



Refugee and Asylum Seekers in Canada: Barriers To Health Care Services

Tara Saberpor

Abstract:

This paper will examine prevalent barriers to health care services faced by refugees and asylum seekers in Canada, a country that promises universal health care to all. Through applying the anti-oppressive (social work) theory, it becomes evident that health care disparities are a pressing issue for oppressed groups like refugees and asylum seekers in Canada. This analysis will be examined in the first and second section. In the third section of the paper, several recommendations will be made to ensure that the Canadian government and all key actors eliminate oppressive policies on the basis of immigration status in order to have high quality and accessible health care for all refugees and asylum seekers.

Résumé :

Cet essai examinera les obstacles fréquents à l'accès des réfugiés et demandeurs d'asile aux services de santé dans le contexte canadien, soit dans un pays qui promet des soins de santé universels pour tous. En appliquant la théorie anti-oppressive (travail social), il devient évident que les disparités dans les soins de santé sont une question pressante pour des groupes opprimés comme les réfugiés et les demandeurs d'asile au Canada. Cette analyse est examinée dans la première et la deuxième sections. La troisième section de l'essai contient plusieurs recommandations afin de garantir que le gouvernement canadien et tous les acteurs clés éliminent les politiques oppressives sur la base du statut d'immigrant et ce, afin d'avoir des soins de santé accessibles et de haute qualité pour tous les réfugiés et les demandeurs d'asile.

Introduction

Refugee migration is rooted in many world issues including social, political, environmental, economic, humanitarian, and health. Access to essential health care is a basic human right, to which every human being is entitled. Canada's obligation under International Law guarantees the right of every individual to enjoy the highest attainable standard of physical and mental health, which must be exercised without any discrimination.¹ Despite Canada's promise of universal health coