targeting refugee claimants. Backgrounders are press release statements that are official briefings or handouts giving background information on a subject, in this case, the immigration reforms in 2012. Backgrounders differ from legislative bills or orders in council, which focus on proposed amendments to law and policy and often are devoid of the rationale or reasoning behind the proposed reforms and amendments. I scanned the 11 backgrounder documents for core proposals that rationalize why the reforms to the immigration system were believed to be needed (following Floret's [2019] step 1 as described above). Three documents contained core proposals related to refugee claimants and their access to healthcare. The first document, titled *Backgrounder – Designating Human Smuggling Events* (Government of Canada, 2012l), addressed reforms to tackle the broad border security problem and the need for immigration reform to solve this problem. The second document, titled *Backgrounder – Designated Countries of Origin* (Government of Canada, 2012a), addressed the reforms to tackle the problem of unfounded refugee claims. Lastly, the third document, titled *Backgrounder – Cracking down on Human Smugglers who Abuse Canada's Immigration System* (Government of Canada, 2012b), addressed the reforms to tackle unfounded asylum claims, specifically, the problem of health insurance being temporarily available to all refugee claimants whether legitimate or illegitimate in their claim. The three backgrounder documents contained similar statements regarding immigration reform, although each focused on a different aspect of the system.

Table 3: Immigration reform policy documents used in question 1

Step 1: What's the problem represented to be in a specific policy or policies?		
Document Title	How is the document used?	Chapter
Backgrounder – Designating Human Smuggling Events. Government of Canada (2012l)	The primary document used in the identification of the first problem representation. This document provides the reason and rationale for the 2012 legislative revisions to immigration law and policy.	Section 4.1
Backgrounder – Better Tools to Successfully Prosecute and Impose Mandatory Prison Sentences on Human Smugglers. Government of Canada (2012h)	A secondary document that provides additional context to clarify key terms in the first problem representation.	Section 4.1
Backgrounder – Deterring Abuse of the Refugee System. Government of Canada (2012f)	A secondary document that provides additional context to clarify key terms in the first problem representation.	Section 4.1
Backgrounder - Protecting our Streets and Communities from Criminal and National Security Threats. Government of Canada (2012i)	A secondary document that provides additional context to clarify key terms in the first and third problem representation.	Section 4.1 Section 4.3
Backgrounder – Designated Countries of Origin. Government of Canada (2012a)	The primary document in the identification of the second problem representation. This document provides the reason and rationale for 2012 legislative revisions to the refugee claimant policy.	Section 4.2
Backgrounder – Designated Countries of Origin. Government of Canada (2012j)	A secondary document that provides additional context to clarify key terms in the second and third problem representation.	Section 4.2 Section 4.3
Backgrounder – Overview of Canada's Refugee Programs. Government of Canada (2012m)	A secondary document that provides additional context to clarify key terms in the second and third problem representation.	Section 4.2 Section 4.3
Backgrounder – Overview of Canada's New Refugee System. Government of Canada (2012k)	A secondary document that provides additional context to clarify key terms in the second problem representation.	Section 4.2
Making Canada's asylum system faster and fairer. Government of Canada News Release. Government of Canada (2012c)	A secondary document that provides additional context to clarify key terms in the second problem representation.	Section 4.2

Table 3: Continued

Backgrounder – Cracking down on Human Smugglers who Abuse Canada's Immigration System. Government of Canada (2012b)	A primary document in the identification of the third problem representation. This document provides the reason and rationale for 2012 legislative revisions to the refugee claimant's health insurance policy. Also analyzed as a secondary document that provides additional context to clarify how key terms are problematized in the first, second, and third problem representation.	Section 4.1 Section 4.2 Section 4.3
Reform of the Interim Federal Health Program ensures fairness, and protects public health and safety. Government of Canada (2012e)	A secondary document that provides additional context to clarify key terms in the third problem representation.	Section 4.3

3.5.2 Q2: What deep-seated presumptions or assumptions underlie this representation of the "problem"?

My intent was to identify the meanings or conceptual logic within the policy. This includes identifying the presuppositions, assumptions, knowledge, and discourses that accord intelligibility, coherence, and truthfulness of a problem representation. My second intent was to identify how the problem representation is constructed. This means identifying the concepts and binaries a problem representation relies upon, such as citizen/migrant and genuine/bogus. My third intent was is to identify and reflect upon the possible patterns contained within the problematization that operationalize a particular political or governmental rationality (Bacchi & Goodwin 2016, p.19).

Question 2 is a Foucauldian-like archaeological[15] analysis of discourses that form truth from socially produced knowledge. The point is not to ask why the proposal happened but how it

[15] Ziai has explained Foucault's archaeological approach as follows: "Archaeology is the analysis of discursive formations. It thus looks for the rules of formation that constitute the unity of discourse. These rules concern the objects, concepts, enunciative modalities and strategies of a discourse. It also examines the limits of what can be

exists the way it does and what meanings need to be in place for it to be accepted and make sense. This process involves the researcher standing back and questioning how they are being governed. The method also requires the researcher to understand how knowledge acquires a 'truth' status and locate this knowledge within the relevant networks of relations and practices that produced it (Bacchi & Goodwin 2016, p.19). For example, an object of analysis like asylum-seeking would require a researcher to be aware, examine, and question their deep-seated cultural premises and values on citizenship, immigration, protection, security, and community. It is important to note that the objective here is not to develop new theories or understandings of what discursive meanings need to be in place for a proposal to make sense or be accepted. Instead, a researcher is to situate the identified problem representations within a field of study. For the researcher, this means utilizing scholarship and secondary sources to bring to the forefront this body of knowledge that can explain the deep-seated presumptions or assumptions which underlie the problem representations. For example, in this thesis, I pay careful attention to terms like "illegal," "unfounded," and "unfair" contained within the problem representations identified from the core proposals in step 1 as reveal the hidden assumptions that need to be accepted for the identified problem representations to be valid.

Table 4: Immigration reform policy documents used in question 2

Step 2: What deep-seated presuppositions or assumptions underlie the problem representation? What presuppositions and meanings are necessary for this representation of the problem to make sense?
No documents are used within this section. Instead, I draw upon scholarship and theory to identify the discourses that form *truth* from socially produced knowledge within this step.

said within the discourse and what is excluded – the repressive dimension of representing power. Its productive dimension is also relevant: which objects are created, which statements are provided possible, which realities are constructed in the discourse? In archaeology, texts are being analyzed not as statements produced by individual subjects, but by the structures of the discourse, by rules which impose themselves on anyone who speaks in this discursive field" (Ziai 2016: 21).

3.5.3 Q3: How has this representation of the "problem" come about?

The purpose of question 3 is two-fold. My first goal was to highlight the conditions that allowed the identified problem representation to take shape and assume dominance over other competing problem representations in the course of history. Mysecond, purpose was to illustrate the plethora of alternative developments that could have existed. My intent was to establish the history (genealogy, in the language of Foucault[16]) of the problem representations and to upset any assumptions about their "natural" evolution. Conducting such a genealogy destabilizes the problem representations that have been taken for granted as true and natural by providing insight into the relations of power that have affected the success of some problem representations and the defeat of others (Bacchi 2009, p. 10-11).

I started with conducting a genealogy of the problem representation, by starting with the problem representation in its present form and tracing it back in time. It was essential to ask how we had gotten here from there, identifying the specific points when critical decisions took an issue in a particular direction (Bacchi & Goodwin 2016, p.21). The analysis revealed the twists and turns that led to the emergence of a specific problem representation. The minor knowledge at the margins of history makes the problem representation susceptible to change. It is essential to mention that my objective here was not to develop this historical account of history inductively but to rely upon various sources from secondary literature to establish a history of the conditions that allowed the identified problem representations to take shape. Therefore, in this thesis, I traced the history of refugee claimant healthcare to illustrate how major changes that occurred in

[16] Foucault's genealogical approach is a means to show that a given system of thought is the result of turns of history, not the outcome of rational inevitable trends. It investigates how taken-for-granted "truths" such as "scientific truths" are historically constructed and have their roots in specific social and political agendas (Saukko, 2003)

policy over time resulted from competing social and political agendas, which led to the problem representations identified.

Table 5: Immigration reform policy documents used in question 3

Step 3: How has this representation of the "problem" come about?		
Order Respecting the Interim Federal Health Program, 2012 SI/2012-26. Government of Canada (2012 g)	A secondary document that provides context to the introduction of amendments to the Interim Federal Health Program in 2012.	Chapter 6
Balanced Refugee Reform Act Government of Canada (2010)	A secondary document that provides context to the introduction of the Designated Countries of Origin (DCO) refugee claimant category.	Chapter 6
Protecting Canada's Immigration System Act. Government of Canada (2012d)	A secondary document that provides context to the introduction of new immigration penalties for specific categories of refugee claimants.	Chapter 6

3.5.4 Q4: What is left unproblematic in this problem representation? Where are the silences? Can the "problem" be conceptualized differently?

This fourth step in the analysis encourages the researcher to destabilize the existing problem representation by asking what fails to be problematized within it (i.e., what is left out). The goal is for the researcher to highlight the constraints, limitations, and inadequacies of how a problem is represented (Bacchi 2009, p. 12-14). The analysis from questions 2 and 3 is instrumental here; for example, examining the binaries in question 2 indicates the distortions and misrepresentations, while the genealogy in question 3 highlights the policy discourses that have competed for dominance within history. Both of those questions, then, assist in identifying the silences inherent in those problem representations that have gained institutional endorsement. However, this step may also involve comparing problematizations across time or cross-culturally. This comparison alternatively promotes thinking of an issue and identifying the particular combination of practices and relations that gave a problem shape within a specific context. I analyzed the presuppositions, identified the binaries, examine the premises of the problem representations, and utilized critiques drawn from scholarly literature to identify the

distortions and misrepresentations of the identified problems. In addition, I compared Canada's problem of refugee healthcare with policies of the United States and the United Kingdom to illustrate how the problem was shaped within a country's cultural and institutional context and that alternative framings of the problem exist.

Table 6: Immigration reform policy documents used in question 4

Step 4: What is left unproblematic in this problem representation? Where are the silences? Can the "problem" be conceptualized differently?		
Order Respecting the Interim Federal Health Program, 2012 SI/2012-26. Government of Canada (2012 g)	A secondary document that provides context to the introduction of the amendments to the Interim Federal Health Program in 2012.	Chapter 7

3.5.5 Q5: What effects (discursive, subjectification, lived) are produced by this representation of the problem?

The fifth question analyzes political implications rather than only measurable "outcomes" of the identified problem representation(s). Three kinds of effects are considered in question five: discursive, subjectification[17], and lived effects. These effects are interconnected and mutually reinforcing as part of what Foucault called "dividing practices" (Foucault, 1982, p. 777-795). Dividing practices produce uneven social consequences by being harmful to some social groups and not others. In one form or another, separate groups of people are made "governable" subjects by being divided within themselves (Bacchi 2009, p.16). Discursive effects illustrate the terms of reference created by a problem representation that limits what can be thought and said relative to it. Subjectification effects implicate "subjects" within problem representations by establishing the kind of "subject" they can be. Lived effects are how discursive, and subjectification effects

[17] *Subjectification* is a term that Carol Bacchi (2009) uses, adopted from the scholarly work of Foucault (1998). It refers to the process by which the subject (an individual or person) is led to observe himself or herself, analyze themself, interpret their own thoughts, behaviors, and actions, and recognize their-self as a domain of possible knowledge. Stated alternatively, "subjectification" is a process by which a person becomes a person and can often be confused with subjectivity which refers to the experience of being a human subject.

translate into people's lives. To investigate the lived effects, the researcher can employ a wide gamut of empirical techniques, including quantitative measures of social location, ethnographic studies, and interviews. However, such studies are not always required. It is acceptable within the WPR method (depending upon the scale of a research study) to rely upon the secondary literature and work of others to demonstrate and highlight the observed effects of a problem representation.

The overall goal of question 5 is to say which aspects of the problem representation have harmful effects on specific groups and may need to be rethought and to provide a means to consider the long-term implications of policy interventions. Earlier questions laid the groundwork for question 5 (for example, the discourses identified in question 2 focused on subject positions). Bacchi (2009) asks that the following sub-questions be regarded as an integral part of the analysis of the fifth question (p.18):

> *"1. What is likely to change with this representation of the 'problem'?*
>
> *2. What is likely to stay the same?*
>
> *3. Who is likely to benefit from this representation of the 'problem'?*
>
> *4. Who is likely to be harmed by this representation of the 'problem'?*
>
> *5. How does the attribution of responsibility for the 'problem' affect those so targeted and the perceptions of the rest of the community about who is to 'blame'?"*

In this thesis, utilizing the work of steps 2, 3, and 4, I illustrate the terms of reference created by the problem representations. The problem representations limit what can be thought and said relative to it, establish the kind of "subject" refugee claimants can be, and discuss how discursive and subjectification effects translate into the real world by materially affecting the

lives of refugee claimants. Lastly, I consider the long-term implications of policy decisions regarding the problem of refugee claimants accessing healthcare.

Table 7: Immigration reform policy documents used in question 5

Step 5: What are the effects (discursive, subjectification, lived) produced by this representation of the problem(s)?		
Order Respecting the Interim Federal Health Program, 2012 SI/2012-26. Government of Canada (2012 g)	A secondary document that provides context to the introduction of the amendments to the Interim Federal Health Program in 2012.	Chapter 8 Appendix A
Balanced Refugee Reform Act Government of Canada (2010)	A secondary document that provides context to the introduction of the Designated Countries of Origin (DCO) refugee claimant category.	Chapter 8
Protecting Canada's Immigration System Act. Government of Canada (2012d)	A secondary document that provides context to the introduction of new penalties for specific categories of refugee claimants.	Chapter 8

3.5.6 Q6: How and where has this representation of the problem been produced, disseminated, and defended? How has it been and/or how can it be disrupted and replaced?

The goal of question 6 is to analyze how the problem representations have been promoted, achieved legitimacy and authority, and alternatively, how it has been contested—highlighting the instances within policy mobility practices where individual and group networks install and authorize a particular problem representation. With similar intent to step 3, step 6 emphasizes the possibility of contestation and destabilizing the taken-for-granted "truths" (Bacchi & Goodwin 2016, p. 23-4). Question 6 starts by reviewing secondary literature sources, asking which groups or classes and individuals have access to the underlying discourse of a problematization. By investigating the role of media in disseminating and supporting a particular problem representation, focusing on the relationship between the dominant discourses, prominent speakers, and its destined audience, a researcher makes explicit how the problem representation was institutionalized. In this thesis, I analyze how and where the problem has been promoted in media and in government by highlighting the instances where networks of groups or classes of

individuals installed and authorized the problem representation. I focus on the instances where resistance challenged the pervasive and authoritative problem representations by examining the events and actions undertaken to resist the policy amendments. Lastly, I discuss alternative interventions to the problem of refugee claimant healthcare and argue how an opportunity was missed.

Table 8: Immigration reform policy documents used in question 6

Step 6: How and where has this representation of the "problem" been produced, disseminated, and defended? How has it been and/or how can it be disrupted and replaced?		
Order Respecting the Interim Federal Health Program, 2012 SI/2012-26. Government of Canada (2012 g)	A secondary document that provides context to the introduction of the amendments to the Interim Federal Health Program in 2012.	Chapter 9
Balanced Refugee Reform Act Government of Canada (2010)	A secondary document that provides context to the introduction of the Designated Countries of Origin (DCO) refugee claimant category.	Chapter 9
Protecting Canada's Immigration System Act. Government of Canada (2012d)	A secondary document that provides context to the introduction of new penalties for specific categories of refugee claimants.	Chapter 9

3.5.7 Step 7: Apply this list of questions to your own problem representation

Step 7 is not a question but an invitation for self-reflexivity and problematizing one's research questions and thereby the problem representations. Bacchi (2009) notes that we are all located within historically and culturally entrenched forms of knowledge, and we need to subject our ways of thinking to the same critical scrutiny. It's imperative that researchers not simply buy into certain problem representations. That space and critique are taken to reflect upon their origins, purposes, and effects (p.19). In this thesis, I do so in a subsection in the overall thesis conclusion.

3.6 Chapter summary and next steps

Chapter one introduced the subject of my critical analysis that refugee claimants in Canada lack the legal right to access healthcare. Chapter two reviewed the research literature on

refugee claimants' access to healthcare and barriers globally and then narrowed it to provide an overview of the Canadian context. Chapter three introduced how I approached my examination of the problem of refugee claimant healthcare, which falls within the field of policy analysis. I detailed my use of Carol Bacchi's (2009) "What's the Problem Represented to be?" (WPR) method to analyze how the 2012 Interim Federal Health Program amendments emerged out of the intersection of historical, political, and cultural interests, which creates the problem of refugee claimant healthcare. The following chapters present my analysis. Each chapter is dedicated to one WPR step.

In Chapter 4, I conduct step 1 of the WPR process. This requires working backwards to reconstruct the problem representation by explicitly stating what is assumed to be problematic within the text. I review the 11 background press release statements I identified as central public documents that report on policies about refugee claimants' access to healthcare and in which are embedded three problem representations I identify.

Chapter 5 (step 2) is where the actual analysis begins in the WPR method. Here, I draw upon immigration theory and scholarship, which includes the work of researchers like Castle (2003), Jorgensen (2012), and Beatson (2016), to identify the meanings or conceptual logics of the problem representations that accord it intelligibility, coherence, and truthfulness.

In Chapter 6 (step 3), I rely upon scholarly sources, legal documents, and government texts to conduct a Foucauldian genealogy of the problem representations. Here, I identify how the problem representations came about by determining how they took shape in history and competed for dominance. The objective is to illustrate the plethora of alternative developments that could have shaped the problem differently and to upset any assumptions about the problem's "natural" evolution.

Chapter 7 (step 4) continues the work of step 3 by drawing upon various academic sources and policy commentators to identify and highlight the problem representation's constraints, limitations, and inadequacies. Step 4 also goes beyond the Canadian context by drawing on international comparisons to upset the notion of 'naturalness' in the problem of access to healthcare by refugee claimants.

Chapter 8 (step 5) directs the analysis toward the political implications rather than only the measurable outcomes of the problem representation. I examine the discursive effects, subjection effects (subjectification), and lived effects of the problem representation*;* a representation which separates refugee claimants from other groups. The objective of step 5 is to identify which aspects of these effects are harmful and why these effects may need to be rethought by considering the long-term implications of these effects within published research.

Chapter 9 (step 6) examines how the problem representation has been promoted and achieved legitimacy and authority. I draw upon scholarship, government documents, and news articles that directly discuss the 2012 IFHP amendments. The objective of step 6 is to investigate the role of media and the relationship between dominant discourses, prominent speakers, and target audiences. The intent is to make explicit how the problem representation came to be institutionalized and discuss the possibility of contestation and destabilization of the problem.

Finally, I present an overall discussion and conclusion to my thesis in Chapter 10. I conclude by arguing that a rights-based approach driven by a human rights policy discourse is needed in addressing the policy problem of refugee claimants' access to healthcare. Without adopting a human rights discourse to reposition refugee claimants as rights-holders little has been done or can be done to elevate a refugee claimant's status within Canada.

Chapter 4: *WPR Step 1*, Identification of the Problem Representations.

The first step of the WPR method is to ask: "What's the problem represented to be in a specific policy or policies?" This step involves identifying and clarifying the problem representations by working backwards from a policy or proposal document to see what is problematized and by making explicit what is assumed to be problematic in the text. Although identifying the problem representation may seem straightforward and uncritical, a logic of operation outlining how to work backward to determine what the problem is represented to be is missing from Bacchi's (2009) WPR analysis method. To fill this gap, I have turned to other research studies that have employed Bacchi's (2009) WPR method in their work. Floret (2019), in her thesis on the United Nations New Urban Agenda, fills the gap present in Bacchi's first step by providing her logic of process for identifying a problem representation. Floret's four steps involve: (1) determining what the document proposes to do about something; (2) from this proposal, identifying what is implied to be necessary to change or to be done; (3) from what is implied as necessary to change or to be done, determine what is apparently assumed to be problematic; (4) from what is apparently assumed as problematic, indicate what the problem is represented to be. The intention of the first step in a WPR analysis is not to impose an interpretation onto the intentions of the policy creators. Instead, the researcher engages with what they interpret as the assumptions behind the problem representation.

By the end of step 1, using Floret's 4 stage process, I had identified three different but related problem representations in my WPR analysis of the three primary backgrounder press release statements: (1) the "abuse of Canada's immigration system"; (2) "unfounded refugee claims"; and (3) the "unfair provision of health insurance benefits to those unfounded refugee claimants."

These three problem representations nest hierarchically in terms of the scope of policy reform. At the macro-level of the immigration system, the first problem representation -- the "abuse of Canada's immigration system" -- concerns how groups of people arrive illegally at Canada's borders. At the meso level of the refugee protection system, the second problem *representation* concerns how the "illegal" arrivals can enter Canada and remain while their refugee claim is processing. At the micro-level of government services and benefits, the third problem representation concerns the idea that providing temporary health insurance to refugee claimants is a major motivating factor for "illegal" arrivals to migrate to Canada to make "unfounded" claims for refugee protection.

In what follows (subsections 4.1, 4.2, and 4.3), I present this Step 1 analysis, working through Floret's process for each of the three backgrounder documents. In each subsection, I begin by making explicit the core proposal identified in the backgrounder (which corresponds to Floret's first step). Then, I examine the text from the specific backgrounder document and, continuing through Floret's process, identify what I believe was assumed necessary to change or to be done, what I think was assumed to be problematic, and, finally, what the problem is represented to be. Alongside the text analysis from the three backgrounders themselves, in each subsection, I also examine the text from the eight remaining backgrounder statements to unpack the meanings of key terms identified in the analysis.

4.1 The abuse of Canada's immigration system: macro-level problem representation

The first of the three problem representations identified was the "abuse" of Canada's immigration system. That problem representation was most apparent in the government document, *Backgrounder - Designating Human Smuggling Events* (Government of Canada, 2012l).

> *The Protecting Canada's Immigration System Act will help to end the abuse of Canada's immigration system by human smugglers. It ensures the integrity and fairness of Canada's immigration system, the security of Canada's shores, and ensures that those who apply to come to Canada legitimately and play by the rules are not penalized by those who try to jump the queue. (Government of Canada, 2012l, para 3).*

From this quote, I worked backwards using Floret's (2019) 4-step approach to Bacchi's first step of policy analysis, asking: (i) What does the document propose? (ii) What was assumed necessary to change or to be done? (iii) What was assumed to be problematic? and, finally, (iv) What is the problem represented to be?

4.1.1 What does the document propose? To end the abuse of Canada's immigration system.

The primary document, *Backgrounder - Designating Human Smuggling Events,* states that the aim is to help "…end the abuse of Canada's immigration system by human smugglers" (Government of Canada, 2012l, para 3).

Examining the eight secondary source documents, what is meant by the word "abuse" from the primary document can be ascertained. The government document, *Backgrounder - Better Tools to Successfully Prosecute and Impose Mandatory Prison Sentences on Human smugglers,* expands upon the concept of abuse. The backgrounder explains that human smugglers exploit, take advantage, and thus "abuse immigration systems designed to help those in need" (Government of Canada, 2012h, para1). According to the same backgrounder, the abused immigration systems highlighted within the primary document are those "designed to help those in need." The abused system refers specifically to the refugee protection system, identified in the document as the target of human smuggling operations. According to the secondary source document, *Backgrounder - Deterring Abuse of the Refugee System, "*Canada's generous refugee

system delivers help for vulnerable persons who genuinely need it, and does so in a fair, ordered and compassionate manner*"* (Government of Canada, 2012f, para1). In one way or another, such human smuggling operations, the backgrounder asserts, negatively impact "help for vulnerable persons who genuinely need it." The persons who "genuinely need it" include refugees. Argued is that it is hard for officials to determine if a person is actually in need of help or not "if an individual has directly or indirectly misrepresented or withheld material facts relevant to their situation" (Government of Canada, 2012f, para1).

4.1.2 What was assumed necessary to change or to be done? Change immigration laws.

According to the primary document, *Backgrounder - Designating Human Smuggling Events*, within the core proposal identified, the objective is to "end the abuse of Canada's immigration system by human smugglers." This implies changes to existing immigration laws are needed (Government of Canada, 2012l, para 3).

The assumption that changes to immigration laws are needed to end the "abuse" of the immigration system by human smugglers is also evident in the secondary source document, *Backgrounder - Deterring Abuse of the Refugee System*. That backgrounder states that change to immigration law is necessary to ensure the refugee system continues to deliver help as "it is important to protect its integrity from those who would abuse Canada's generosity" (Government of Canada, 2012f, para1). Similarly, one of the other secondary source documents, *Backgrounder - Cracking Down on Human Smugglers who abuse Canada's Immigration System,* states that the government "must take action to end the abuse of Canada's immigration system by human smugglers… as it…is unfair that those who have not followed the rules be rewarded for their actions" (Government of Canada, 2012b, para 1, 11). In addition, the backgrounder also states that to protect the immigration system*,* "we must have laws and measures in place that will

dissuade individuals from coming to Canada by way of illegal human smuggling venture as opposed to well-established means of seeking immigration status or refugee protection in Canada" (Government of Canada, 2012b, para2). The quotes taken together imply that change is needed to immigration law and that either no law is in place or the existing laws are inadequate.

4.1.3 What was assumed to be problematic? Border security

The core proposal from the government is that the approach towards human smuggling must change. Thus, the pre-existing immigration legal approach to human smuggling is assumed to be ineffective in ensuring "the integrity and fairness of Canada's immigration system" (Government of Canada, 2012l, para 3).

What is assumed to be problematic is border security. The border security problem is clarified in one of the eight secondary source documents, *Backgrounder - Better Tools to Successfully Prosecute and Impose Mandatory Prison Sentences on Human Smugglers.* In this backgrounder, human smuggling operations are presented as being motivated by "big businesses, generating significant profits for sophisticated criminal organizations and others who engage in this crime*"* (Government of Canada, 2012h, para1). Such for-profit operations by criminals and criminal organizations facilitate "the illegal entry of persons into a country to receive a financial or other material benefit" (Government of Canada, 2012h, para1). In another secondary source document, *Backgrounder - Protecting our Streets and Communities from Criminal and National Security Threats,* "illegal" individuals who arrive via human smuggling are individuals that often "do not have documents, rely on fraudulent or fraudulently obtained documents, or have destroyed documents in order to hide their identity" (Government of Canada, 2012i, para 1). The assumption is that "illegal" individuals "hide their identity." In other words, these individuals are constructed as a problem for government authorities. The document identified that officials

"cannot identify potential security and criminal threats, including human smugglers, traffickers, terrorists, or individuals who have committed crimes against humanity" (Government of Canada, 2012i, para1). For organized human smuggling and the persons that have arrived via these methods, their presence in the country is illegitimate or illegal, according to the government. The government argues in the same backgrounder document that "it is essential that the government authorities have the ability to detain, to impose conditions of release, and to remove those who are inadmissible to Canada" as a means to "ensure the fairness and integrity of Canada's immigration and refugee systems, and to protect the safety and security of the Canadian public" (Government of Canada, 2012i, para 3). "Integrity" in the context of the backgrounder is aimed at policies that prevent human smugglers' corruption of the immigration system. The "integrity" is about fostering high standards of behaviour to help reinforce the idea that credibility and legitimacy are involved in how people enter the country and a need for the immigration system to safeguard the public interest. Similarly, "fairness" is not aimed at decision-makers but at human smugglers or others who abuse the system by entering the country outside the established legal channels for migration. Entry through human smuggling, which circumvents immigration policies and procedures, is framed in secondary source documents (like *Backgrounder - Cracking Down on Human Smugglers who abuse Canada's Immigration System)* as "unfair that those who have not followed the rules be rewarded for their actions" or "unfair" to those migrants who have followed the rules and conducted themselves in a manner deemed acceptable by immigration officials (Government of Canada, 2012b, para 11).

4.1.4 What was the problem represented to be? "Abuse" of the immigration system

To summarize, so far in the process of identifying what the problem is represented to be for this first problem statement: (i) The core proposal was to end the abuse of Canada's

immigration system (ii) What was assumed necessary to change is immigration law; (iii) what was assumed to be problematic is border security. The document proposes that there is a problem of "abuse" and a need for immigration reform to solve it, specifically related to border security.

By identifying the proposal, its proposed change, and the assumption of what is problematic, I can articulate what the problem is represented to be. Let us briefly return to the direct quote from the primary document: "The Protecting Canada's Immigration System Act will help to end the abuse of Canada's immigration system by human smugglers. It ensures the integrity and fairness of Canada's immigration system, the security of Canada's shores, and ensures that those who apply to come to Canada legitimately and play by the rules are not penalized by those who try to jump the queue" (Government of Canada, 2012l, para 3). The problem is assumed to be an abuse of the immigration system. Specifically, there is an assumption that there is a porous and unfair immigration system that lacks appropriate penalties for the act of human smuggling, leading to the systemic abuse of the immigration system.

This problem representation is broad in its representation -- "abuse of the immigration system" encompasses the entirety of the immigration system. Nested within that problem representation are two additional problem representations. In the following sections (4.2 and 4.3), I analyze these, using the same 4- step process that Floret (2019) proposed for identifying problem *representations*: (i) What does the document propose; (ii) What was assumed necessary to change or to be done; (iii) What was assumed to be problematic; all leading to (iv) What is the problem represented to be?

4.2 Unfounded refugee claims made by those who arrive illegally: meso level problem representation

The mid-level of the three problem representations was the problem of unfounded refugee claims being made by those who arrive illegally. That problem representation was most apparent in the primary government document, *Backgrounder - Designated Countries of Origin.*

> *Under the Balanced Refugee Reform Act (BRRA), which received Royal assent in June 2010, the government has the authority to identify designated countries of origin (DCO). DCOs are countries that do not normally produce refugees, respect human rights and offer state protection. The ability to designate such countries and accelerate the processing of refugee claimants from those countries provides the government with a tool to respond to spikes in claims from countries that do not normally produce refugees. […] The aim of the DCO policy is to deter abuse of the refugee system by people who come from countries generally considered safe. Refugee claimants from DCOs would have their claims processed faster. This would ensure that people in need get protection fast, while those with unfounded claims are sent home quickly through expedited processing." (Government of Canada, 2012a, para 2-3).*

Working the same as the first identified problem representation from the quote above, I worked backwards using the Floret (2019) approach to determine the problem representation within a text detailed in the following steps.

4.2.1 What does the document propose? To respond to the spikes in claims from countries that do not normally produce refugees

The quote from the primary document *Backgrounder - Designating Countries of Origin* proposes to do something about the "spikes in claims from countries that do not normally produce refugees." (Government of Canada, 2012a, para 2-3)

The word "spikes" is also found in the other eight secondary source documents, *Backgrounder - Designated Countries of Origin [2]*. In this backgrounder, it is said the government needs to "respond to spikes in claims… as…Canada is currently receiving a disproportionately high number of asylum claimants who come from countries that historically have very low acceptance rates at the independent Immigration and Refugee Board of Canada (IRB)" (Government of Canada, 2012j)[18]. This idea of the "spikes" in claims linked to a "disproportionally high number of asylum claimants" is expanded within the secondary document, *Backgrounder - Overview of Canada's Refugee Programs.* Within the backgrounder, the issue of the high number of claims is linked to a backlog of asylum claims and is raised within the comment that there were "60,000 claims in 2009" that were still pending determination by government officials at the beginning of 2012 (Government of Canada, 2012m, para 42).

4.2.2 What was assumed necessary to change or to be done? The ability to designate certain countries as safe with claimants from those countries as not needing protection to accelerate government processing

According to the primary document, *Backgrounder - Designated Countries of Origin,* what needs to change is "the ability to designate such countries and accelerate the processing of refugee claimants" in order to "respond to spikes in claims from countries that do not normally produce refugees" (Government of Canada, 2012a, para 2).

[18] The *Designated Countries of Origin (2012j) backgrounder,* while having the same title as the primary document, is actually a document with the same title that was released on a different date but in the same year as the primary document (i.e., 2012a). Therefore, for clarity, I will refer to this second document as *The Designated Countries of Origin [2] (2012j) backgrounder.*

In one of the eight secondary source documents, *Backgrounder - Designated Countries of Origin [2],* the statement "accelerate the processing of refugee claimants" is expanded. According to the backgrounder, accelerated processing will "ensure that people in need of protection get it quickly, while those with unfounded claims are sent home faster through expedited processing" (Government of Canada 2012j, para 5). Those with "unfounded claims," according to the document, *Backgrounder - Overview of Canada's New Refugee System,* require procedural changes where "faster decisions must be complemented by faster removals" (government of Canada, 2012k, para 12). In the primary document, *Backgrounder - Designated Countries of Origin*, it is reasoned that the "authority to identify designated countries of origin (DCO)… [means that]… DCOs will have their claims processed faster. This will ensure that people in need get protection fast, while those with unfounded claims are sent home quickly through expedited processing" (Government of Canada, 2012a, para 2,4). In addition, within the primary document, it is assumed that the use of DCOs will grant the government the power "to respond to spikes in claims from countries that do not normally produce refugees" and will reduce the "many tax dollars … spent on asylum claimants who are not in need of protection" (Government of Canada, 2012a, para 1-2). Lastly, the DCO categorization would work to "deter abuse of the refugee system by people who come from countries generally considered safe" (Government of Canada, 2012a, para3). According to the secondary source document, *Making Canada's Asylum System Faster and Fairer*, such measures are acceptable government interventions. The DCO categorization is acceptable because "many developed democracies use a similar authority to accelerate asylum procedures for the nationals of countries not normally known to produce refugees" (Government of Canada, 2012c, para 14).

4.2.3 What was assumed to be problematic? Refugee claimants illegally arriving from safe countries are abusing the system by making "unfounded claims."

The core proposal from the primary document, *Backgrounder - Designating Countries of Origin,* is that the approach is taken towards "countries that do not typically produce refugees" needs to change. Thus, the pre-existing immigration approach to "the processing of refugee claimants" is assumed to be problematic in realizing a refugee system free of "abuse… by people who come from countries generally considered safe" (Government of Canada, 2012a, para 2-3).

In one of the eight secondary source documents, *Backgrounder - Designating Countries of Origin* [2], the problem of "countries that do not typically produce refugees" is framed. The problem of "countries that do not typically produce refugees" is stated as originating from "countries such as those in Europe with solid democratic and human rights… that are… countries generally considered safe" (Government of Canada, 2012j, para 1, 2, 5). The backgrounder explains that these countries are considered safe due to the "existence of an independent judicial system." This "independent judicial system" is coupled with a "recognition of basic democratic rights and freedoms, including mechanisms for redress if those rights or freedoms are infringed," as well as independent public oversight through the "existence of civil society organizations" (Government of Canada, 2012j, para 17). According to the primary document, *Backgrounder - Designated Countries of Origin,* the government assumes that with an independent judiciary, recognition of rights and freedoms, and mechanisms for redress and public oversight, there is a need for the Canadian government to have the "authority to identify designated countries of origin (DCO)… which…will ensure that people in need get protection fast, while those with unfounded claims are sent home quickly through expedited processing (Government of Canada, 2012a, para 2,4). The "unfounded claims" are expanded upon in the

secondary source document, *Backgrounder – Designated Countries of Origin* [2], and linked to "spikes in claims from countries that do not normally produce refugees," which is believed to be motivated by "Canada's social assistance programs and other generous benefits…that are a…draw for many" (Government of Canada, 2012j, para 9). In addition, "the abuse of Canada's immigration system" is directly linked to the first problem representation, with its emphasis on how some individuals undertake criminal methods to arrive in Canada. According to the secondary source document, *Backgrounder – Cracking down on Human Smugglers who Abuse Canada's Immigration System,* Canada must have laws and measures in place to "dissuade individuals from coming to Canada by way of an illegal human smuggling venture as opposed to well-established means of seeking immigration status or refugee protection in Canada" (Government of Canada, 2012b, para2). The "illegal" arrival of "unfounded" refugee claimants is a central theme in the primary document, *Backgrounder – Designating Countries of Origin;* it is argued that the "large numbers of unfounded refugee claims are a financial burden on the economy" (Government of Canada, 2012a, para 9). According to the secondary source document, *Backgrounder – Designated Countries of Origin* [2], this "financial burden" requires the government to have the ability to designate certain source countries as a "safe country of origin" and to have tools to "designate such countries and accelerate the processing of these asylum claims" to facilitate their faster removal from the country (Government of Canada 2012j, para 7, 9, 12).

4.2.4 What was the problem is represented to be? "Unfounded" refugee claims are made by those who arrive illegally

To summarize, so far, the process of identifying what the problem is represented to be for this second problem statement: (i) the core proposal was to respond to the spikes in claims from

countries that do not normally produce refugees, (ii) what was assumed necessary to change was the ability to designate certain countries as safe with claimants from those countries as not needing protection to accelerate government processing (iii) what was assumed to be problematic was refugee claimants arriving illegally from safe countries and abusing the system by making "unfounded claims." The document proposes a problem of refugee claims being made by those who do not need protection.

What is assumed to be problematic in the core proposal is the pre-existing refugee system that had enabled the processing of refugee claims by people who come from countries generally considered safe. From this assumption, I can articulate what the problem is represented to be. The problem is the "abuse" of the refugee system by "unfounded" refugee claims made by persons who arrive illegally from countries that do not typically produce refugees.

This problem representation of "unfounded" refugee claims is narrower than the first problem representation regarding systemic "abuse" of the immigration system. It does not encompass all that arrive at the nation's borders. Instead, it problematizes only those who utilize the refugee system to enter and remain in Canada. It includes a singular framing of how the refugee system is "abused" by persons who illegally arrive from "countries generally considered safe" and reasons that they make their claim to take advantage of "Canada's social assistance programs and other generous benefits."

Turning now to the third and final problem representation, we see that Canada's social programs and benefits are critical to the overall representation of the problems with Canada's immigration system and represent the micro-level problematization within this nested hierarchy.

4.3 An unfair provision of health insurance benefits to unfounded refugee claimants: micro-level problem representation

The government document, *Backgrounder – Cracking down on Human Smugglers who Abuse Canada's Immigration System,* contains a core proposal that presented the most unambiguous indication of a problem that the government thought needed to be solved – that there is an "unfair" provision of health insurance benefits to "unfounded" refugee claimants:

> *"Canadians enjoy health services that are among the best in the world. However, it is unfair that those who have not followed the rules be rewarded for their actions by having access to more generous benefits than the average Canadian receives. The proposed measures would ensure that the health benefits for those who arrive illegally in Canada are not more generous than what Canadians receive from the government." – Cracking down on Human Smugglers who Abuse Canada's Immigration System (Government of Canada, 2012b, para 12)*

From this quote, I worked backwards, again using the Floret (2019) four-step approach for identifying the problem representation.

4.3.1 What does the document propose? To make sure that those who have not followed the rules will not be rewarded for their actions by having access to more generous benefits than the average Canadian is entitled to

The quote from the primary document, *Backgrounder – Cracking down on Human Smugglers who Abuse Canada's Immigration System,* proposes to make sure that "…those who have not followed the rules…" will not be "…rewarded for their actions by having access to more generous benefits than the average Canadian receives" (Government of Canada, 2012b, para 12).

What is referred to as "those who have not followed the rules" also pertains to the second problem representation ("unfounded refugee claims made by those who arrive illegally"), as well as to the first problem representation ("abuse of the immigration system"). According to the secondary source document, *Backgrounder – Protecting our Streets and Communities from Criminal and National Security Threats*, "those who have not followed the rules" are those individuals who enter the country illegally as "irregular arrivals, potentially involving human smuggling operations" which presents "many challenges for authorities identifying individuals involved in the case". Due to the premeditated nature of the operation, individuals often do not have documents, or rely on fraudulent or fraudulently obtained documents, or have destroyed documents in order to hide their identity, "which makes it challenging for authorities to identify, detain and remove them" (Government of Canada, 2012i, para 1). Being "rewarded for their actions by having access to more generous benefits than the average Canadian receives," according to the secondary source document *Reform of the Interim Federal Health Program ensures fairness, and protects public health and safety* (Government of Canada, 2012e), refers to the health insurance benefits that refugee claimants are eligible for under the Interim Federal Health Program (IFHP). According to the document, the IFHP provides "temporary healthcare coverage to eligible protected persons, refugee claimants and others who do not qualify for provincial and territorial health insurance plans" (Government of Canada, 2012e, para 3-4). Thus, the core proposal in the primary document, *Backgrounder - Cracking down on Human Smugglers who Abuse Canada's Immigration System,* is that "those who have not followed the rules" should not be rewarded for their actions by having access to more generous benefits than the average Canadian receives. The change is necessary as it derives from unfounded refugee claims in the second problem representation ("unfounded refugee claims made by those who

arrive illegally") having been "rewarded for their actions by having access to more generous benefits than the average Canadian receives" (Government of Canada, 2012b, para 12).

4.3.2 What was assumed necessary to change or to be done? Health benefits for those who have not followed the rules should not be greater than those for average Canadians

According to the primary document, *Backgrounder - Cracking down on Human Smugglers who Abuse Canada's Immigration System,* what needs to change is the "unfair" reward of health benefits (defined as benefits greater than the health benefits available to the average Canadian) for "those who have not followed the rules." What needs to be done is the introduction of measures that "…would ensure that the health benefits for those who arrive illegally in Canada are not more generous than what Canadians receive from the government" (Government of Canada, 2012b, para 12).

One of the eight secondary source documents, *Reform of the Interim Federal Health Program ensures fairness and protects public health and safety,* discusses that for the government to "ensure fairness," reform is needed. According to the document, reforms "ensure that tax dollars are spent wisely and defend the integrity of our immigration system all at the same time" (Government of Canada, 2012e, para7). The reform, according to the primary document, *Backgrounder Cracking down on Human Smugglers who Abuse Canada's Immigration System,* means that "the individual would not have access to a health and benefits package that is more generous than what Canadians receive from the government" (Government of Canada, 2012b, para 9). The secondary document, *Backgrounder - Overview of Canada's Refugee Programs,* also discusses "access" and the need for reforms in a way that meshes with the second problem representation discussed above ("Unfounded refugee claims made by those who arrive illegally"). By emphasizing how policy reforms target the removal of illegal arrivals

and refugee claimants that have failed to prove their need for state protection. An unfounded refugee claimant's deportation, it is argued, will "save taxpayers millions of dollars on social assistance programs, health care, and other taxpayer-funded services" (Government of Canada, 2012m, para 40).

4.3.3 What was assumed to be problematic? That refugee claimants have access to health benefits that are more generous than those available to the average Canadian

According to the primary document, *Backgrounder - Cracking down on Human Smugglers who Abuse Canada's Immigration System*, it is problematic that "unfair" health benefits for "those who arrive illegally in Canada" are "more generous than what Canadians receive from the government" (Government of Canada, 2012b, para 12).

In one of the eight secondary source documents, *Reform of the Interim Federal Health Program ensures fairness, and protects public health and safety,* the term "unfair" is expanded. According to the document, "a federal program that provides health-care benefits to protected persons, refugee claimants and others is being reformed to ensure fairness for Canadian taxpayers while emphasizing the need to protect public health and safety." The backgrounder goes on to detail that what is "unfair" is healthcare "benefits for protected persons and refugee claimants that are more generous than what [Canadians] are entitled to themselves" (Government of Canada, 2012e, para 1-2). In the same backgrounder, these "generous" healthcare benefits are detailed as "basic health-care coverage, similar to what is provided through a provincial or territorial health insurance plan, as well as coverage for supplemental health-care services, including pharmaceutical care, dentistry, vision care and mobility assistive devices." The document goes on to argue that is unfair because "Most Canadians, however, do not have access to government-funded supplemental health care." (Government of Canada, 2012e, para 3-4). In

addition, the backgrounder details that these "generous" healthcare benefits are problematic as most Canadians "do not have access to government-funded supplemental health care" (Government of Canada, 2012e, para 4). How these healthcare benefits are distributed, according to the secondary source document, *Backgrounder – Cracking down on Human Smugglers who Abuse Canada's Immigration System*, is through the Interim Federal Health Program. The IFHP, according to the backgrounder, provides healthcare benefits to all "refugee claimants (including failed refugee claimants who are awaiting removal), convention refugees, and others in refugee-like situations" (Government of Canada, 2012b, para13). In the secondary source document, *Reform of the Interim Federal Health Program ensures fairness, and protects public health and safety;* the provision of healthcare benefits to all refugee claimants regardless of the legitimacy of their claim is further problematized. The problem is that such healthcare benefits are described as an incentive to those "people who may be considering filing an unfounded refugee claim in Canada" (Government of Canada, 2012e, para 7).

4.3.4 What was the problem is represented to be? The unfair rewarding of health benefits greater than what the average Canadian receives by those who arrive illegally in Canada to make unfounded refugee claims

To summarize, so far in the process of identifying what the problem is represented to be for this third problem statement: (i) the core proposal was to make sure that those who have not followed the rules will not be rewarded for their actions by having access to more generous benefits than the average Canadian is entitled to; (ii) what was assumed necessary to change was the health benefits for those who have not followed the rules, so they should not be greater than those for average Canadians; (iii) what was assumed to be problematic is that refugee claimants have access to health benefits that are more generous than those available to the average Canadian. That is,

the document proposes a problem of "unfair" rewarding of health benefits and a need for reforms to solve it, specifically related to the Interim Federal Health Program.

What is assumed problematic in the primary document is that "those who have not followed the rules" are being "rewarded for their actions by having access to more generous benefits than the average Canadian." From this assumption, I can articulate what the problem is represented to be. The problem is the "unfair" rewarding of health benefits greater than what the average Canadian receives by those who arrive illegally in Canada to make "unfounded" refugee claims.

This problem representation of "unfair" rewarding of health benefits is narrower than the macro-level of the first problem representation regarding "abuse" of the immigration system by human smuggling and more limited than the meso-level of the second problem representation regarding "unfounded" refugee claims by those who arrive illegally. Instead, the third problem representation problematizes at the micro-level the healthcare benefits for those who have come "illegally" and have made an "unfounded" claim for refugee protection and are "rewarded" with health benefits that are "greater" than what the average Canadian receives. It includes a singular framing of how "unfounded" claimants have "abused" the refugee system by receiving health benefits and that this abuse is "unfair" to the average Canadian. The third problem *representation* is specifically concerned with the Interim Federal Health Program and its provision of "unfair" health benefits.

4.4 Chapter summary of "problem representations"

In section 4.1, I conducted the first step of the WPR analysis by asking, "what is the problem represented to be in a specific policy or policies?" That first step involved identifying

and clarifying problem representations by scanning the 11 backgrounder press release statements I identified during my data collection. Three of the 11 backgrounder press release statements contained an explicit problem within their core proposal and thus became primary documents for my analysis. By following Floret's (2019) process logic for Step 1 of the WPR method, I articulated the problem in each of the three backgrounder press release statements. Three of the problem representations identified nest hierarchically regarding their scope of immigration policy reform, from the macro to the micro-level of reform. The first problem representation at a macro-level pertains to the broad problem of a porous and unfair immigration system that lacks appropriate penalties for the act of human smuggling, leading to the systemic "abuse of the immigration system." The second problem representation is at a meso level, narrowing down to one aspect of the "abuse of the immigration system," which concerns refugee protection and is articulated as the "abuse" of the refugee system by "unfounded" refugee claims made by those who arrive "illegally" from countries that do not typically produce refugees. The third problem representation falls within the micro level, narrowing the scope to one aspect of the refugee protection system -- the temporary provision of health benefits to refugee claimants. This was articulated as "an unfair provision of health insurance benefits to unfounded refugee claimants" greater than what the average Canadian receives and given to those who arrive "illegally" in Canada. This third problem representation relates specifically to my inquiry into why refugee claimants do not have a legal right to access healthcare in Canada.

The following chapters continue with steps 2 to 6 of the WPR analysis process. My analysis focuses primarily on the third problem representation, as it focuses on healthcare which is the subject of my analysis. In contrast, the first two problem representations are more about immigration and border security. Still, I do include reference to the first and second problem

representations in terms of how these representations contribute to the third problem representation and the problem of refugee claimant access to healthcare. I begin in Chapter 5 with the second step of the WPR analysis, where I identify the conceptual logic of the identified "problem representations" by drawing upon existing theory and scholarship.

Chapter 5: *WPR Step 2*, Identifying the Deep-Seated Presuppositions or Assumptions that Underlie the Problem Representation(s)

Step 2 is where the analysis begins of the "problem representations." Building upon step 1 of the WPR method, step 2 asks: "What deep-seated presuppositions or assumptions underlie the problem representation? What presuppositions and meanings are necessary for this representation of the problem to make sense?" Step 2 is a Foucauldian-like archaeological analysis of the discourses that form "truth" from socially produced knowledge. The point is not to ask why the policy happened but how it happened and what meanings need to be in place for it to be accepted and make sense. Step 2 also requires the researcher to understand how knowledge acquires a 'truth' status and locate this 'truth' within the relevant networks of relations and practices. Step 2 includes identifying the presuppositions, assumptions, knowledge, and discourses that accord intelligibility, coherence, and truthfulness to a problem representation. A presupposition is an implicit assumption (i.e., an assumption not consciously apparent) about the world or a background belief relating to a "truth" that is taken for granted in discourse and must be understood as true to make sense of a given line of reasoning. An assumption is like a presupposition, but instead of pertaining to a propositional element (premise) of a given line of reasoning, it pertains to the line of reasoning as a whole. It is integral to the reason or structure of an argument (Plumer, 2017). Both assumptions and presuppositions are necessary to step 2, as they provide context to the concepts and binaries of a problem representation and clarify how a problem representation was constructed. In step 2, developing new theories or understandings of the discursive meanings that need to be in place for a problem representation to make sense or be accepted is unnecessary. Instead, drawing upon scholarship and theory to identify the discourses that form truth from socially produced knowledge is acceptable. For this thesis, identifying the

discourses that form "truth" involves reviewing scholarship related to the field of immigration. Sources that I drew on to complete this task include the work of Beatson (2016), Castle (2003), , Connoy (2018), Dauvergne (2000), Flores (2002), Goldring and Colleagues (2007), Jorgensen (2012), Liempt & Sersli (2013), Malkki (1996), Nadig (2002), , Schneider & Ingram (2005), , van Dijk (2009 , and Villegas & Blower (2019). The work of these and other scholars was key to helping me identify the deep-seated assumptions and the associated presuppositions that underlie the problem representation.

In the following subsections, I present my analysis of the problem representations extracted within step one of the WPR method. In subsection 5.1, I analyze the first and second problem representations. First, I examine the keywords within the first and second problem representations as they are essential to identifying the assumption relevant to both. With that assumption identified, I examine scholarship to determine the essential presuppositions (implicit assumptions) or taken-for-granted "truths" in discourse that are important to make sense of the assumption identified. I then analyze the presuppositions, detailing the conceptual logic as it involves binaries that the problem representation relies upon to support the idea that it is truly a problem that needs to be solved through policy. In subsection 5.2, I analyze the third problem representation, which derives from the first and second problem representations concerning the "illegitimacy" of arrivals and refugee claimants. However, this third problem representation differs in that it problematizes healthcare provision, which crosses into the field of state welfare entitlements. Following the same steps in subsection 5.1, I examine the problem representation keywords to identify its assumption. With the assumption identified, I examine the relevant scholarly literature to identify the essential presuppositions (implicit assumptions) or taken-for-granted "truths" within the discourse that are important to make sense of the assumption

identified. Again, like subsection 5.1, I examine the presuppositions and discern the binaries involved in the conceptual logic because the problem representation relies upon them to support the idea that it is truly a problem that needs to be solved through policy. Finally, I conclude this section by summarizing the significant points and discussing how they will inform Step 3 of the WPR method.

5.1 Assumption that "illegal" migrants threaten society

The first and second problem representations overlap in their concern for "abuse" of the immigration system by "illegal" migrants. What differs is the scale of the problem representation. The first problem representation pertains to the problem of a porous and unfair immigration system that lacks appropriate penalties for the act of human smuggling, leading to the systemic "abuse" of the immigration system. Thus, the first problem representation concerns all arrivals who enter the country "illegally." By contrast, the second problem representation pertains to the problem of an "abuse" of the refugee system by "unfounded" refugee claims made by persons who arrive "illegally" from countries that do not typically produce refugees. The overlap between the problem representations is the shared concern with the arrival of "illegal" migrants. This arrival through "illegal" means is an "abuse," according to the government. This "abuse" is assumed to affect the "integrity" and "fairness" of the immigration system and, more specifically, the refugee protection system. Within the first and second problem representations, these individuals are deemed untrustworthy for not following the law. As such, their actions undermine the "integrity" and "fairness" of the institution of immigration and, therefore, need to be dealt with to protect the state and society. The broad assumption of the first and second problem representations is that "illegal" migrants threaten society. Looking to immigration scholars like Castles (2003), Flores (2003), Goldring and Colleagues (2007), Jorgensen (2012),

Liempt and Sersli (2013), Nadig (2002), and Schneider & Ingram (2005), , , I identified four presuppositions (implicit assumptions) necessary to make sense of the given assumption.

5.1.1 The presupposition that irregular migration is a "crisis" for national security.

In his 2003 work, Castles argues that an assumed "crisis" exists in immigration policy that rests upon an implicit assumption that irregular migrants represent a severe "transnational threat" against "national security," especially those who claim refugee protection (p.16). Scholars like Jorgensen (2012) reaffirm the "crisis" idea by arguing that the unexpected and illegal arrival of migrants is framed as something that cannot be controlled,threatening and associated with the "potential for criminal activities and terrorism" (p.51). Flores (2003) argues that this presupposition relies upon a connection between "criminality" and "immigration", and that this connection creates a "slippage" in language use between the two that has become "almost natural" (p.363). A polar binary is established here between those who arrive with the state's consent and those who come without the state's consent. The first group is framed as law-abiding, and the second group is framed as criminal. This presupposition is necessary to assume that "illegal" migrants are a threat to society as they are implicitly assumed to be disruptive criminal elements that are uncontrollable and dangerous criminal elements.

5.1.2 The presupposition that irregular arrivals are "unlawful"

Liempt and Sersli (2013) articulate how the presupposition that irregular arrivals are "unlawful" rests upon an assumption regarding irregular migrants who arrive via human smuggling activities. According to the authors, these activities represent an explicit act of undermining the state's sovereignty over its borders and its system of immigration. Such smuggling activities challenge border laws, thereby making the action "unlawful." The people engaged in such activities are assumed to be criminals as it is reasoned that persons(s) who can

afford to pay smugglers must have legitimate means to enter the country. The assumption is that any person who utilizes human smuggling as means of entry and then attempts to remain by claiming the need for refugee protection is not "genuine" or "deserving" in their claim for refugee protection (p.1030-4). Nadig, in her 2002 work, explains that the belief that irregular arrivals are "unlawful*"* connects with the assertion that there are sufficient means by which migrants can find access to legal protection as refugee claimants both within and outside the country. Subsequent to the assertion that there are sufficient means for lawful entry, the second assertion is that the border security tools to deter irregular immigrants do not negatively affect the ease with which persons can claim protection. The presupposition that irregular arrivals are "unlawful" rests on the binary of "legal" and "illegal." "Legal" migrants are those who follow immigration laws and procedures. At the same time, "illegal" migrants work outside the law by taking actions that are constructed as "jumping the queue" by entering the country in a manner that avoids border security measures. "Illegal" migrant behaviours burden the government and burden those "legal" migrants who have followed law and procedure. The presupposition that irregular migrants are "unlawful" is a necessary precursor to the assumption that "illegal" migrants threaten society as their actions are implicitly assumed to have negative burdens for both the state and "legal" migrants.

5.1.3 The presupposition is that migrant irregularity is an individual choice

In their research on migration, Schneider and Ingram (2005) argue there is an implicit assumption in immigration discourse that all migrants are responsible agents and responsible for their fate. When migrants engage with human smugglers, utilizing forged paperwork and employing other means of deception, they are placed outside the norms of acceptable behaviour within society by the state. This unacceptable behaviour legitimizes restrictive actions by the

state to disempower these “illegal” migrants. These “illegal” migrants are opposed to “legal” migrants, establishing a binary relationship. “Illegal” migrants are seen as deviant due to their actions which violate the law. At the same time, “legal” migrants are law-abiding because they follow policies and procedures. The presupposition that migrant irregularity is an individual choice is necessary to assume that “illegal” migrants are a threat to society. Migrants are implicitly assumed to be free agents with choice and thus responsible for their behaviours and actions. The implicit assumption is that if an individual engages in “illegal” acts like human smuggling, forging paperwork, or other forms of deception not acceptable to society, it is acceptable to take action to disempower these “illegal” migrants to protect the state and society.

5.1.4 The presupposition is that irregular migrants contribute to societal disorder and instability

Goldring and colleagues (2007) argue that, within immigration discourses, irregular migrants are assumed to work outside of law and procedure and to have the means to overwhelm public and state institutions. This presupposition is concerned with public and state institutions such as the labour market, welfare systems, and healthcare. These institutions have finite resources that citizens depend upon, participate in, and contribute to financially. Goldring and colleagues go on to argue that it is presumed in migration discourse that these institutions require protection against excessive demand, especially by those who are non-citizens. This concern for public and state institutions underpins the implicitly assumed justification of restrictive policies and the disempowerment of irregular migrants. Jorgensen (2012), in his work on immigration, states that the use of restrictive policies “sends a powerful symbolic message that the state is in control and holds the power to decide who is deserving and who is not” (p.52). Jorgensen argues that states often “territorialize human rights” by turning them into “citizen-based rights” if it is believed to

lead to social stability and protection of state institutions (p.52). According to Jorgensen (2012), the concern for stability justifies using "illiberal means, for example, deporting people without conducting a proper case investigation." According to the state, such an approach is justified if it helps restore social order (p.52). A binary opposition has been constructed between irregular migrants and citizens based on a concern for social stability. Irregular migrants are implicitly assumed through their "illegal" behaviours to contribute to social disorder and instability; they are framed as non-contributing and thus undeserving access to the public and state institutions. Citizens are opposed to irregular migrants and are constructed as law-abiding, contributing, and deserving of access to state and public institutions. The presupposition that irregular migrants contribute to societal disorder and instability is necessary to assume that "illegal" migrants are a threat to society. They are implicitly assumed to be agents of chaos and instability through their "illegal" behaviour at the expense of citizens and other "legal" migrants.

5.1.5 A summary of the analysis of presuppositions contained in the first and second problem representations

In examining the first and second problem representations for their overlapping elements, one common assumption important to both and integral to the structure of the problem(s) represented is that "illegal" migrants threaten society. Four presuppositions are essential to giving "truth" to this assumption. These presuppositions are foundational for making sense of any given line of reasoning within the first and second problem representation. The first presupposition is that irregular migration is a "crisis" for national security. An immigration "crisis" must be "true" for migrants to be seen as a threat. The second presupposition is that irregular arrivals are "unlawful." Irregular migrant's actions must be seen as violating the law to be classified as "illegal" migrants, and "illegal" migration is essential to the first part of the

assumption. The third presupposition is that migrant irregularity is an individual choice. Irregular migrants must be seen as having a choice when violating the law, and the state must be seen as doing nothing that would prevent legal migration, thereby establishing irregular migrants' actions as "illegal." Lastly, the fourth presupposition is that irregular migrants contribute to societal disorder and instability. Irregular migrants must be implicitly assumed to be agents of chaos and instability through their "illegal" behaviours, making them a threat to society, for the assumption identified to be valid.

5.2 Assumption that "unfounded" refugee claimants are undeserving of welfare benefits like healthcare

In subsection 5.1, I analyzed the first and second problem representations and identified the assumption relevant to both. With that assumption identified, I examined scholarship to identify its four essential presuppositions (implicit assumptions) or taken for granted "truths." In subsection 5.2, I will analyze the third problem representation for its underlying assumption and supportive presuppositions.

The third problem representation pertains to the "unfair" rewarding of health benefits greater than what the average Canadian receives by those who arrive "illegally" in Canada to make "unfounded" refugee claims. Essential to this third problem representation is that "illegal" migrants have made "unfounded" claims for refugee protection. In addition, the third problem *representation* emphasizes that it is "unfair" to Canadians that those with "unfounded" claims have been given health benefits greater than what the average Canadian receives. The financial and material rewards of irregular migration are significant to this problem representation, which derives from but is different in scope than the first and second problem representation, which were concerned with how the immigration system is "abused" by irregular migrants.

The primary assumption of the third problem representation is that "unfounded" refugee claimants are undeserving of welfare benefits like healthcare. Looking to immigration scholars like Agamben (2005), Beatson (2016), Connoy (2018), Dauvergne (2000), Olsen and colleagues (2014), Malkki (1996), van Dijk (2009), and Villegas & Blower (2019), I identified five presuppositions (implicit assumptions) necessary to make sense of the given assumption.

5.2.1 The presupposition is that welfare is a matter of discretion and not a moral obligation

The presupposition that welfare is a matter of discretion and not a moral obligation is clarified by Jorgensen's (2012) work. Jorgensen argues that states and citizens assume welfare benefits like health insurance are a matter of discretion, not a "moral obligation" (i.e., something owed to refugee claimants) or a matter of law (p.58). Agamben's (2005) argument strongly correlates with the idea that welfare benefits are a matter of discretion. Agamben argues that migrants who claim refugee protection are not yet citizens, as their claim is not deemed legitimate until the state makes a positive decision. A refugee claimant's individual or human rights to benefits like healthcare are diminished when they are assigned a migrant status that is indeterminate in status and position by a state that has claimed power over them. Beatson (2016) and Connoy (2018) expand upon this idea that since refugee claimants are not citizens, it is the state's prerogative to debate over what legitimate claims they have on finite taxpayer resources like healthcare. A binary is established, distinguishing between refugee claimants and citizens. On the one side, refugee claimants have yet to have a decision by the state and thus have an illegitimate claim to healthcare. On the other side is citizens, who are legitimately entitled to finite taxpayer resources like healthcare as members of the state and taxpayers. The presupposition that welfare is a matter of discretion and not a moral obligation is necessary to assume that "unfounded" refugee claimants are undeserving of welfare benefits like healthcare.

5.2.2 The presupposition is that refugee claimants are either "genuine" or "bogus"

The presupposition that refugee claimants are either "genuine" or "bogus" is described in Malkki's (1996) work on how refugee claimants have limits placed upon their ability to construct their stories. Refugee claimants, according to Malkki, are discursively constructed in ways that entail generalizations and deny their complexity and uniqueness as individuals. For example, "irregular" migrants who utilize human smugglers to circumvent border security are often depicted in popular media as "criminals," "illegals," and "unfounded" in their claims for refugee protection as they have the money and means to cross borders. Beatson (2016) argues that such negative characterizations are found in popular media and policy. Beatson states that media and policy present an active attempt to dehumanize refugee claimants as "swarms of insects or catastrophic floods" (p. 128). In my own previous work (2014), my colleagues and I argue that refugee claimants are often feared. They are depicted as threatening a country's culture, economy, and welfare through their efforts to circumvent law, policies, and measures intended to deter them. Alternatively, refugee claimants may be assigned a victim status and characterized as helpless, needy, weak, or passive if they embody vulnerability through their story and actions (Van Dijk, 2009; Villegas and Blower, 2019). A binary, then, is established. On the one hand is the construction of refugees as dehumanized and feared, which depicts refugee claimants as those who have the money and the capacity to cross borders lawfully and who is a threat to the state and society by being deceptive, fraudulent, and thereby "bogus" in their claim for refugee protection. On the other hand, refugee claimants are constructed as helpless, needy, and passively law-abiding individuals who are legitimately in need of aid and therefore "genuine" in their claim for refugee protection. This presupposition that refugee claimants are either "genuine" or "bogus" is necessary to assume that "unfounded" refugee claimants are

undeserving of welfare benefits like healthcare as they are judged to have the money and capacity to help themselves.

5.2.3 The presupposition is that only those in "genuine" need are deserving of help

The presupposition that only those in "genuine" need are deserving of help is explored in the research by Villegas and Blower. According to Villegas and Blower (2019), the question of who is in "genuine" need rests upon societal norms regarding "deservingness"[19]. Villegas and Blower (2019) argue that deservingness judgments are about how non-citizens fit into existing systems of social entitlement. These judgments rest upon concepts of humanitarianism that promote vulnerable populations such as refugees as deserving of protection by the host state. Judgements about deservingness also rest on beliefs regarding security, border protection, and financial responsibility that promote notions that most refugee claimants and other irregular migrants are "frauds" and "criminals" seeking to exploit the country's welfare institutions (p.75). Alternatively stated, refugee claimants face evaluation regarding their morality and deservingness. If deemed to engage in criminal acts before, during, or after they arrive in Canada that, if committed in Canada, would violate the law, they are deemed immoral and undeserving and thus "bogus" or "unfounded" in their claim. Criminal acts that make refugee claimants "bogus" can include employing human smugglers to circumvent immigration law to make an asylum claim or utilizing fake migration papers to enter the country to make an asylum claim.

[19] Deservingness as discussed by Willen (2012) involves a process evaluation of the morality of individuals and groups to decide who should or should not have access and entitlement. This is operationalized conceptually to discuss responses to poverty, healthcare, immigration, etc. (Villegas & Blower, 2019). However, it is also used in the formation of symbolic boundaries that are comprised of negotiated categories like people, objects, space, practices, and time that can lead to "unequal access to and unequal distribution of resources (material and nonmaterial) and social opportunities" (Lamont and Molnar, 2002, p.168). Also, deservingness has an effect in terms of social entitlements that when performed lead to divides between citizen and non-citizen that lead to the production of migrant illegalization (Villegas & Blower, 2019).

According to Connoy (2018), within public discourse, "bogus" or "unfounded" refugee claimants' actions negatively affect "genuine" refugee claimants by "jumping the queue" and creating delays for those in "genuine" need. "Bogus" or "unfounded" refugee claimants are described as selfish, disingenuous, and undeserving of taxpayer services like healthcare. Villegas and Blower (2019) explain that public discourse assumes that when taxpayer dollars are going to benefit these "bogus" or "unfounded" refugee claimants, this is understood to be rewarding immoral behaviour and "unfair" to law-abiding citizens and migrants. Again, the binary is between "genuine" refugee claimants and "unfounded" (or "bogus") refugee claimants. "Genuine" refugee claimants are those who are vulnerable, moral, and deserving of help. "Unfounded" refugee claimants are immoral, criminal, and therefore undeserving of help. The presupposition that only those in "genuine" need are deserving of help is necessary to assume that "unfounded" refugee claimants are undeserving of welfare benefits like healthcare as they are implicitly assumed to be immoral and criminal.

5.2.4 The presupposition is that the extension of welfare benefits is an act of charity

This presupposition is related to the first, second, and third presuppositions. It is premised upon the idea that healthcare for refugees and refugee claimants is an act of charity (or humanitarianism). Dauvergne, in his 2000 work, explains that the humanitarian act of providing healthcare is not a moral obligation (something that is owed) or an obligation of health-based rights that derive from some sort of fundamental rights such as human rights. According to Beatson (2016), providing healthcare access is an act of charity. Beatson (2016) argues that it is often articulated in terms of deservingness, upon which refugee claimants are judged and determined worthy, rather than on the legitimacy of access by uninsured individuals as their human right. These acts of charity underscore notions about Canadian values and romanticize

humanitarian missions from years past. Blower and Villegas (2019) note, "for the humanitarian 'Canadian values' frame to be effective, it needed to be applied onto 'deserving' subjects: those identified as having a 'legitimate' need for protection" (p.78). Thus, by framing healthcare as an act of charity for a vulnerable and needy group, a binary exists between those without agency and those with agency. The first group comprises "legitimate" or "genuine" refugee claimants who are helpless, needy, weak, or passive and assumed incapable of supporting themselves. The second group is "bogus" or "unfounded" refugee claimants who have the money, capacity, and agency to choose where they go to seek asylum. Thus, it is implicitly assumed they can take care of themselves. This presupposition that the extension of welfare benefits is an act of charity is necessary to assume that "unfounded" refugee claimants are undeserving of welfare benefits like healthcare, as extending healthcare benefits is an act of charity to those vulnerable victims.

5.2.5 The presupposition is that only those who contribute socially and economically should receive benefits

The presupposition that only those who contribute socially and economically should receive benefits relies upon beliefs about taxpayer cost and contributions. Villegas and Blower (2019) argue that refugees and refugee claimants are depicted as noncontributors to the economy and the state taxation system. Contribution is essential to the entitlement of welfare services like healthcare. However, there is a distinction between refugees and refugee claimants with respect to their depiction as noncontributors. Refugees are entitled to become permanent residents. They can legally work within the country, pay taxes, benefit from welfare support, and, if they remain for a long enough time, they can apply to become citizens. In addition, refugees are understood to be victims deserving of humanitarian aid. Linked to the first, second, third, and fourth presupposition, refugees are vulnerable charitable cases worthy of access to public welfare

resources like healthcare. Despite not initially being tax contributors, public welfare resources are available to assist those vulnerable persons in finding independence, employment, and becoming social/economic contributors.

In contrast, refugee claimants awaiting a decision regarding their case are treated with suspicion. They are not seen as "genuine" refugees until their case is deemed legitimate by the state. Thus, until a refugee claimant has their claim determined to be legitimate, they are seen as exploiting limited public resources of the nation, like healthcare. A binary between refugees and refugee claimants exists. In addition, a binary between refugees and citizens exists. Across these two binaries is a hierarchy of belonging based upon economic and tax contribution, which determines who is entitled and who is not. Within this hierarchy, citizens are at the top and at the bottom are refugee claimants who have yet had the legitimacy of their claims determined. This presupposition that only those who contribute socially and economically should receive benefits is necessary to assume that "unfounded" refugee claimants are undeserving of welfare benefits like healthcare. Extending healthcare benefits is only justified for those who are or will be contributors to the economy and the taxation system.

5.2.6 Summary of analysis of presuppositions contained in the third problem representation

The assumption underlying the third problem representation (i.e., the "unfair" rewarding of health benefits greater than what the average Canadian receives by those who arrive "illegally" in Canada to make "unfounded" refugee claims) is that "unfounded" refugee claimants are undeserving of welfare benefits like healthcare. This assumption rests upon five presuppositions that contribute to the assumption and are essential to give "truth" to the assumption. The assumption is taken for granted as evident and can be drawn on to make sense of any given line

of reasoning within the third problem representation. The first presupposition is that welfare is a matter of discretion and not a moral obligation. The second is that refugee claimants are either "genuine" or "bogus." The third presupposition is that only those in "genuine" need are deserving of help. The fourth is that the extension of welfare benefits is an act of charity. Lastly, the fifth presupposition is that only those who contribute socially and economically should receive benefits. Each presupposition is necessary for the assumption that "unfounded" refugee claimants are undeserving of welfare benefits like healthcare, as they are not seen as having a legitimate reason or cause to be awarded access to healthcare.

5.3 Chapter summary

Step 2 of the analysis identified and analyzed the discourses that form "truth" from socially produced knowledge and developed insight into how the problem representations were constructed. The next chapter (Chapter 6) contains the third step of the WPR analysis. Step 3 builds upon the discourse analysis work of step 2 and involves a form of Foucauldian genealogy that involves reviewing scholarship related to the history of immigration in Canada. Step 3 is where I highlight the conditions that allowed the identified problem representations to take shape and assume dominance over other competing problem representations in history.

Chapter 6: *WPR Step 3*, How the Problem Representation(s) Came About

Building on the work of steps 1 and 2, step 3 asks: "*How has this representation of the "problem" come about?*". The purpose of step 3 is two-fold: first, to highlight the conditions that allowed the problem representations identified in step 1 to take shape and assume dominance over other competing problem representations in history; second, to illustrate a plethora of developments that also took place that could have alternatively shaped the problem representations if they had gained dominance.

The goal of step 3 is to establish how the problem representations have a history (genealogy) and to upset any ideas regarding their "natural" evolution. By documenting the history (genealogy) of the problem representations, the taken-for-granted "truth" or naturalness of its underlying assumptions/presuppositions are destabilized. The history provides insight into the relations of power that underpin the success of some problem representations and the defeat of other problem representations. Step 3 involves a form of Foucauldian genealogy and starts with the problem representation in its present form and traces back in time the specific points when critical decisions occurred and took a particular issue in a specific direction. The analysis here reveals the twists and turns that led to the emergence of the problem representations. The developments at the margins of history illustrate where the problem representation is susceptible to change.

Step 3 relies upon the work of others who highlight important events, document change, provide commentary and critique, and provide insight into the conditions surrounding policy implementation and change. I relied upon various sources to analyze discursive formations within history, including scholarly works, political commentaries, newspaper articles, government documents, and legal documents. Abu-Laban (1998), Bauder (2011), Canadian Council for Refugees (2010), CDRC v Canada (2014), Collacott (2002), Dauvergne (2005), Dhand & Diab (2015), Dirks (1977; 1995), Dirks (2003), Hathaway (1992), Hathaway & Neve (1996), Lowry (2002), Mahtani & Mountz (2002), Nevins (2002), Quan (2017), Simmons (1999), Stoffman & Kelly & Trebilcock (2010), Toussaint v Canada (2010), and Wood (1987) are all sources that I drew upon to complete this task. Utilizing secondary sources is essential to this Foucauldian genealogy to help identify the structures of discourse and the rules that impose themselves on anyone who speaks in this discursive policy field.

In the following subsections, I present my analysis of the history of the problem representations extracted within step one of the WPR method. In subsection 6.1, I provide a timeline of significant events, starting with the policy reforms implemented in 2012 and working backwards toward the origins of the subject of my critical analysis, which is refugee claimant healthcare. I identify that origin as the first time the government decided to pay for medical and hospital expenses for foreign nationals in 1946. I conclude the subsection with what I think are the three most important discourses that have competed against each other for dominance in the course of history to shape the problem representations identified in step 1. I highlight and pay particular attention to the conditions that allowed the identified discourses to take shape in history. In subsection 6.2, I trace the significant changes and evolution of the humanitarian immigration discourse from its early beginnings following the second world war. In subsection 6.3, I trace how the economic migrant discourse emerged to dominance and displaced the briefly dominant humanitarian discourse in policy development and reform. Subsection 6.4 traces the significant changes and evolution of the security and deterrence discourse and how it competed against and gained dominance over both humanitarian and economic discourses. Finally, I conclude this chapter by summarizing the significant points in this history, and reaffirming that this historical analysis effectively upsets any notions of the naturalness of the problem representations identified in step 1.

6.1 Timeline of significant events

In 2012, policy reforms to the Interim Federal Health Program (IFHP) and refugee claimant processing were implemented for the first time. I begin my analysis at that point, working backwards to trace in history the specific moments when critical decisions occurred to take a particular issue in a specific direction. In this section, I present a backwards timeline

(Figure 1) of those vital decisions, focusing on decisions related to the right to access healthcare by refugee claimants. The endpoint for this timeline is the earliest form of health insurance coverage for refugees or refugee-like groups. According to the federal court case *Toussaint v Canada* (2010), the government instituted the earliest form of health insurance for migrant groups in need under Order in Council P.C. 3112 of 1946. I include within the timeline those events that helped shape the legal inclusion of refugees and refugee claimants into the 1976 Immigration Act. I exclude significant immigration reforms that do not discuss refugees or refugee claimants, as those other groups (either economic or family class migrants) fall outside the subject of my analysis in another stream of the immigration system.

Figure 1: Timeline of Vital Decisions for Refugee Claimant Healthcare

Figure 2: Continued

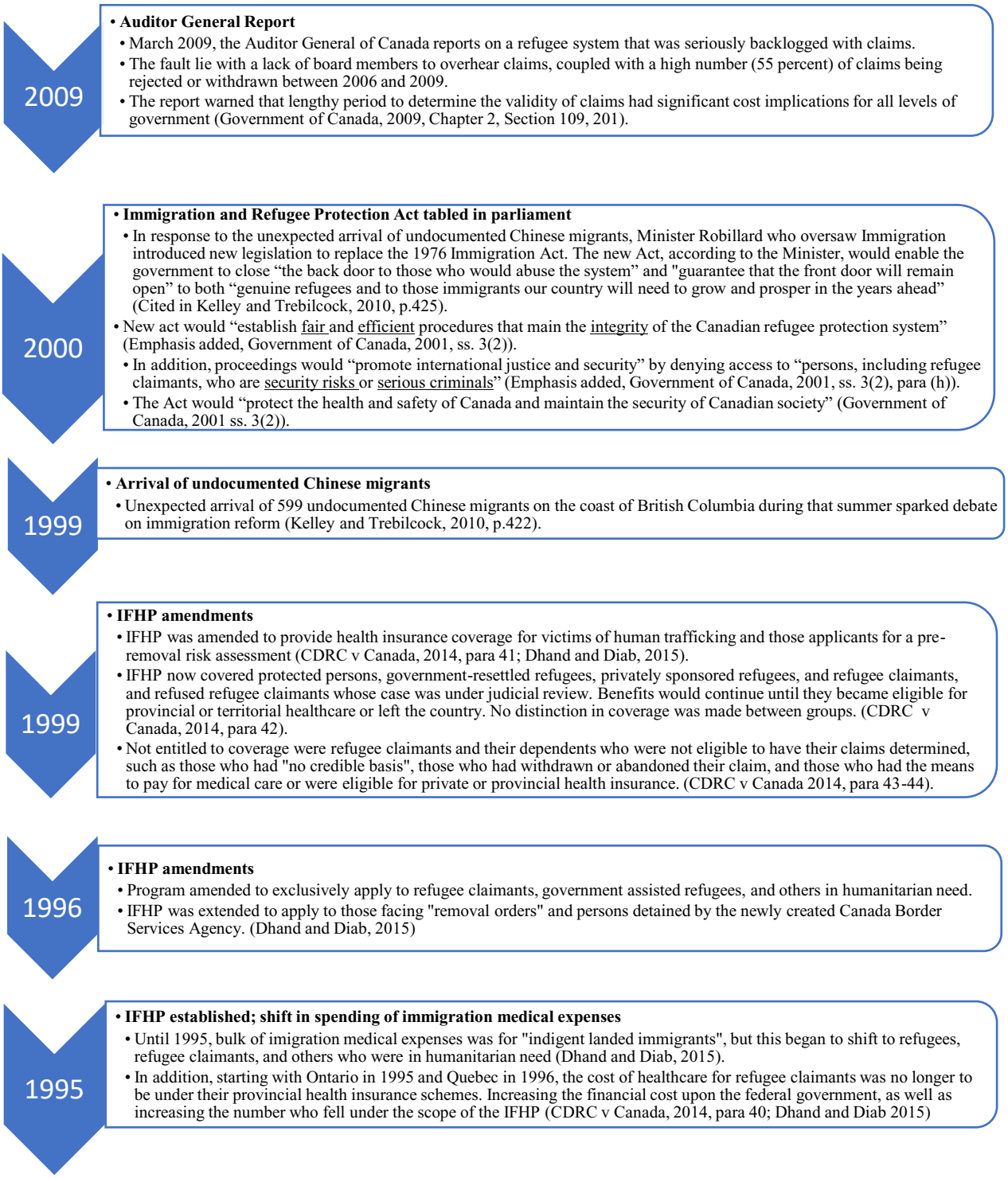

Figure 3: Continued

Figure 4: Continued

The timeline above traces the history of significant policy developments and reforms between 1946 and 2012 related to refugees, refugee claimants, and the development of the Interim Federal Health Program. Three policy discourses explain the relations of power that shaped the critical decisions that were taken and led to specific outcomes in policy related to healthcare access for refugees and refugee claimants. I have labelled these the *Humanitarian Immigration Discourse*, the *Economic Migrant Discourse*, and the *Security and Deterrence Discourse*. In the next three sections (6.2, 6.3, and 6.4), I examine these three policy discourses in turn. From this point forward, I place particular importance on the third *problem representation* identified in step 1. It directly relates to the subject of my analysis: the lack of a legal right for refugee claimants to access healthcare. The third *problem representation* is the micro-level *problem* of the "unfair" rewarding of health benefits, greater than what the average Canadian receives, by those who arrive "illegally" in Canada to make an "unfounded" claim for refugee protection. The first and second *problem representation*, while important, focus on a macro and meso level issue of "abuse;" I refer to these two levels only when they directly inform upon discourses that relate to the most relevant third *problem representation*.

6.2 Humanitarian immigration discourse

Humanitarian immigration discourse in Canadian policy development has a long history. At specific periods, it is viewed as a strength of Canadian society and, at other times, a vulnerability for Canada. Bauder (2011) notes that Canadian humanitarianism is one of the three pillars of Canada's immigration system, next to economic and family-oriented immigration. Admission of persons in need of protection goes as far back as the arrival of British loyalists who fled during and following the American war of independence. In addition, Canada was a destination for the "underground railroad" and the resettlement of persecuted religious minorities

in the late nineteenth and early twentieth centuries (P. 98, 100). Dauvergne (2005) notes that humanitarianism through the admission of refugees enables Canadians to express a positive dimension of national identity (p.73). A link between humanitarian immigration and national identity is key for Canada's international reputation as a compassionate and generous country. This reputation significantly discourages the complete retraction of humanitarian assistance to vulnerable groups like refugees within policy reform.

Three presuppositions of the five identified in Step 2 underpin the third problem representation of "an unfair provision of health insurance benefits to unfounded refugee claimants" originating within the Canadian humanitarian immigration discourse. The first presupposition that "welfare benefits are an act of charity" started with the migration of 4000 Polish ex-soldiers in 1946, which led to a move to providing healthcare to certain classes of immigrants. The polish ex-soldiers were in refugee-like situations following the second world war and could not afford medical treatment upon arriving in Canada for employment. According to government documents presented during the federal court case, *CDRC v Canada* (2014), the provision of welfare benefits was an action that the government rationalized as the humane thing to do at the time. A second presupposition, that "only those who contribute socially and economically should receive benefits," is also strongly linked to the labour movements within refugee resettlement in Canada following the second world war. According to Dirks (1977), during the 1950s, Canada resettled hundreds of thousands of refugees through sponsored labour programs. At the same time, payments for hospital, dental, medical, and incidental expenses to any person under the responsibility of the Department of Immigration were expanded through various Orders in Council by Ministers in charge. According to documents presented during the federal court case *Toussaint v Canada* (2010), the Ministers involved argued that providing

temporary health coverage was humane and in the public interest by having healthy and employable migrants who could be independent and financially established. For decades, the responsibility for temporary health coverage was not at the sole discretion of the Department of Immigration and Manpower but rather a responsibility shared with the Department of National Health and Welfare under their immigration medical services program (Government of Canada, 1956; Toussaint v Canada 2010, para 36). However, linked to a third presupposition – "that welfare is a matter of discretion and not a moral obligation" – the provision was made that those under the responsibility of immigration officials only receive temporary health coverage. These early healthcare policies were implemented through various Orders in Council by the Ministers in charge and are not laws. The Ministers were primarily concerned with the humane interests of charitable relief and, more importantly, the public interest of healthy and employable migrants (Toussaint v Canada, 2010, para44).

Humanitarian immigration discourse in policy supports the continuation of the provision of healthcare on humanitarian grounds to those who need it. Canada's humanitarian discourse gained dominance within immigration policy for a few decades by the beginning of the 1960s. According to Hathaway (1992), Canada signed the 1951 United Nations Convention and 1967 Protocol in 1969, paving the way for refugees to be a distinct legal migrant status in immigration law. In addition, by 1973, Canada established the first convention-based standard for asylum hearings, and by 1976 the UN definition and articles regarding refugees became part of the Immigration Act. Even in the following century, by 2006, it was promoted by the government of Canada as a method of "contributing to the optimal health outcomes in a fair, equitable and cost-effective manner" (quoted in Canadian Healthcare Association, 2012). However, a negative image of humanitarian immigration discourse persists, negatively affecting Canadian

immigration policy. Polarizing situations, such as during the 1985, 1987, 1999, and 2009 unexpected migrant boat arrivals, continue to be utilized to construct an image of Canada as soft and weak by letting people through the "backdoor" of its refugee protection system (Bauder 2011, p.101, 102; Mahtani and Mountz, 2001 p.29). Humanitarianism is a vulnerability within competing economic migration and security & deterrence discourses.

6.3 Economic migrant discourse

Economic migrant discourse is arguably one of the oldest discourses in Canadian immigration policy and shapes policy development and amendments in various ways. Economic immigration, as mentioned by Bauder (2011) above, is one of the three pillars of Canada's immigration system, along with humanitarianism and family-oriented immigration. Polices continuously reflect the aim to develop and pursue the stimulation of economic development and growth through labour migration. Bauder (2011) notes that economic interest could be the fundamental motivation behind Canada's immigration policies (p.116). Nevins (2002) has observed similarly that this economic motivation reflects within public and media debates that characterize, on the one side, regular migrants, no-status immigrants, and temporary and seasonal migrants as competing in the secondary labour market, undermining existing labour and wage standards. However, according to Bauder (2011), on the other side of such debates, immigrants can and continue to be critical contributors to economic restructuring from both the bottom and the top of the labour market. Canada, since its beginnings, has been influenced by economic interests whereby the need for a workforce shapes immigration and settlement policies. Following the second world war, Canada's immigration policy underwent several significant changes, such as a "post-war economic boom", the "removal of racial bias" in admissions, and

an “explicit reference” to economic migrants in the 1976 Immigration Act to foster economic development (Bauder 2011, p.117).

The third problem representation, with its concerns about whether refugee claimants deserve welfare benefits like healthcare, is also shaped by this economic migrant discourse. The provision of healthcare, while dominated by the humanitarian discourse in its earliest inception, was constrained by and competed against the economic migrant discourse. The presupposition that “only those who contribute socially and economically should receive benefits” is shaped by humanitarian and economic discourses but derives significantly from the latter. The temporary coverage first granted to the 4000 Polish ex-soldiers was to ensure they were employable in agricultural work; it was not provided just because they were refugees in need. In the federal court case *CDRC v Canada* (2014), government documents detail the understanding by officials that covering medical costs was necessary for this group to be self-sufficient. Dirks (1977) notes that the prioritization of economic concerns occurred during the resettlement of refugees in the late 1940s and into the 1950s, whereby many refugees selected were based on the country's labour needs (p.210-11). The expanded authority to pay for hospitalization, medical care, dental care, and other expenses for immigrants granted under the 1952 and 1957 Orders in Council was about temporary coverage and not about continual ongoing support. In *Toussaint v Canada* (2010) and *CDRC v Canada* (2014), government documents submitted highlight that health coverage only extended for as long an individual was under the responsibility of the Minister and “pending placement in employment.” In both cases, the courts ruled that health coverage was not about any fundamental right to healthcare explicitly written into law (CDRC v Canada, 2014, para 35; Toussaint v Canada, 2010, para 35). The decades that followed constrained Canada’s

generosity regarding humanitarianism to prioritize the economic well-being of Canadians first and foremost.

The third problem representation reflects the significance that economic migrant discourse plays in policy formation regarding welfare entitlements. Humanitarian discourse led to a hallmark modification of immigration laws. As mentioned above, significant events include the adoption of the 1951 UN Convention in 1969, the introduction of convention-based standards for asylum hearings in 1973, and the 1976 Immigration Act, which adopted the 1951 UN Convention definition of refugees and articles. However, Hathaway (1992) notes that Canada's economic needs tempered policy revisions dominated by humanitarian policy discourse. The presupposition that "only those in 'genuine' need are deserving of help" can be traced to debates before the drafting and adoption of the 1976 Immigration Act. Hathaway (1992) describes senior immigration officials consistently warning that in-land asylum would create a possible "magnet effect" of hundreds or possibly thousands of migrants seeking asylum that would undermine and overwhelm Canada's economic and welfare institutions (p.76). The adoption of the 1951 Convention into the 1976 Immigration Act stopped short of automatically granting asylum seekers the "right" to enter and remain in Canada, which was limited to citizens and persons under the Indian Act (Government of Canada, 1976). In addition, Hathaway (1992) details a letter between senior immigration officials arguing that the law should define "'refugee' strictly and concisely" (p.77). Essential to the 1976 Immigration Act for these officials is a clear legal distinction between "refugee" and a much wider assortment of "threatened classes deserving of special attention although not the full range of post-arrival benefits conferred upon 'refugees'" (Hathaway, 1992, p.77). The result for all persons seeking refugee status in Canada is that their

assessment determines if their claim was “genuine,” with many persons not receiving a favourable determination regarding their refugee claim.

The economic migrant discourse is also essential in the presuppositions that underpin the first and second problem representations assumption concerning how migrants threaten society. Simmons (1999) notes that by the mid-1980s and into the 1990s, economic development became focused on attracting immigrants rich in human and monetary capital that would create opportunities for all Canadians. A policy favouring wealthy and skilled immigrants left little public acceptance for uneducated and unskilled migrants. The presupposition that irregular migrants contribute to societal disorder and instability grew in importance within policy reasoning during this period. Bauder (2011) notes that public fears pertain to how uncontrolled migrants could “flood the labour market,” thereby “diminishing the job prospects” of non-immigrants or earlier immigrants (p.124). The positioning of immigrants within the discourse as potential threats to the economic well-being of Canadians motivates the restrictions placed upon undesirable migrants to protect labour market needs for citizens and residents.

This particular concern over the entry of undesirable migrants seeking employment and government support influenced policies regarding refugees and refugee claimants. The third problem representation derives from several presuppositions that have influenced decisions on the inclusion of non-citizens into the welfare state. Presuppositions include: only those who contribute socially and economically should receive benefits; only those in “genuine” need are deserving of help; the extension of welfare benefits is an act of charity. These presuppositions influenced decisions regarding healthcare entitlements for refugees and asylum seekers, in stark contrast to the situation for economic migrants, who are part of the 1985 Canada Health Act. In the federal court case *CDRC v Canada* (2014), economic migrants' inclusion into the Canada

Health Act is argued to be due to their contribution to taxpayer-funded services. Their tax contribution entitles them to access provincial and territorial healthcare (para 28). The introduction of the Canada Health Act affected the immigration medical services program provided by the Department of National Health and Welfare, the forerunner to the IFHP. According to the case *CDRC v Canada* (2014), following the adoption of the 1985 Canada Health Act, the program narrowed to cover mostly "indigent landed immigrants" and not all immigrants who were the responsibility of immigration officials (as had been the case before the Act) (para 39). This exclusion of refugees and refugee claimants from the Canadian Health Act meant that the discretion over who can be covered remains with immigration officials.

6.4 Security and deterrence discourse

During the 1980s to the 2000s, amendments in immigration policy shifted towards a concern for border security. Security and deterrence are arguably the dominant discourses in Canadian immigration policy. The discourse shapes the development and amendment of policy in various ways to limit the influence of the competing humanitarian and economic discourses. Following the drafting of the 1976 Immigration Act, a dramatic change began to occur within immigration policy. The humanitarian immigrant discourse, which had led to the temporary extension of citizen benefits like healthcare and welfare to those in need, began to lose importance. According to Collacott (2022) and Stoffman and Dirks (2003), the economic immigrant discourse also shifted post-1976; increasingly, citizens viewed immigrants as competitors that undercut domestic wages and labour standards and cost taxpayers millions every year in public services. Abu-Laban (1998) describes an immigration policy shift towards emphasizing the "self-sufficiency" and "economic worth" of migrants (p.205). Lowry (2002) explains that policy shifted by the early 1990s, with a growing international asylum crisis that

saw a dramatic increase in “undocumented” migrants arriving and claiming asylum in Canada. The security and deterrence paradigm grew within this increasing movement of migrants and asylum seekers in the 1980s.

The first and second problem representation presupposition that “irregular migrants contribute to societal disorder and instability” took root in the economic discourse due to border security concerns in the 1980s. These security concerns became the basis for a new policy discourse concerned with border security and deterrence measures. New policies were introduced via legislative amendments in the 1980s to deter and prevent “undocumented” migrants from entering the country and restricting their right to claim asylum. According to Hathaway (1992), the goal was to reduce the perceived financial burdens upon taxpayers by those “irregular” and “illegal” arrivals who made claims under the refugee system (p.40-1). Concerns regarding the burden of “irregular” arrivals underpinned policies that argued that deterrence produces no harm to “genuine” refugee claimants and only affects “unfounded” refugees. According to Hathaway and Neve (1996), policymakers believed “irregular,” “illegal,” and “undesired” migrants will not exploit Canada’s refugee system if they are no longer able to “pick and choose” the destination countries where they could claim refugee protection (p.217). An assumption came to be adopted within the security and deterrence discourse that “genuine” refugees would accept an immediate solution so long as they were free from fear and persecution.

The first and second problem representations assume that the immigration and refugee system is “abused” by migrants derives from the security and deterrence discourse. The presupposition that “irregular migration is a ‘crisis’ for national security” links to the various unexpected arrival events. According to Kelly and Trebilcock (2010), the unexpected migrant arrivals in 1985, 1987, 1999, and 2009 were events that anti-asylum advocates used to construct

Canada as a country needing greater security and deterrence at its borders (Kelley and Trebilcock 2010, p.599; see also Quan 2017 and Wood 1987). Part of the reason for these unexpected arrival events was the collapse of the Soviet Union in 1991, which increased the number of refugee events. By 1992 Canada had become a country of asylum where refugee claims vastly outnumbered government resettlement efforts each year (Government of Canada, 1996, p.11). The presuppositions that "migrant irregularity is an individual choice" and that "irregular arrivals are 'unlawful'" grew in importance in policy development during the 1990s as refugee claims grew each year. According to Hathaway and Neve (1996), opposition party critics constructed refugee claimants as unknown criminals who circumvented Canadian laws and would-be economic migrants who sought to exploit Canada's generous welfare programs through its refugee system.

The security and deterrence discourse informs the third problem representation regarding refugee claimants' deservingness of welfare benefits. By the early 1990s, in response to critics, the government attempted to consolidate the immigration and refugee system and its programs. According to Dhand and Diab (2015), in 1993, a memorandum of understanding was signed between the Department of National Health and Welfare and the Canadian Employment and Immigration Commission (precursor to IRCC). Various programs like the Immigration Medical Services program were transferred and, by 1995, renamed the Interim Federal Health Program. The program continues under the discretion of the Minister of Immigration outside of any federal, provincial, or territorial healthcare system. As a result of the discursive policy shift away from the humanitarian discourse as an Immigration Medical Service program, the provinces of Ontario and Quebec, in 1995 and 1996, respectively, announced that they would no longer bear the financial responsibility for refugee claimants' healthcare, shifting the burden onto the federal

government. According to the federal court case *CDRC v Canada* (2014), by 1999, the IFHP had become much more limited in scope than the Immigration Medical Service program had been. It no longer covered all immigrants under the care of immigration officials. Instead, it was limited to protected persons, GAR's, PSR's, refugee claimants, and others seeking protection on humanitarian grounds. The presupposition from the third problem representation that "refugee claimants are either 'genuine', or 'bogus'" originates within these policy shifts; a critique of that representation of refugee claimants is foundational to critiques of the IFHP. According to Bauder (2011), despite the continuation of the IFHP, the immigration system and specifically refugee claimants faced scrutiny following an Auditor General report in 1997 that criticized the refugee program for being too open to "abuse" by "unfounded" refugee claimants (p.52). Many of the "unfounded" claims were framed as individuals who have the money and capacity to cross borders and were not the helpless, needy, and passive objects of aid that make refugee claimants "genuine."

By 2000, Canada had adopted a the IRPA. According to the Minister in charge at the time, the new immigration act enabled the government to close "the back door to those who would abuse the system… and guaranteed…that the front door will remain open…to both…genuine refugees and to those immigrants, our country will need to grow and prosper in the years ahead" (Cited in Kelley and Trebilcock, 2010, p.425). In the 2000s, Canada's generosity and humanitarianism were increasingly the sources of conflict, as many government officials saw the country as vulnerable and in need of greater security and deterrence measures. The 2009 Auditor General report, like the 1997 report, highlighted a system "overburdened" by rejected or withdrawn refugee claims (Government of Canada, 2009, Ch. 2, S. 109). Events such as the arrival of undocumented migrants in 2009 sparked a political debate that culminated in

Bill C-11, entitled the "Balanced Refugee Reform Act" (2010), and Bill C-31, "Protecting Canada's Immigration System Act" (2012). Both acts enabled the government to enforce strict laws against smugglers, classify irregular arrivals, increase the detention of irregular arrivals, shorten timelines for refugee claimant processing, restrict appeals, and create new funding for deportation (CCR, 2010; Government of Canada, 2012d; Quan, 2017). The IFHP -- like other aspects of Canada's refugee protection system due to critical events such as the unexpected arrivals in 2009 and the Auditor General's report (2009) -- was no longer seen as a vital emblem of Canada's humanitarian national identity by the government policymakers, but instead was utilized to construct an image of Canada as soft, weak, and exploited. The federal court case *Toussaint v. Canada* in 2010 further contributed to calls for reform in immigration policies. These calls for policy reform were from advocates informed by a security and deterrence discourse. In the Toussaint v Canada (2010) case, the judge ruled that the government was not under any obligation to provide undocumented migrants with healthcare. The court's ruling was due to the 1957 Order in Council that had guided Immigration Medical Services and later the IFHP. The 1957 Order in Council was a discretionary policy whereby decisions regarding its application or amendment were not subject to debate in parliament by elected officials. Being a discretionary policy meant that the provision of temporary healthcare was not the product of any state law or a right that made access to or the provision of healthcare a positive state obligation (Toussaint v. Canada 2010). The IFHP, between 2010 and 2012, was placed under review to be guided by the principles of "temporariness," "fairness" to Canadians, "protecting" public health and safety, "integrity," deterrence of "abuse," and containment of "financial cost" (CDRC v Canada, 2014, para 53).

It is clear, then, that the principles of the 2010 to 2012 IFHP review established by policymakers derive from the security and deterrence discourse. The IFHP review subsequently led to the *Order Respecting the Interim Federal Health Program* in 2012. The Minister of Citizenship and Immigration justified the policy amendment to the IFHP as necessary. In a statement to the press, the Minister argued that "Canadians have been clear that they do not want illegal immigrants and bogus refugee claimants receiving gold-plated healthcare benefits that are better than those Canadian taxpayers receive" (CDRC v Canada, 2014, para 56).

6.5 Chapter summary

Chapter 6 continues the WPR analysis with a third step asking, "How has this representation of the 'problem' come about?" This section presented my analysis of the history of the problem representations extracted within step one of the WPR method. I began with a timeline of significant historical events relating to refugee claimant healthcare. Upon reviewing the literature, I discussed how I determined these events fall within three competing discourses that shaped them. Section 6.2 traced the significant changes and evolution of the humanitarian immigration discourse. Section 6.3 traced the substantial changes and development of the economic migrant discourse, which was described as opposed to the humanitarian immigration discourse. Section 6.4 traced the significant changes and evolution of the security and deterrence discourse from its beginnings following the adoption of the UN Convention definition of refugees, the drafting of the 1976 Immigration Act, and the discourse's dominance over competing humanitarian and economic discourses in the present-day policy.

Each of the discourses is reflective of how the problem representations could have been alternatively shaped. If the humanitarian discourse had been dominant, refugee claimants might have had a fundamental "right" to refugee status, and healthcare (which is part of the welfare

system) may have become a legal right. If the economic migrant discourse had been dominant, the opposite might be true: refugee claimants and refugees may only have been permitted if they fill an economic need and have the potential to contribute to national economic growth. Today, the security and deterrence paradigm is the dominant discourse: if there were no competition from humanitarian and economic migrant discourses, refugee claimants might not be able to enter, and healthcare may not be accessible at all. I do acknowledge that this is a simplification of an ongoing debate in the literature. I made a decision not to detail in full the complexities of humanitarian, economic, and security/deterrence discourses in order to narrow my scope of discussion. There is a rich literature examining and critiquing these discourses, with researchers on various sides examining the issue of public policy discourse in immigration through their respective theoretical lenses (see, for example, Côté-Boucher, 2017; Fritova, 2021; Irvine, 2011; Joseph, 2018; Lawlor & Paquet, 2021).

This third step of the policy analysis detailed the conditions that allowed the problem representations identified in step 1 to take shape and assume dominance over other competing "problem representations" in history. Chapter 7 contains the fourth step in the WPR analysis and builds on the work of steps 2 and 3 by identifying what is not discussed or critiqued in how the problem is represented. Step 4 shifts the analysis from the historical underpinnings of the problem representation to the problem representation itself by examining the constraints, limitations, and inadequacies in how it is represented.

Chapter 7: *WPR Step 4*, What is Left Unproblematic in the Problem Representation

The previous three sections detailed the first three steps of my WPR analysis. Step 1 identified the problem representations, step 2 identified the deep-seated assumptions and presuppositions that underlie the problem representation, and step 3 highlighted the historical conditions that allowed the problem representations to take shape and assume dominance.

Step 4 builds upon the work of steps 2 and 3 by problematizing the problem representations by subjecting them to critical scrutiny. Step 4 asks, *"What is left unproblematic in the problem representation? Where are the silences? Can the 'problem' be thought about differently?"* The goal is for the researcher to bring silenced issues and perspectives into the discussion. This goal is achieved by identifying the constraints, limitations, and inadequacies of how a problem is being represented. The work of Step 2 is applicable here as the binaries contained within the presuppositions indicate simplifications that distort or misrepresent an issue. The genealogy in Step 3 draws attention to the history of problem representations, whereby discourses compete for dominance within history, which assists in identifying the silences in those problem representations that have gained institutional endorsement. Now, in step 4 of the analysis, I critically analyze the problem representations and draw on cross-cultural comparisons between countries to help us realize that the way of thinking about a problem is reflective of the cultural and institutional context upon which the problem representations are contingent (Bacchi, 2009, p14). For this thesis, identifying the silences of a problem representation and asking if a problem can be thought about differently involves reviewing scholarship related to the field of immigration, including the work of scholars like Barnes (2012), Boesveld (2012), Caulford & D'Andrade (2012), Dhand & Diab (2015), Eggerston (2013), Gusmano (2012), Hathaway

(1992), Harris and Zuberi (2015), Jackson (2014), Rehaag and Colleagues (2015), Sheridan & Shankardass (2015), and Zimmerman (2011). Each of these scholars is essential to identifying the distortions and misrepresentations of a problem and identifying the silences in those problem representations that have gained institutional endorsement.

In the following sub-sections, I present my analysis of the constraints, limitations, and inadequacies of how the problem is represented. First, in section 7.1, I analyze the presuppositions of the first, second, and third problem representations that distort and misrepresent the problem of "irregular" migration, which facilitates its adoption. I identify the binaries that simplify the problem and discuss which discourses these binaries fall within. I examine the government's premises during its decision-making, drawing upon critiques offered in the scholarly literature. In section 7.2, I analyze the presuppositions of the first, second, and third problem representation that distort and misrepresent the problem of the "high costs" of "unfounded" refugee claims. I identify the binaries that simplify the problem, discuss which discourses these binaries fall within, and examine the premises that the government relied upon during its decision-making, drawing on critiques offered in the scholarly literature. In section 7.3, I analyze the presuppositions of the third problem representation that distort and misrepresent the problem of "fairness" regarding the provision of healthcare to refugee claimants. Again, I identify the binaries that simplify the problem, discuss which discourses these binaries fall within, and examine the premises that the government relied upon during its decision-making, drawing on critiques offered in the scholarly literature. Section 7.4 discusses cross-cultural comparisons of the United States and the United Kingdom to provide alternative ways of thinking about a problem and how the problem of refugee healthcare reflects the cultural and institutional context that frames policy problems and their solutions. Finally, I conclude this

section by summarizing the significant points and discussing how they will inform step 5 of the WPR method.

7.1 Distortions and misrepresentations in the *problem* of "unfounded" refugee claims.

The first, second and third problem representations, as analyzed in step 2, are based upon presuppositions that hinge upon simple binaries that distort or misrepresent the issue of "irregular" migration. Four presuppositions overlap regarding "irregular" migrants who make "unfounded" claims for refugee protection. The presupposition that irregular migration is a "crisis" for national security, the presupposition that irregular arrivals are "unlawful," and the presupposition that migrant irregularity is an individual choice all simplify into the binary of "legal" vs. "illegal" or law-abiding vs. criminal. The binary between "legal" vs. "illegal" reflects the distinction between migrants who follow law and procedure to arrive in the country and make asylum claims and "irregular" migrants who circumvent the law to exploit the refugee protection system. Overlapping with this binary is the third problem representation presupposition, that refugee claimants exist within a binary of "genuine" or "bogus," which is about the legitimacy of a claim based on lawfulness, neediness, and passivity. Those who have the money and means to "illegally" circumvent the law are constructed (in opposition to "genuine" claimants) as illegitimate objects of aid, as they have the money and capacity to help themselves. These binaries simplify and distort the problem of "unfounded" refugee claimants, leading to its uncritical adoption in policy reforms by policymakers working within a security and deterrence policy discourse.

The rhetoric of policy reform to curb "irregular" arrivals, during a period in which the discourse of security and deterrence was dominant, strengthened its uncritical adoption by policy

makers. During the 2012 immigration policy reforms, the political rhetoric spoke of many people arriving in Canada who claimed refugee status but whose claims were ultimately rejected or withdrawn. Sheridan & Shankardass (2015) note that Citizenship and Immigration Canada spokespersons often referred to the high number of failed refugee claims as overwhelming government officials. As highlighted by government officials, these failed claims were disproportionately from nations within the European Union. In a similar critique, Harris and Zuberi (2015) highlight that government officials who were proponents of reform framed these failed refugee claimants as economic migrants motivated to take advantage of Canadian welfare and healthcare systems. This framing of failed refugee claimants was a critical element in the reasoning behind why such refugee claims were "unfounded." The then Minister of Citizenship and Immigration, Jason Kenny, similarly argued that reforms to the refugee system were necessary by drawing upon examples of Hungarian Roma refugees as "unfounded" in their claim of persecution because they "overwhelmingly abandon [their claim] and withdraw their own claims… but they all do show up on Ontario's welfare program" (Boesveld, 2012). However, it is important to emphasize that the statement by Minister Kenny was a fabrication and that refugee claimants do not qualify for welfare (Canadian Council for Refugees, 2022). The impact of such a statement is that it distorts facts and misrepresents refugee claimants as taking advantage of Canadians.

The distortions and misrepresentations in the problem of "unfounded" claimants can be identified by reviewing the scholarly literature that critiques the reforms implemented in 2012. First, the premise that "unfounded" refugee claimants overwhelmingly abandon or withdraw their cases is problematic when reviewing refugee claimant cases. A review of refugee claim cases for Hungarian Roma, conducted by Rehaag and colleagues (2015), found that "unfounded"

claims are fundamentally impacted by three aspects of the bureaucratic proceedings within a refugee claim determination. First, rejection and withdrawal rates are affected by an institutional bias of partial decision-makers. In their interviews, Rehaag and colleagues point to decision-makers being influenced by: negative portrayals of Roma as being "bogus" refugee claimants, as depicted in the comments made by the Minister of Citizenship and Immigration Jason Kenny; a fear that if a decision maker had too many positive determinations, then they would not be reappointed; and a push by the government to reduce the percentage of positive decisions in claims regardless of whether or not the claim was legitimate (p. 748-751). Second, the lack of policy and procedural consistency between decision-makers often negatively affects an outcome of a claim (p. 751- 755). Third, the poor quality of counsel affects any positive results in refugee claim hearings, which often leads to the mismanagement of a refugee claimant's case (p. 755-757). The second premise that "unfounded" claimants are economic migrants motivated to take advantage of Canadian welfare and healthcare is also problematic. Zimmerman (2011), in a review of asylum seekers' socioeconomic motivations, reveals that refugee claimants relocate to Canada for more than economic reasons: this included intersections between "targeted persecution" or "conflict;" the social and economic effects of living in areas affected by danger; and the desirability to avoid these outcomes by leaving their home (pg. 342 – 346). Leaving one's country involves seeking safety and opportunities to lead ordinary lives, including having an income and a home. The third premise that those seeking refugee claims are motivated to take advantage of Canadian welfare and healthcare systems is problematic. Harris and Zuberi (2015) note those seeking asylum do not choose to travel to a country to receive benefits like health or welfare; this is often not even "considered" before fleeing persecution . Instead, it is primarily about escaping "torture," "rape," "displacement," or "death threats" (pg. 1045).

In the following section, I expand upon the problem of "unfounded" refugee claims and how such claims were distorted and misrepresented as a problem that is presented as a "high cost" to the functioning of the refugee protection system, which burdened taxpayers funded that system.

7.2 Distortions and misrepresentations in the problem of the "high cost" of "unfounded" refugee claims

The first, second and third problem representations, as analyzed in step 2, contained presuppositions that hinge upon simple binaries that distort or misrepresent the problem of the "high costs" of "unfounded" refugee claims. Two presuppositions overlap regarding the "high costs" of irregular migrants who make "unfounded" claims for refugee protection. The presupposition of the first and second problem representations that "irregular" migrants contribute to societal disorder and instability, and the presupposition of the third problem representation that only those who contribute socially and economically should receive benefits both simplify into a binary of "non-contributing" refugee claimants versus "contributing" citizens. The binary between "non-contributing" refugee claimants versus "contributing" citizens is the difference between citizens characterized as social and economic contributors to public welfare in contrast to non-contributing refugee claimants who may be illegitimate and burdensome on state and public welfare. Citizens are constructed as deserving of the government's money, whereas non-citizens, like refugee claimants, may or may not be "genuine" in their claim and are less deserving. This binary simplifies and distorts whether refugee claimants, whether legitimate or illegitimate in their claim for protection, contribute socially and economically and whether they are deserving of welfare supports like healthcare. These binaries simplify and distort the problem of the "high costs" of "unfounded" refugee claims, which led to

its uncritical adoption in policy reforms by policy makers working within a security and deterrence policy discourse.

The rhetoric of policy reform to reduce the "high costs" of "unfounded" refugee claims during a period of security and deterrence discursive dominance strengthened its uncritical adoption by policy makers. The "high cost" of "unfounded" refugee claims traces back to the decade before the 2012 immigration policy reforms, where inefficiencies arose with the administration of refugee protection. Sheridan & Shankardass (2015) note that these inefficiencies, officials asserted, were related to the increased number of "unfounded" refugee claims. As a result of this increased number of individuals making refugee claims, there was an increase in those covered by the IFHP, which the government asserted should not be. Harris & Zuberi (2015) highlight that during policy debates, proponents of immigration reform argued that refugee claimants should not have access to public welfare services and programs like healthcare because they have not paid into "our system" as taxpayers (pg. 1046). Dhand & Diab (2015) also point out that government officials had argued that the costs associated with programs like the IFHP were too high for taxpayers, as they cost more than $83 million per year (pg. 358).

The scholarly literature that critiques the 2012 immigration reforms describes the distorted and misrepresented facts about asylum-seeking that underpinned the assumptions behind the problem of the "high costs" of "unfounded" refugee claims. First, there was an increasing backlog in the number of refugee claimants, which meant that claimants remained on IFHP coverage for more extended periods, thus increasing the program's costs over the long term. However, this was not exclusively due to rising refugee claims. Instead, Kelly and Trebilcock (2010) note that the government's unwillingness to fill vacant positions for decision-makers resulted in more than 35 percent of those jobs being vacant in 2008. These vacancies

accumulated between 2006 and 2008, resulting in undecided cases rising from zero to more than 62,000 by 2009 (p.445-446). Second, asserting that refugee claimants do not make financial contributions through taxes is problematic. Jackson (2014) argues that while awaiting a determination on their claim, all refugee claimants contribute to the government through the same forms of taxation as citizens when they obtain temporary work permits, get jobs, and pay the same level of tax as everyone else. In addition, Cauldord & D'Andrade (2012) note that refugee claimants also pay federal and provincial taxes on goods and services while in Canada. Third, the assertion that the costs associated with the IFHP are too high for taxpayers is problematic. Dhand & Diab (2015) note that the annual cost of the IFHP per capita before 2012 was $552 or roughly a little more than 10 percent of the per capita cost annually for a Canadian, which was $5,401.34. In addition, the program's total cost was merely 4/100ths of one percent of the total health expenditure in Canada, or about "60 cents per taxpayer per year" (p.358).

In the following section, I expand upon the problem of "unfounded" refugee claims and their "high cost" to the functioning of the refugee protection system and the taxpayers who funded that system, by discussing the distortions and misrepresentations in the problem of the "unfair" provision of healthcare to such "unfounded" refugee claimants.

7.3 Distortions and misrepresentations in the problem of healthcare "fairness"

As analyzed in step 2, the third problem representation contains presuppositions that hinge upon simple binaries that distort and misrepresent the problem of "fairness" concerning the provision of healthcare to refugee claimants. The third problem representation presupposition, that welfare is a matter of discretion and not a moral obligation, simplifies into a binary of entitled citizens versus unentitled refugee claimants. This simple binary concerning entitlement is related to the binary of "genuine" refugee claimants versus "unfounded" refugee claimants that

is foundational to the presupposition that only those in "genuine" need are deserving of help and to the presupposition that the extension of welfare benefits is an act of charity. Together, these presuppositions purvey and promote the idea that while citizens are deserving and entitled members of society who have healthcare rights, in contrast, access to healthcare for refugee claimants is contingent upon discretionary charity. Alternatively said, charity depends upon a person's deservingness (whether the individual is "genuinely" or "illegitimately" in need). The binaries here simplify and distort whether the charitable act of providing healthcare resources to refugee claimants, who may or may not be "genuine," is "fair" to entitled citizens. These binaries simplify and distort the healthcare "fairness" problem*,* which led to its uncritical adoption within policy reform by policy makers working within a security and deterrence policy discourse.

The rhetoric of policy reform to ameliorate the "unfair" provision of healthcare to refugee claimants arose during the dominance of the security and deterrence discourse, which strengthened its uncritical adoption by policymakers. The problem was that the healthcare insurance package provided through the IFHP was framed as more comprehensive than what Canadians could avail of themselves through provincial and territorial health systems, which was described as "unfair" to Canadians (Canada, 2012g). The then Minister of Citizenship and Immigration stated to the press that supplemental services like dental, prescription drug coverage, eye care, etc., were "gold-plated healthcare benefits… better than those Canadian taxpayers receive" (Wherry, 2012). The government promoted these health benefits as an "abuse of Canada's overburdened healthcare system by bogus refugees," a burden that was framed as unnecessary for Canadians to bear (Parry, 2012).

The rhetoric around providing the IFHP to refugee claimants as "unfair" was, at best, misleading and inaccurate. The "fairness" problem arose during the early implementation of the

2012 immigration policy reforms and was described as the unnecessary burden of an overtaxed healthcare system due to the medical needs of undeserving "bogus" ("unfounded") refugee claimants. First, as detailed in the federal court case *CDRC v Canada* (2014), until 2012, all IFHP beneficiaries received health care coverage that was broadly comparable with what Canadian citizens and permanent residents received through provincial and territorial insurance plans. In addition, supplemental benefits such as dental, prescription drugs, eye care, etc., were not more significant than what persons in the lowest income bracket would receive as part of provincial social assistance plans (CDRC v Canada, 2014; CHA, 2012). Harris & Zuberi (2015) conducted a comparison of coverage and challenged the assertion that "gold plated" healthcare was even better than what taxpaying Canadians receive. Harris & Zuberi (2015) agreed with the federal court case CDRC v Canada (2014) that the program was, at best, on par with what the lowest income receives and provide coverage at a much lower per-capita cost than the coverage for average Canadians. They further argued that the 2012 IFHP amendments had overburdened the healthcare system by increasing the number of persons seeking emergency medical care who could not afford to cover the cost of treatment. Reports by Barnes (2012), the Canadian Hospital Association (2012), and Eggerston (2013) describe many IFHP recipients following the 2012 reforms shifting from visiting family physicians to visiting emergency health care services for chronic and acute health conditions. When IFHP recipients could not pay the financial cost associated with treatment not insured by the new program, the provinces absorbed the higher costs, thus negating any argument for the immediate savings forecasted by the federal government following the reforms (Harris & Zuberi, 2015).

The argument regarding the deservingness of "genuine" and "unfounded" refugee claimants is more complicated than the simple binary detailed above. In the following section, I

will continue this critical analysis by making international comparisons with countries where Canada has close political and economic ties to illustrate how the healthcare problem for refugee claimants is framed differently in the United States and the United Kingdom.

7.4 International comparisons

Canada's reliance on simple binaries that underpin presuppositions (implicit assumptions) within policy discourse to identify policy problems for which policy solutions derive is not the only way of framing a problem. A cross-cultural comparison between countries can help us realize that the practice of thinking about a problem reflects the cultural and institutional context upon which the problem representations are contingent. Canada has ties culturally, politically, and institutionally to the United States and the United Kingdom. They are relevant comparisons for the problematization of irregular migrants who make claims for asylum and their access to healthcare.

In the United States, healthcare services are provided to refugees and asylum seekers, regardless of their status, through the Refugee Medical Assistance program, for up to eight months while their claim is processing. The Refugee Medical Assistance program is federally funded and begins when an asylum seeker enters the United States and files a claim (Dhand & Diab, 2015). This program is provided through the Office of Refugee Resettlement and overseen by the Department of Health and Human Services. Unlike the situation in Canada, where the IFHP is at the sole discretion of immigration officials, healthcare is the responsibility of health officials in the United States. According to Dhand & Diab (2015), additional programs exist and become available to persons claiming refugee protection, like Medicaid, the Children's Health Insurance Program, and other healthcare coverage options for those awaiting status or who have obtained their status (p.365). Beyond refugee claimants, undocumented migrants have some

fundamental rights if they are not eligible for these programs. According to Gusmano (2012), undocumented migrants may still access emergency medical treatment through the Emergency Medical Treatment and Active Labor Act until their medical condition has stabilized. Lastly, migrants can also access Federally Qualified Community Health Centers and Migrant Health Centers, not-for-profit organizations funded by the government. This approach to healthcare programs and services contrasts with Canada's. Policies and laws regarding access to healthcare and medical treatment in Canada concern deservingness and entitlement to taxpayer-funded services. The federal court case Toussaint v Canada (2010) ruling made it clear that there is no positive obligation under the law to provide healthcare to refugee claimants, failed refugee claimants, or irregular or undocumented migrants. In the United States, specific legislative and legal rights within laws exist to address who is covered, who has access, and who has rights, whether citizen or not. While covering the cost of treatment may not be indefinite in the United States, the policy debate is not about the legitimacy of a person's presence or claim to refugee protection regarding healthcare. The policy problem concerns what rights a person must have to access healthcare when they require medical treatment.

The United Kingdom is another example that provides an alternative model for addressing access to healthcare by refugee claimants. Healthcare coverage for refugee claimants and refugees falls within the National Health Service (NHS) and not under the United Kingdom Immigration Service. Placing healthcare under the responsibility of a government department responsible for health is similar to the process in the United States but differs from that of Canada. According to the NHS constitution, "access to NHS services is based on clinical need, not an individual's ability to pay. NHS services are free of charge, except in limited circumstances sanctioned by Parliament" (UK, 2013). According to Dhand and Diab (2015),

refugees and refugee claimants receive coverage while awaiting the determination of their claims. This coverage includes hospital, clinical, specialist, and dental and eye care. Because the United Kingdom has a publicly funded healthcare system, failed claimants are deemed not to have passed the residence test, which triggers NHS eligibility. Thus, they are not exempt from charges for care. In 2014, the government passed Bill 110 of the Immigration Act, which revised healthcare coverage for undocumented migrants who would now be charged for primary care and have limited access to secondary care, including medical specialists (UK, 2013). However, unlike the 2012 IFHP amendments in Canada[20], within the UK, no immediately necessary treatment is to be withheld due to coverage issues, citing that medical treatment cannot be withheld to secure a patient's payment (UK, 2014). The United Kingdom, like the United States, has specific legislative and legal rights within laws that exist to address who is covered, who has access, and who has rights. The policy problem in the United Kingdom is about the individual right to medical treatment when they are ill and not about deservingness or entitlement like within Canada. In the United Kingdom, in many ways like the United States, what is important is that emergency treatment is accessible regardless of a person's immigration status or inability to pay. Thus, the United States and the United Kingdom provide evidence that access to healthcare is a policy problem with alternative framings. Canada's policy problems and solutions reflect the practices of thinking within a cultural and institutional context contingent on assumptions regarding healthcare and refugee claimants that government officials believe to be true. However, such beliefs depend on the premises mentioned above and binaries that constrain, limit and simplify an issue by ignoring alternative ways of thinking.

[20] Denial of care to refugee claimants is briefly discussed within Section 2.6 and will be further discussed in section 8.1

7.5 Chapter summary

Section 4.4 continued the WPR analysis with a fourth step, asking, "*What is left unproblematic in the problem representation? Where are the silences? Can the 'problem' be thought about differently?"* This section analyzed the constraints, limitations, and inadequacies of how the problem is being represented. Building upon the work of steps 2 and 3, an analysis of the binaries contained within the presuppositions of the three problem representations indicated simplifications that distort or misrepresent the problem of refugee claimant healthcare. These simplifications fall within three constraints that silence the alternative ways of thinking about the problem. Section 7.1 detailed and challenged the misrepresentations and distortions within the problem of "unfounded" refugee claims. Section 7.2 built off of the problem of "unfounded" refugee claimants by challenging the distortions and misrepresentations of the "high costs" problem that "unfounded" refugee claimants were argued to have placed on the functioning of the refugee protection system and the taxpayers who funded that system. Section 7.3 continued the critical examination of the distortions and misrepresentations of "unfounded" refugee claimants by challenging the problem of the "unfair" provision of healthcare to "unfounded" refugee claimants. Section 7.4 concluded the critical examination by comparing and contrasting the problem of refugee claimant healthcare as contingent upon the cultural and institutional context of a country.

The silences within each of the three problem representations reflect the limitations, constraints, and inadequacies in how the problem of refugee claimant healthcare is represented in Canada. The simplified binaries in discourse shape a policy problem by constraining how policymakers think a problem exists and what is necessary to solve that problem. Canada's reliance on simplified binaries about legitimacy, cost, and fairness narrows down the problem of

who is deserving of healthcare and who is not. However, as seen in other jurisdictions like the United States and the United Kingdom, the discursive language surrounding rights to medical treatment can conceptualize the problem of refugee claimant healthcare differently.

Chapter 8 contains the fifth step in the WPR analysis and builds off the work of steps 2, 3, and 4 by analyzing the political implications of the identified problem representation(s). Step 5 shifts the analysis from exploring the underlying discourses and limits of the problem representations toward an interrogation of how they function to benefit some and harm others and what can be done about this.

Chapter 8: *WPR Step 5*, The Effects (Discursive, Subjectification, Lived) Produced by this Representation of the Problem(s)

Step 5 builds on the work of steps 2, 3, and 4 by analyzing the effects of the identified problem representations. Step 5 starts with the presumption that problem representations create harm for members of some social groups more so than for other groups. Step 5 shifts the analysis of the problem representation to identify where and how problem representations function to benefit some and harm others. Chapter 3 explained that the form of analysis conducted in this thesis does not refer to the standard policy approach that focuses on "outcomes." Instead, the analysis is on the effects of the problem representations as understood more subtly in the poststructural sense and includes discursive effects, subjectification[21] effects, and lived effects. The analysis in steps 2, 3, and 4 helped identify discursive effects by identifying the assumptions and presuppositions of the problem representation, the discourses they derive from, and their silences. *Discursive* effects illustrate the terms of reference created by a problem representation, and the terms of reference limit what can be thought and said relative to a problem representation. Such limitations dictate what options have been closed off for consideration and how this affects certain people. Subjectification effects implicate "subjects" within problem representations by establishing the kind of "subject" they can be. Significant within subjectification effects is how the problem representations within a policy can set groups of people in opposition to each other, with what Foucault calls "dividing practices." "Dividing

[21] As I had previously explained in a Chapter 3 footnote, "subjectification" is a term that Carol Bacchi (2009) uses, adopted from the scholarly work of Foucault (1998). It refers to the process by which the subject (an individual or person) is led to observe himself or herself, analyze themself, interpret their own thoughts, behaviors, and actions, and recognize theirself as a domain of possible knowledge. Stated alternatively, "subjectification" is a process by which a person becomes a person and can often be confused with subjectivity which refers to the experience of being a human subject.

practices" produce uneven social consequences by harming some social groups and not others. Within "dividing practices," separate groups of people are made "governable" subjects by dividing them from other groups and within themselves (Bacchi 2009, p.16). Last are the *lived* effects, which are how discursive and subjectification effects translate into the real world by materially affecting lives. The researcher can employ many techniques to investigate the *lived* effects of the problem representation; such research is not always necessary. It is accepted within the WPR method (depending upon the scale of a research study) to rely upon the secondary literature and work of others to demonstrate and highlight the observed effects of a problem representation. For this thesis, identifying the effects of a problem representation involves reviewing scholarship related to the field of immigration, including the work of scholars like Barnes (2012), Beiser (2005), Campbell et al. (2014), Chen et al. (2018), Connoy (2019), Edberg (2011), Eggerston (2013), Erickson (2019), Evans et al. (2014), Harris & Zuberi (2015), Keboa et al. (2019), Kirmayer et al. (2011), Kueli et al. (2007), McKeary & Newbold (2010), Marwah (2014), Merry et al. (2011), Oda et al. (2017), Ruiz-Casares et al. (2016), Sanmartin & Ross (2006), Willen (2012), and Wrzesnewsky (2016). The overall goal of step 5 is to say which aspects of the problem representation have harmful effects on specific groups and may need to be rethought and provide a means to consider the long-term implications of policy interventions.

In the following sections, I present my analysis of what effects are produced by the problem representations. Section 8.1 builds off the work of steps 2, 3, and 4 by illustrating the terms of reference created by the problem representations, which place limits on what can be thought and said relative to it. I remind the reader of the assumptions and presuppositions of the problem representation, the discourses they derive from, and the alternative arguments they silence. What follows the discursive effects is an analysis of subjectification effects that

implicate “subjects” within problem representations by establishing the kind of “subject” they can be. I identify within the three problem representations that irregular migrants are the “subject” that is held responsible for the “abuses” of the immigration and refugee system that have led to the “unfair” distribution of health insurance coverage. I explore how the problem representations reinforce existing power relations that differentiate irregular migrants from citizens and deserving "genuine” refugee claimants from “undeserving” irregular migrants who claim refugee protection. Lastly, I rely upon the secondary literature to discuss how discursive and subjectification effects translate into the real world by materially affecting the lives of the refugee claimants. I explore how the 2012 immigration reforms complicated refugee protection and made access to claims difficult for irregular migrants. I also explain how the IFHP became a tool of deterrence that complicated access to health services and exasperated pre-existing conditions. Section 8.2 concludes the chapter by explaining which aspects of the problem representation have harmful effects on specific groups. I consider the long-term implications of policy decisions for refugee claimants’ access to healthcare in Canada.

8.1 Effects that are produced by the problem representations

Discursive effects illustrate the terms of reference created by a problem representation that limits how a problem is thought about and what can be said about it. The discursive effects of the problem representations dictate what options have been “closed off” for consideration and the impact of this “closing off” on refugee claimants. The presuppositions of the problem representations influence the responses made by government officials and close off the possibility of irregular arrivals claiming refugee protection as beneficial persons or persons in need. As a result of the presuppositions, laws are introduced that punish human smugglers, classify irregular arrivals as “unfounded” in a multitiered asylum system, broaden grounds for

detention, and limit access to legal protections and recourse through appeals. A related effect is that the policy decisions close off the consideration that irregular migrants may be in genuine need of protection as refugees. Policy tools are created that limit access to refugee protection claims, limit access to public and state institutions such as employment, welfare, and healthcare, and include the use of illiberal means such as deportation without proper case investigation (CCR, 2010; Government of Canada, 2012d; Quan, 2017). These discursive effects translate into what can be said about the "subjects" of the "problem representations" and into the real world in a form that affects peoples' lives through subjectification effects.

Subjectification effects implicate "subjects" within problem representations by establishing the kind of "subject" they can be. Recall the three problem representations: the macro problem of the "abuse" of the immigration system by human smugglers; the meso problem of an "abuse" of the refugee system by persons who arrive "illegally;" and the micro "problem" of the "unfair" rewarding of health benefits to those arrive "illegally" to make "unfounded" claims for refugee protection. At each level, irregular migrants are the subject of the problems. Important within these problem representations is how policy has set groups of people in opposition to each other, with what Foucault calls "dividing practices" that stigmatize targeted minority populations and serve the purpose of indicating and encouraging desired behaviours amongst the majority population (Bacchi, 2009, p.18). Within "dividing practices," separate groups of people are made "governable" subjects by being divided within themselves (Bacchi 2009, p.16). The representation of the problem contains an explicit expression of who is responsible for the "problem" in the first place, thus producing uneven social consequences by harming some social groups and not others.

The three hierarchical problematizations construct irregular migrants as the group responsible for the immigration and refuge system "abuses" that have led to the "unfair" distribution of healthcare insurance coverage. There are four presuppositions of the macro and meso problem representations: irregular migration is a "crisis" for national security; irregular arrivals are "unlawful;" migrant irregularity is an individual choice; and irregular migrants contribute to societal disorder and instability. The four presuppositions underpin the assumption that "illegal" migrants threaten society. The assumption positions irregular migrants within a binary as different from and therefore less than law-abiding citizens. Within the security and deterrence discourse, "irregular" migrants exist as a problem of "criminality," "illegitimacy," and "abuse" that overburdens and exploits the refugee system by making "unfounded" claims for refugee protection.

Scholars like Kelly and Trebilcock (2010) and Rehadd & Colleagues (2015) note that this framing of irregular migrants as a "crisis" distracts attention from disabling structures. Examples of such disabling structures include the tools of deterrence that limit migration to Canada, an institutional bias of decision-makers in asylum hearings, mismanagement of refugee claimant cases, and vacancies in crucial decision-maker positions. Distracting attention from these disabling structures subsequently affects the framing of irregular migrants who receive healthcare benefits while making refugee protection claims. This negative framing includes assumptions that: the extension of welfare benefits is an act of charity; welfare is a matter of discretion and not a moral obligation; only those in "genuine" need are deserving of help; refugee claimants are either "genuine" or "bogus;" and only those who contribute socially and economically should receive benefits. These assumptions all derive from the broader framing of irregular migrants as undeserving exploitative criminals. The presuppositions frame irregular

migrants who claim refugee protection as (in contrast to citizens and taxpayers) a “high cost” by increasing the bureaucratic inefficiencies and financial costs to taxpayer systems like healthcare, which is “unfair” to Canadians.

This framing of the “subject” (irregular migrants) can distract and take attention away from migrants’ positive capacities or similarities with law-abiding citizens. This framing silences other ways of imagining the subject including: the financial contribution irregular migrants make through taxation when they obtain temporary work permits while awaiting a refugee claim; the low annual cost per capita of programs like the Interim Federal Health Program compared to state welfare supports provided to Canadians; and the fact that the health insurance benefits that irregular migrants who make asylum claims receive, often described as “gold-plated healthcare,” are not better than those to which Canadian taxpayers are entitled (Wherry, 2012; Parry, 2012). The framing of the irregular migrant “subjects” within the problem representations distracts from how Canada's healthcare services and coverage are distributed. As mentioned in Chapter 7, when health coverage is assessed and compared, it is not better than what taxpayers receive. At best, it is on par with what the lowest income Canadian receives due to their financial need but at a much lower per-capita cost. By representing irregular migrants as the problem, government responses are constructed as justified, protective, and fair and allow for the reinforcement of existing power relations that differ irregular migrants from citizens. Power relations rank and prioritize persons within a hierarchy of deserving citizens over the “undeserving” irregular migrants and deserving "genuine’ refugee claimants over “undeserving” irregular migrants who claim refugee protection. These divisions construct irregular migrants who make claims for refugee protection as unfounded, fraudulent, undeserving, and thus “bogus.” Refugee claimants, overall, are impacted and divided between those who are “genuine,” and those who are “bogus”

or "unfounded" through their behaviours, stories, capacity, and method of arrival. "Genuine" refugee claimants as the "subject" category oppose citizens by being constructed as a non-contributing burden whose only purpose is to promote and reaffirm national identity traits of generosity and compassion onto those deemed deserving. This framing translates into the real world through material effects on the lives of irregular migrants who make claims for refugee protection.

Specific policy reforms, resulting from the assumptions underpinning the three problem representation*s* identified in this thesis, have lived effects which have been particularly harmful to "irregular" arrivals but extend to include anyone within the protection stream of the immigration system. First, in 2012 a new multi-tiered refugee protection system subjected irregular arrivals to vastly different treatment under the *Balanced Refugee Reform Act (*Government of Canada, 2010*).* This system included mandatory periods of detention for irregular arrivals, expedited timeframes for refugee claims, modified and restricted appeals process, limited access to pre-risk removal assessments, and applications for a stay of removal on humanitarian and compassionate grounds. According to Harris & Zuberi (2015), the most controversial reform was creating the designated country of origin (DCO) list. The DCO list enabled government officials to designate "safe" countries as not typically producing refugees, thereby introducing measures to treat them with differential treatment. Second, the multi-tiered refugee protection system further differentiated the treatment of refugee claimants with further reforms under the *Protecting Canada's Immigration System Act (*Government of Canada, 2012d*).* The *Protecting Canada's Immigration System Act* immigration reforms instigated changes in the Interim Federal Health Program through the *Order Respecting the Interim Federal Health Program, 2012* (Government of Canada 2012g). According to Evans &

Colleagues (2014) and Harris & Zuberi (2015), refugees and refugee claimants were divided into government-assisted, sponsored, "genuine" claimants, DCO, or failed/rejected claimants. Each refugee category received the same funding for previously offered services or restricted benefits through the IFHP. Government-assisted and sponsored refugees (which exclude refugee claimants) began to receive fully funded services under an "expanded health care coverage" category. At the same time, "genuine" refugee claimants received urgent or essential services within the "health care coverage" category until they had been awarded refugee status. Lastly, DCO or failed/rejected refugee claimants received "public health and public safety coverage," which only provided healthcare if they were considered to be a "threat" to the health and safety of the public (See Appendix A for table).

Even before the 2012 policy reforms introduced material implications for refugee claimants, there were various pre-existing barriers to access to healthcare for refugee claimants. According to multiple studies, before 2012, refugee claimants were twice as likely to encounter challenges in accessing care than Canadians due to limited or no health insurance, low economic status, language barriers, unfamiliarity with health systems, cultural differences, and discrimination. As a result, refugee claimants were much more likely to self-report a lower health status compared to other immigrants (Beiser, 2005; Edberg, 2011; Kirmayer et al., 2011; Kulie et al., 2007;; McKeary & Newbold, 2010; Merry et al., 2011; Sanmartin & Ross, 2006). The IFHP amendments of 2012 exasperated both the pre-existing barriers and the insufficient access to medical care. The pre-existing barriers are the product of the humanitarian and economic migrant discourses on policy development over multiple decades that limited healthcare as an act of discretionary charity intended to assist persons in their independence and employment and to become social/economic contributors. The dominance of the security and deterrence discourse in

the few decades before the 2012 amendments exploits this idea of discretionary charity by emphasizing its application to only the deserving "genuine" refugees.

In 2012, refugee claimant healthcare reforms were a tool to deter access to health services. According to Barnes (2012) and Harri & Zuberi (2015), treatment for conditions like diabetes, heart disease, or even prenatal care depend upon one's refugee claimant category and its associated coverage. Services and medications were often limited in the most restrictive insurance coverage to treating conditions that seemed to be a public health or safety concern. The IFHP changes increased pre-existing confusion surrounding funding and reimbursement due to its operation outside provincial and territorial health plans with which health service providers were familiar. The lack of information and support, delays in reimbursement, and complexity of care meant many health service providers were unfamiliar with the program and frustrated with delays in reimbursement or lacking reimbursement. Many health service providers denied care to refugees before the amendments because of the burdensome bureaucratic processes. Various scholars highlight that the 2012 amendments compounded the issue of healthcare access by refugee claimants, which resulted in an even greater number of health providers unwilling to provide care to IFHP recipients due to the increasing complexity of different insurance schemes (Connoy, 2019; Evans et al., 2014; Harris & Zuberi 2015; Ruiz-Casares et al., 2016). Eggerston's (2013) research showed that in the province of Ontario, only 5 out of 30 walk-in clinics and private practices surveyed in Toronto continued to serve refugees. The same decrease was found in Ottawa, whereby only 9 out of 33 clinics following the 2012 IFHP amendments were willing to help IFHP beneficiaries. Research by Barnes (2012), Evans and colleagues (2014), and Harris & Zuberi (2015) highlight that the elimination of supplemental benefits like prescription medication, mental health services, and eye and dental care, depending upon the refugee

claimant category, meant that many feared the impact of medical bills. Often, persons would delay seeking health care, exacerbating pre-existing conditions and increasing the utilization of expensive emergency services. Lastly, many IFHP recipients face discrimination when seeking treatment. Researchers, including Campbell and colleagues (2014), Connoy (2019), and Marwah (2014) describe experiences in walk-in clinics and emergency departments where staff tried to convince IFHP recipients that they did not have a medical emergency or require medical care, or asked patients to pay for medical expenses upfront.

8.2 Long-term impacts of the problem representations

The goal of step 5 in the WPR method is to say which aspects of the problem representation have harmful effects on specific groups and may need to be rethought and to provide a means to consider the long-term implications of policy decisions. The 2012 immigration reforms and IFHP amendments introduced or exasperated discursive, subjectification, and lived effects for refugee claimants. However, they also brought attention to how the Canadian health system depends on one's location within citizenship, immigration, and asylum. The 2012 amendments were overturned in 2016 by a newly elected Liberal government, re-establishing the pre-2012 IFHP coverage for all refugee claimants. However, despite the reinstatement of pre-2012 IFHP coverage for refugee claimants, the program still is inadequate and cumbersome to navigate.

Previously and currently, the IFHP attributes responsibility for healthcare to its recipients. The IFHP coverage is federal health insurance that operates outside provincial and territorial healthcare systems but depends upon them to provide health, dental, and optical services. With IFHP coverage being a federal responsibility, providers are not included in the program's decisions. The IFHP also does not include provincial and territorial decision-makers,

thereby leaving IFHP recipients with the burden of having few knowledgeable supports when trying to access care within the program. Various barriers exist within the IFHP, both pre-2012 and post-reforms, highlighted in the subsection above. Researchers like Keboa et al. (2019) and Wrzesnewsky (2016) highlight that IFHP coverage following reinstatement in 2016 still does not align with accepted standards for care. It provides limited access to interpretive services, resulting in delayed consultation, poor quality of care, limitations in choice, high patient costs, and longer wait times. Erickson (2019) found that following the 2016 reinstatement, maternal health outcomes are poorer for refugees and refugee claimants than citizens due to a lack of culturally competent provision of care. In addition, a study by Oda and colleagues in 2017 on the arrival of government-resettled Syrians following the reinstatement of the IFHP found that Syrian refugees, more so than the general population, did not have access to a family doctor (20.2% vs. 14.9%). In addition, 49.0% of study respondents reported having unmet health care needs, versus 11.2% of the Canadian population. The reasons cited include long waiting times, unavailability of services, and the required time and cost. The study highlighted systemic gaps in the Canadian healthcare system and that comprehensive care and management failed to extend beyond the initial support provided by the federal government (Oda et al., 2017). Researchers like Willen (2012) note in the period before 2012, in many parts of the world, state ideological considerations often shunt asylum seekers into a "two-tiered or multi-tiered health care systems that provide high-quality care to citizens and authorized residents while shunting individuals with precarious status into patchy and unreliable networks of NGO- or charity-based care" (p.807). Chen and colleagues (2018), in their study of the 2016 reinstatement of the IFHP, echoed Willen's statement. They found that despite the 2016 reinstatement of the pre-2012 IFHP, there were ongoing problems in access to health services. Gaps persist in coverage for

benefits for mental health, and there remains inadequate coverage for children of refugees, burdensome administrative hurdles for service providers, and misinformation that discourages service providers from taking on IFHP beneficiaries (p. 98-99).

Research conducted in the aftermath of the 2016 reinstatement of the IFHP identifies the persistence of a healthcare system that segregates refugee claimants. While the harmful effects of the policy on specific groups have been rethought, much of the underlying discursive and subjection effects have not. According to the studies that have researched refugee claimants' access to healthcare, refugee claimants continue to exist in a two-tiered or multi-tiered healthcare system that prioritizes citizens and establishes barriers to healthcare for non-citizens like refugees claimants. Until the hierarchy of belonging extends to refugee claimants and recognizes their value and contributions, they will continue to exist on the periphery of society and its public institutions for welfare like healthcare. It is essential to consider the long-term implications of the policy interventions introduced; as evidenced above, when the policy interventions are repealed, such as in the case of the IFHP in 2016, the effects can be challenging to change.

8.3 Chapter summary

This chapter continued the WPR analysis with a fifth step, asking, "*What effects are produced by this representation of the problem?*" This chapter shifted the analysis of the problem representations towards identifying where and how the problem representation's function. The overall goal of step 5 was to say which aspects of the problem representation have harmful effects on specific groups and may need to be rethought and provide a means to consider the long-term implications of the policy interventions. Section 8.1 built off the work of steps 2, 3, and 4 by identifying how and where the problem representations function to benefit some and harm others through *discursive*, *subjection*, and *lived* effects that negatively impact irregular

migrants who make refugee claims. Section 8.2 concluded the chapter by considering the long-term harmful effects of the problem representations by examining the long-term implications of policy decisions and reforms that impacted Canada's refugee claimants' healthcare access.

The effects of each of the three problem representations reflect the terms of reference created, limiting what can be thought and said about refugee claimants and limiting the options for consideration of how they as a group have been problematized. These terms of reference produce uneven social consequences by dividing and placing in opposition refugee claimants from refugees, and refugees from citizens, reducing their complexity to simple binaries and making each of these marginalized groups governable through policy. The discursive and subjectification effects translated into the real world through the 2012 immigration reforms, which made access to claims difficult for irregular migrants and reshaped IFHP as a tool of deterrence that complicated access to health services and exasperated pre-existing system barriers.

Chapter 9 contains the sixth and final step in the WPR analysis and asks how and where the problem representation of the problem has been promoted and how it could be questioned, disrupted and replaced. Step 6 shifts the analysis from the effects of the problem representations to how the problem representations have been promoted, achieved legitimacy and authority, and alternatively, if they have been contested.

Chapter 9: *WPR Step 6*, How the Problem Representations were Promoted and Questioned, and can they be Disrupted and Replaced

The previous chapters contained the first five steps of my WPR analysis. Step 1 identified the problem representation. Step 2 identified the deep-seated assumptions and presuppositions that underlie the problem representations. Step 3 highlighted the historical conditions that allow the problem representations to take shape and assume dominance. Step 4 identified what is left unproblematic and silent in the problem representations and considered if it can be conceptualized differently by drawing upon cross-cultural comparisons. Step 5 determined the harmful effects produced by the problem representations and considered the long-term implications of the associated policy interventions.

Step 6 is the last and final step of the WPR analysis and asks, "*How and where has this representation of the "problem" been produced, disseminated, and defended? How has it been and/or how can it be disrupted and replaced?*" Step 6 aims to analyze how the problem representations have been promoted and have achieved legitimacy and authority and if they have been contested. This step highlights the instances within the practices of policy mobility where networks installed and authorized the problem representation. Building off the work of step three, step six also directs attention to the processes and practices that allow certain problem representations to dominate. Question 6 begins by reviewing secondary literature and documents, asking which groups or classes of individuals have access to the underlying discourses of the problematizations. The literature drawn on for this step of the analysis includes Barnes (2013), Beatson (2016), Beck and Colleagues (2019), Boesveld (2012), CBC (2010), CBC (2016), CCR (2012), CDRC (2012), CDRC v Canada (2014), CHA (2012), CUPE (2012), Dauvergne (2000), Denton (2012), Dhand & Diab (2015), Dirks (1995), Edge & Newbold (2013), Gottlieb and

Colleagues (2012), Harris & Zuberi (2015), Holtzer and Colleagues (2017), Huot and Colleagues (2016), Irvine (2011), Kelly and Trebilcock (2010), Keung (2012), Kurasawa (2015), Malkki (1996), Marwah (2014), Matlin and Colleagues (2018), National Post (2012), Parry (2012), Quan (2017), Reitz (2012), Ruger (2006), Ruiz-Casares and Colleagues (2016), Sheridan & Shankardass (2015), Slim (2000), Ticktin (2006), Toussaint v Canada (2010), Villegas & Blower (2019), and Wherry (2012). By investigating the role of media in disseminating and supporting the problem representations and examining the relationship between dominant discourses, prominent speakers and the destined audience, it becomes explicit how the problem representation is institutionalized. Step 6 also opens the space for reflection on the forms of resistance that challenge the pervasive and authoritative problem representations (Bacchi & Goodwin 2016, p.21-23). This reflection also encourages the researcher to examine opposition that arose to the problem and seek a means to reframe the problem representation less harmfully.

In the following sub-sections, I present my analysis of how the problem representations have been promoted, achieved legitimacy and authority, and how they have been contested. In subsection 9.1, I analyze how and where the problem has been promoted by highlighting the instances within the practices of policy mobility where networks installed and authorized the problem representation. Section 9.2 focuses on the resistance that challenged the pervasive and authoritative problem representations by examining the events and actions undertaken by allied professionals who launched a collective action against the government concerning reforms of the IFHP. Finally, section 9.3 discusses alternative interventions to the problematization of refugee claimant healthcare. I argue how the opportunity was missed during collective opposition to the immigration reforms to problematize the lack of rights to services like healthcare.

9.1 How and where has the "problem" been promoted

Step 6 highlights the instances within the practices of policy mobility where networks installed and authorized the problem representation and identifies which groups or classes of individuals have access to the underlying discourses of the problematizations. Recall that step one of the WPR analysis had identified three hierarchical problem representations. The first is a macro-level problem of a porous and unfair immigration system that lacks appropriate penalties for the act of human smuggling, leading to the systemic "abuse" of the immigration system. The second is a meso-level problem that concerns the "abuse" of the refugee system by "unfounded" refugee claims made by persons who arrive "illegally" from countries that do not typically produce refugees. The third is a micro-level problem of the "unfair" rewarding of health benefits, greater than what the average Canadian receives, by those who arrive "illegally" in Canada to make an "unfounded" claim for refugee protection. The three hierarchical problem representations can be traced to public statements and actions taken by the government based on the security and deterrence discourse.

According to a news article by Quan (2017), in 2009, the MV Ocean Lady carrying 76 Tamil asylum-seekers landed on the coast of British Columbia, and a year later 2010, the MV Sun Sea carrying 500 Tamil asylum-seekers also arrived. The events sparked debate and provided a window of opportunity to reframe public perceptions of refugees and open discussions about the risk of "human smugglers" or "terrorists" among refugee claimants. Irvine (2011) notes that the events of 2009 and 2010 brought into immigration debates concerns regarding Canada's asylum system. Since the 1980s, public discourse has increasingly positioned irregular arrivals as a national security and border safety threat. Holtzer and Colleagues (2017) note that as a result, questions grew regarding Canada's "excessively generous humanitarian"

immigration policy (p.48). Reitz (2012) comments that by 2010, 70% of Canadians had doubts about the validity of many refugee claims (p.291-310).

With many politicians and the public concerned about the risk to safety and the security threat believed to be present within the refugee protection system, the opportunity was there for both politicians and the media to use the events to argue for immigration reform. The incumbent government during the 2010 election didn't hesitate to use coverage of the events to set a new policy agenda, with former Prime Minister Stephen Harper stating during an interview:

> *"We will not hesitate to strengthen the laws if we have to, because ultimately as a government, we're responsible," Harper said. "It's a fundamental exercise of sovereignty, and we're responsible for the security of our borders and the ability to welcome people or not welcome people when they come" (CBC 2010).*

Discourses within media coverage depict irregular arrivals and their claims for refugee protection as an issue of smuggling. Thus, policy debates and the framing of events preference the security and deterrence discourses that frame irregular migrants as criminals instead of characterizing them as persons in need of refugee protection. Villegas & Blower (2019) describe how government and media framing of the irregular immigration events led to parliamentary debates on the issue, featuring arguments for immigration reform due to the uncontrollable arrival of "queue jumpers," "criminals," and "frauds," which were characterized as "illegal," "immoral," and "threats" to border security and fiscal responsibility (p.75 - 76). Huot and Colleagues (2016) note that politicians questioned why irregular arrivals would target Canada. Government officials, in response, argued that welfare programs like IFHP are key "pull factors" that are vulnerable to abuse by economic migrants falsely claiming asylum (p.135). These responses by government officials were like the debates of the 1970s over how refugees should be defined within the law (Kelly and Trebilcock, 2010; Dirks, 1995).

Parliamentary debates demanded a government response. The response included the *Balanced Refugee Reform Act* (Government of Canada, 2010) and the *Protecting Canada's Immigration System Act* (Government of Canada, 2012d). Irregular arrival groups such as the Hungarian Roma were the subject of critic and criticism in the media by the Minister of Immigration and Citizenship at the time (2012). According to Boesveld (2012), Roma was depicted as people who did not have "legitimate" claims of persecution and was an unnecessary burden on social welfare programs. Holtzer and Colleagues (2017) note that in media statements, the Minister of Immigration and Citizenship employed powerful narratives that suggested that all refugee claimants were "bogus" or "unfounded" and seeking to manipulate the system, as opposed to "legitimate" refugees who awaited resettlement near conflict zones (p.50). In addition, within statements to the press, the IFHP became a halo policy reform target. The IFHP was described as "gold-plated" and an "abuse of Canada's overburdened healthcare system by bogus refugees" (Wherry, 2012; Parry, 2012). The government asserted this abuse was an "unfair" disparity for citizens and that such acts of humanitarianism should not extend to those "unfounded" refugee claimants. The Minister of Immigration and Citizenship, as a prominent figure, introduced through the media to the public a quantification of how the public should judge the legitimacy of refugee claims. Claimants were to be sorted into categories of "rejected," "fraudulent," or "unfounded." The refugee claimant categories provide a path for the government to publish numbers regarding rejected claims and frame for the public how one should evaluate a migrant's morality and deservingness concerning the benefits they receive.

Beyond utilizing the media to depict irregular arrivals as 'rejected/failed' refugee claimants, the 2012 amendments were promoted within parliament as only affecting the "bogus" refugees. According to Holtzer and Colleagues (2017), the reforms were rationalized and

justified to both the political opposition and voters as being a means to save the taxpayer money. Beatson (2016) notes that before the tabling of immigration legislation, the term "bogus" refugee appeared more frequently in parliamentary debates and press releases. The healthcare amendments to the IFHP were defended, like much of the 2012 immigration reforms concerned with the integrity of the immigration system. However, the government employed a top-down policy change within the reforms, declaring that public consultation was unnecessary. The amendments to programs like the IFHP were approved by the doctors and nurses who comprised Citizenship and Immigration Canada's own Health Branch. According to Sheridan & Shankardass (2015), the proposal was drafted without consultation with provincial or territorial governments or health service professionals (p.920). The Conservative government squashed all review or opposition from stakeholders from within the Standing Committee on Citizenship and Immigration who had expressed a desire to study the proposed amendments. Last, requests from opposition parties regarding evidence supporting the policy decision-making process were denied on the basis that the amendments were being made at the discretion of the cabinet and its members and thus were not subject to parliamentary oversight (Sheridan & Shankardass 2015, p.922). However, this did not mean that the proposals and the subsequent reforms did not have opposition. Opposition came from various health professionals and allied service providers who organized to directly protest and challenge the government on the reforms.

9.2 Resistance against the problem representations

The resistance that challenged the pervasive and authoritative problem representations took the form of swift opposition by a select group of professionals who had organized when the amendments to the IFHP were first proposed. When the government reframed Canadian immigration policy as requiring greater security and deterrence measures, one measure caught

the attention of healthcare professionals. The amendments to the IFHP, introduced by the federal government, downloaded responsibility for implementing denials for consultation, treatment, and access to medication onto healthcare workers at the provincial level. Not wanting to be wrapped up in anti-asylum politics, organizations representing front-line workers, including physicians, nurses, pharmacists, optometrists, social workers, and dentists, engaged in direct and indirect action. These groups worked with settlement service organizations, newcomer grassroots organizations, lawyers, and allied professionals. Included were protests, political office sit-ins, refusals to cooperate, press statements, policy statements, op-eds, scholarly publications, conference presentations, and letters expressing condemnation of the federal government (Barnes, 2013; CCR, 2012; CDRC, 2012; CHA, 2012; CUPE, 2012, Denton, 2012; Keung, 2012). The result was a significant collective outcry and unprecedented organized protest and advocacy by health professionals and allied refugee settlement professionals.

Critics and advocates argued to politicians, the public, and academic/professional circles that amendments were intended to deter individuals from making asylum claims and force those already within the country to leave more quickly. Initial research published in the National Post (2012) accused the government of not considering the long-term impacts on the demand for acute health services. In addition, there was a growing body of evidence that the policy change had led to adverse health and social consequences, such as increased costs and increased public health risks. The collective of professionals who opposed the IFHP amendments positioned themselves within a humanitarian discourse by arguing that the amendments were inhumane and failed to uphold Canada's humanitarian tradition. Harris & Zuberi (2015) and Villegas & Blower (2019) note that opponents of the reforms utilized personal stories to illustrate what effects the amendments had on children, pregnant women, and other vulnerable asylum-seeking individuals.

The stories made the point that the policy was morally and fiscally irresponsible. This collective of professionals drew upon ideals that all refugee claimants were vulnerable. The amendments challenged a core "value" of Canadian identity and history, protecting vulnerable populations (Villegas & Blower, 2019). Thus, a dichotomy was established between the government and the collective of professionals who allied with refugee claimants.

The collective of allied professionals sought to oppose the immigration reforms through collective activism. In the years following the 2012 IFHP amendments by health service providers, the collective resistance utilized a humanitarian discourse to problematize the representation of the "unfair" access to health benefits by refugee claimants. Their advocacy work counters negative depictions of asylum seekers as "bogus," "failed," or "fraudulent," with notions of asylum seekers as "victims" deserving of publicly funded services like healthcare. In an attempt to humanize refugee claimants, allied professionals adopted paternalistic attitudes contained within the humanitarian discourse that framed refugees as voiceless and powerless, which as Malkki (1996) argues, is a crucial indicator of "refugeeness" (p.385). Humanitarian discourse promotes a duty to protect, aligning with health professionals' values and codes of conduct. However, as Beatson (2016) notes, it relies upon framing the "victim" by emphasizing their passivity and need for charity.

Advocates and critics promoted a narrative that the 2012 IFHP amendments were an offence to Canadian values and against decency and compassion by reaffirming the language "they aren't all bogus." However, as Denton (2012) notes, this inadvertently implied that there must be some who are "bogus." In addition, advocates positioned such offences against Canadian values by utilizing humanitarianism as emblematic of "our country's tradition of giving medical care to refugees" (cited in Villegas & Blower, 2019, p.78). However, as Villegas

& Blower (2019) note, for these values to be practical, they must apply to those deemed as "deserving subjects," such as those having a "legitimate" need for protection (p.78). Advocates and policy critics framed refugees and refugee claimants as "victims" and the most vulnerable members of society "deserving" of Canadian humanitarianism through their experience and persecution. As Kurasawa (2015) highlights, within the humanitarian discourse, there is a need to "actively construct objects and sites for intervention" (p.2). The victim status of refugee claimants draws upon the ideal characteristics of passivity, weakness, helplessness, and neediness. If an individual in question does not fully embody these traits, they can be judged as "undeserving." Portraying refugee claimants then as "victims" risks being overly paternalistic and "others" this population by forcibly creating identities to fit a specific narrative, such as individuals who lack complex consciousness and the capacity for opinions. In a critique of victim identities, Gottlieb and Colleagues (2012) argue that health service professionals' assignment of victim status could be grounded in "medical humanitarianism." Medical humanitarianism contains assumptions about how social resources should be allocated and on what grounds (charity to the "deserving"). As Beatson (2016) argues, the victim frame employed by health professionals and other advocates promoted "a certain connection of health coverage as a type of humanitarian assistance" (p.130).

Allied professionals and health professionals engaged in advocacy and activism within the public and political spaces; they also sought change through legal means by challenging the amendments based on rights. Turning to the Canadian Association of Refugee Lawyers (CARL), health professionals and lawyers submitted a joint application for judicial review to the Federal Court of Canada in 2013. They argued that the reforms implemented by Citizenship and Immigration Canada breaches the Canadian Charter of Rights and Freedoms and international

agreements regarding healthcare for refugee claimants. Judge Mactavish, who presided over the case, heard affidavits from six individuals who chose between life-saving medication and food (CDRC v Canada, 2014). Within the ruling of the case, Judge Mactavish found there was no federal legislation addressing the question of providing healthcare to refugees, claimants, or failed claimants and that provision of healthcare to these groups was a discretionary matter for the government. Thus, Judge Mactavish ruled that there was no violation of the charter's Section 7 (the right to life and security), as the government did not have any positive obligation to provide healthcare (CDRC v Canada, 2014, p.138). However, Judge Mactavish did find that those seeking protection were under the administrative control of the state, and the actions of the state had limited their opportunity to seek treatment, thus violating Section 12 (protection against cruel and unusual treatment) (CDRC v Canada, 2014, p. 257). Lastly, Judge Mactavish held that the amendments had provided health insurance coverage based on national origin. The provision of coverage based upon national origin was a form of discrimination that violated Section 15 (the right to be free of discrimination) (CDRC v Canada, 2014, p.258). Critical in the Judge Mactavish ruling was that refugee claimants did have some rights. However, Dhand & Diab (2015) note this did not include the fundamental right to have healthcare afforded to them; however, if healthcare was provided to refugee claimants, Canadian law obligated the state to provide it in a non-discriminatory manner. The government filed an appeal in response to the courts' orders to restore the IFHP following a successful federal court case against them. According to Ruiz-Casares and colleagues (2016), the government implemented a temporary IFHP on November 5, 2014, just days before the federal court deadline. Despite the successes of allied professionals within the court, the government appeal process and the discriminatory nature of the policy made it difficult to effect permanent change. The temporary IFHP exampled

this difficulty and deterred health service providers by increasing the complexity of insurance from 3 to 6 categories of coverage (See Appendix B).

Resistance achieved change through counter-mobilization that brought the issue of the IFHP into public debate. The government's defeat in federal courts publicized and sensitized Canadians to the plight of refugee claimants and highlighted Canada's failure to uphold its humanitarian tradition values within its 2012 immigration reforms. According to Holtzer and colleagues (2017), during the 2015 federal election, opposition parties like the Liberal Party and the New Democratic Party adopted a humanitarian discourse in their party platforms by committing to a reinstatement of the IFHP and its funding if elected over the incumbent Conservative party. By the end of 2015, a new Liberal government was elected. This new government chose to drop the appeal and, in 2016, reinstated the IFHP to the pre-2012 level of coverage for all refugee claimants. The Liberals defended their move by highlighting mounting provincial health costs, limited access to health services, and the health needs of refugees by stating that "it is the right thing to do" for refugees and to protect the health of all Canadians (CBC, 2016). However, as noted by Beatson (2016), this move avoided any "serious attempt to elevate the status of asylum seekers within Canadian society on a permanent level" (p.130). The provision of healthcare insurance for refugee claimants remains an issue of discretion for immigration officials. There is no positive obligation to provide healthcare. This lack of obligation is due to the lack of law guaranteeing it. Thus, the IFHP continues to operate outside provincial and territorial health systems. The discourses of economic migration and

security/deterrence distrusting and fearful of irregular migrants remain in the form of the Third Safe Country Agreement[22].

9.3 An alternative intervention to the problematization of refugee claimant healthcare

The issue of refugee claimant healthcare is situated between competing discourses of humanitarianism, economic migration, and security and deterrence. Historically, the three competing discourses have been pitted against each other to control the narrative about asylum seekers, particularly in terms of protecting deserving "victims," protecting the economy from irregular and undeserving migrants, and limiting entitlements to welfare services to discourage migration. The result of the intersection between these competing discourses is a refugee protection policy that attempts to strike a balance between providing charitable aid to "genuine" refugees and excluding irregular migrants who make "unfounded" refugee claims by making healthcare a discretionary matter strongly associated with immigration policy.

Before the 2012 amendments, the IFHP is documented to operate informally as a tool of deterrence. Edge & Newbold (2013) argue that before the 2012 reforms, physicians and hospitals could refuse to treat. Patients struggle with a healthcare system that prioritizes citizens and lacks continuity to access and care for non-citizens. Little has changed regarding refugee claimant healthcare since the 1950s. As highlighted in Chapter 6, public and governmental debates frame health coverage for refugee claimants as discretionary humanitarian assistance. However,

[22] Canada's third safe country agreement states that individuals entering Canada at a land port of entry are ineligible to make a refugee claim, and will be return back to the last country they could have applied for asylum (Government of Canada, 2020)

humanitarian aid does not address the fundamental issue that led to the 2012 IFHP amendments: the lack of legal basis for healthcare provision to refugees and asylum seekers.

Humanitarian discourse is "about the exception rather than the rule." To state it differently Ticktin (2006) argues that humanitarian discourse is about seeing those who are "victims" as objects in need of aid rather than as individuals entitled to universal rights. Countries like the United States and the United Kingdom take an alternative path, as highlighted in Chapter 7, and have adopted a universal rights-based discourse in their debates. While coverage is not absolute, there is still a legal basis that guarantees access to emergency healthcare and treatment and minimal standards for access to medication and support until recovery. This legal basis means that pregnant women and persons needing immediate medical treatment must receive treatment despite their immigration status or ability to pay. Whereas in Canada, such guaranteed right to treatment following the 2012 IFHP reforms, according to Marwah (2014), was not provided to a pregnant refugee claimant who was refused care by specialists and the hospital when they could not pay the upfront cost of medical care.

Fundamental rights to healthcare for refugee claimants are sorely missing from Canadian law. The *CRDC v Canada* (2014) ruling highlighted that Canada does not have any positive obligation to care due to a lack of underlying law obligating funding and access to healthcare (para, 510). Slim (200) argues that rights-based advocacy has a different underlying logic of obligation instead of charity. From a human rights perspective, the debate following the 2012 amendments over the deservingness of health coverage would be irrelevant. Rather, the discussion would be about an individual's fundamental right to healthcare and not their "deservingness" that relies upon judgment about the "genuineness" of their refugee claim. Beatson (2016) argues that within rights-grounded advocacy, there is space for the marginalized

to become empowered by being their own advocates, unlike within the "victim" relation set up by a humanitarian discourse.

There is an opportunity to introduce rights-based discourse within public debates about refugee and refugee claimant healthcare. So far, these arguments have been fought primarily in the courts in cases like *CDRC v Canada* (2014) and *Toussaint v Canada* (2010) , whereby success depended upon the interpretation of the Canadian Charter of Rights and Freedoms and not upon a law regarding a right to access healthcare. Like Dauvergne (2000), some critics believe that asserting health rights is often practically ineffective and that centring advocacy on the right to health may also face challenges regarding a consensus of what the "right to health" means. Scholars like Ruger (2006) build upon this position by stating that there is not a more "controversial or nebulous human right than the 'right to health'" (p.273). However, there is some success internationally, especially in Europe. The high levels of migration from countries in Africa, the Middle East, and the former Soviet Union have led to different inclusion levels across countries for documented and undocumented migrants. According to Beck and colleagues (2019) regardless of their status, refugees in Europe are granted access and funding for healthcare under the law. In addition, the International Organization for Migration (2018) argues there is a clear normative framework for the rights of refugees and migrants regarding their access to healthcare. Matlin and Colleagues (2018) argue that such a framework should derive from a global human rights framework like the *Universal Declaration of Human Rights (1948)*, the *World Health Organization constitution (1946)*, and goals and targets adopted within *the 2030 Agenda for Sustainable Development* (2015). There are various pre-existing international legal frameworks to which Canada is a signatory, such as ICESCR, which, if ratified, obligates states to provide equal and non-discriminatory access to health for refugees and non-refugee

groups (United Nations, 1966). However, until it is ratified into law, it is merely an international legal document that Canada has no obligation to abide by.

The rights-based approach has its advantages. For example, the "problem representations" of the "unfair" provision of health benefits to refugee claimants could be reframed to a representation that it is "unfair" that refugee claimants do not have a right to healthcare. This opportunity was missed from 2012 to 2016 in public and political debates over the Interim Federal Health Program. Then, the humanitarian discourse of opposition relied on empathy and compassion for refugee claimants to be judged as "deserving" to be able to access healthcare. If rights-based discourse had dominated the debates, there would no longer be the limitations posed by having compassion as the basis for providing healthcare. Instead, a human rights discourse would reposition refugee claimants as rights-holders; human rights would be the basis for problematizing *healthcare* to meet international obligations, instead of whether it should be provided and to whom.

9.4 Chapter summary

This chapter concluded the WPR analysis with a sixth step, asking, "*How and where has this representation of the "problem" been produced, disseminated, and defended? How has it been and/or how can it be disrupted and replaced?*" (Bacchi, 2009, p.19) This chapter shifted towards analyzing how the "problem representations" have been promoted, achieved legitimacy and authority, and alternatively if they have been contested. Step 6 was broken down into three subsections which analyzed how and where the "problem" has been promoted, the resistance against the problem representations, and an alternative intervention to the problematization of refugee claimant healthcare. I concluded this final step of my analysis by arguing that the rights-based approach has its advantage. A human rights discourse would reposition refugee claimants

as rights-holders and be the basis for problematizing how healthcare should be provided to meet international obligations instead of whether it should be provided and to whom.

Chapter 10: Discussion and Conclusions

This thesis reflected on the 2012 Interim Federal Health Program amendments to examine how and why refugee claimants in Canada remain without a guaranteed right to access healthcare. Specifically, my analysis was concerned with the underlying meanings contained within refugee healthcare policy and with how such policies have constructed the problem of refugee healthcare. In my opinion, Bacchi's method resolves many of the limitations present in other discourse analysis methods such a PDT, RPA, and DHA, as it concerns itself with problematizing a policy problem through discursively analyzing and critiquing the historical underpinnings of a policy problem, exposing and critiquing the "common sense" discursive meanings in policy, and providing a systemic deductive approach to breaking down a policy problem. Approaching the Interim Federal Health Program with Carol Bacchi's (2009) WPR method provided me with the analytical tools that I needed to reframe the problem of refugee claimant healthcare. Through critique and careful examination of policy, I drew attention to how the *problem* indicated is not objectively a "problem" but rather something constructed as a problem by policymakers.

This critical analysis of the 2012 amendments and their place within policy history revealed the power struggles and political conflicts that have shaped the discursive conditions for developing and operationalizing Canada's unique policy. The critique challenged why refugee claimants in Canada remain unable to enact their universal right to access healthcare. It paves the way to present the problem of refugee healthcare alternatively and more humanely approach it through policy. My key finding is that a rights-based approach driven by a human rights policy discourse is needed in addressing the policy problem of refugee claimants access to healthcare.

Without adopting a human rights discourse to reposition refugee claimants as rights-holders, little has been done or can be done to elevate a refugee claimant's status within Canada.

This study, if assessed from a positivist paradigm, may be criticized for having limitations regarding its generalizability, validity, and reliability, which I address here. However, research within the poststructuralist movement does not necessarily require or seek to work towards a universal, objective, and empirical truth. Instead, a transient, contingent, and dynamic credibility is constantly negotiated and renegotiated between the researcher, research, and reader. This approach contrasts with positivist approaches which rely upon triangulation, researcher objectivity, and replicability (Denzin and Lincoln, 2018). Poststructuralist thought denies the idea there is a fixed or objective truth waiting to be discovered. This denial of fixed or objective truth complicates trustworthiness in poststructuralist research. Positivist notions typically considered important in building a study's trustworthiness (validity, generalizability, reliability, etc.) need to be rethought and reconceptualized for the study's applicability and efficacy within the social sciences. The goal of this work was not to seek or work towards revealing a generalizable or replicable truth but instead to participate in an explication of one facet of a multifaceted understanding of truth and make the possibility for difference and change (Frost & Elichaoff, 2014). Like other forms of qualitative research, this study sought to achieve resonance rather than generalizability (Tracy, 2010). Resonance is achieved if the study moves, influences, or affects particular readers or a variety of audiences through transferable findings, naturalistic generalizations, or evocative representation (Tracy 2010, p.840).

Post-structural validity is in stark contrast to many other forms of validity concerned with the quality of being logically or factually sound. Lather (1993) suggested that within poststructuralism, foundational assumptions prompt us to seek to repeatedly construct and

deconstruct discourse to undermine traditional conceptions of universal and grand truths consistent with traditional conceptions of validity. Using Lather's notion of validity characterizes how I assess the validity of this work: did this study participate in opening for questioning that which is presented and understood as true? This study sought to build upon Lather's understanding and depends upon my ability to explore the resources of contemporary inquiry by contributing to unseating closed truths of the past, freeing up the present for new forms of thought and practice (Lather, 1993). However, in keeping with the poststructuralist tradition, this work does not claim to be, nor do I claim for it to be, reliable in the classical sense. The same data I analyze may produce a very different analysis if completed by another researcher. However, it is common practice within qualitative inquiry to counter traditional criticism of both validity and reliability by making transparent any prior assumptions and positioning within the field (Lather 1990), which I have attempted here and throughout the thesis.

Although applying post-structuralist methods is challenging and involving, the utility of critical forms of poststructuralism is an acknowledgement of how politics and power are invisible, making the situations and choices of the present seem inevitable. By de-inevitabilizing the present, these approaches encourage rethinking specific policies and programs that rest on unquestioned premises. Poststructuralist approaches do this by attending to a wide variety of unexamined practices, discourses, and knowledge to render them less than certain (Bacchi & Goodwin 2016). I have found WPRto be a very useful tool to question policy processes critically. I hope that more researchers and analysts will employ this Foucault-influenced post-structural policy analysis method to contest meanings in the policy. For instance, a more extensive historical analysis of the Interim Federal Health Program and its positioning relative to provincial and territorial healthcare systems could reveal some interesting insights into how

IFHP recipients are problematized within provincial healthcare decision-making. Such an investigation could shed light on provincial policymakers' roles in producing barriers to healthcare for IFHP recipients and could open opportunities to develop interventions that minimize such barriers.

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Appendices

Appendix A: 2012 Interim Federal Health Coverage

Class	Coverage
1. Protected Persons (Government Resettled Refugees, Victims of Human Trafficking). 14% of all beneficiaries.	Expanded Health Care Coverage (EHCC). • Hospital/physician services. • Preventative care (i.e. Medication). • Limited Supplemental Services (urgent dental/ limited vision care, psychological counselling). • Laboratory, Diagnostic, and Ambulance service. • Limited Supplemental Products (i.e., homecare, prosthetics).
2. Non-DCO Refugee Claimant/ Privately Sponsored Refugee/ Immigration Detainees/ Positive Pre-Removal Risk Assessment. 62% of all beneficiaries.	Health-Care Coverage (HCC) "only if of an urgent or essential nature". • Hospital, physician, or nursing services. • Laboratory, diagnostic, and ambulance services. • Preventative Care (medication/immunization) only if it is required to 'prevent' or 'treat diseases' that pose a risk to 'public health or safety'.
3. Refugee Claimant from a Designated Country of Origin (Introduced by Bill C-31) / Rejected claimants. 24% of all beneficiaries.	Public Health or Public Safety Health-Care Coverage (PHPS) • No preventative care. • No hospital/physician services except when patient poses a public health or safety risk. • No medication except to treat a condition that poses a public health or safety risk.
4. Withdrawn or Abandon Claimants/ Unfounded Claimants	No Coverage under the IFHP.

Table has been adapted based on information available from Order in Council 2012 (Government of Canada, 2012g; Dhand & Diab 2015)

Appendix B: 2014 Temporary Interim Federal Health Coverage

Class	Coverage
1. Government Assisted Refugees/ Privately Sponsored Refugees/ Victims of Human Trafficking/ All IFHP beneficiaries who are children (under 19 years of age)	Basic, Supplemental and Prescription Drug Coverage. • Basic Coverge (doctor, hospital, laboratory, diagnostic and ambulance services). • Supplemental Coverage (limited dental and vision care, home care and long-term care, services by allied care practitioners, assistive devices, medical supples and equipment, othopedic and prothetic equipment, etc.). • Prescription Drug Coverage.
2. Rejected Refugee Claimants With Deferral of Removal for Generalized Risk/ All IFHP Beneficiaries who are Pregnant	Basic and Prescription Drug Coverage • Basic Coverage • Prescription Drug Coverage
3. Privately Sponsored Refugees without RAP support/ Protected Persons/ Designated Country of Origin Refugee Claimant/ Non-Designated Country of Origin Refugee Claimant/ Individuals who receive a positive decision on their Pre-removal Risk Assessment.	Basic and Public health or Public Safety Prescription Drug Coverage • Basic Coverage • PHPS Prescription Drug Coverage (medications and products **only if required** to prevent or treat a disease or condition that poses a risk to public health or safety).
4. Rejected Refugee Claimants Without a Deferral of Removal for Generalized Risk/ Individuals with Ineligible Refugee Claim but Eligible to make a Pre-Removal Assessment Application.	Public Health or Public Safety (PHPS) Basic Coverage and PHPS Prescription Drug Coverage • PHPS Basic Coverage (only to prevent, diagnose or treat a disease or condition that poses a public health or safety concern). • PHPS Prescription Drug Coverage
5. Persons Detained under the IRPA	Coverage for persons detained under the Immigration and Refugee Protection Act • Medical or limited dental services on site in detention facilities or offsite when medically necessary • Prescription drugs either onsite in detention facilities or offsite when medically necessary
6. Government Assisted Refugees and Privately Sponsored Refugees	Coverage for Immigration Medical Examination • Covers the cost of the IME and IME-related diagnostic tests required under IRPA

Table has been adapted based on information available from 2014 Government Notice and 2014 Medavie notice (Government of Canada, 2014; Medavie Blue Cross, 2014)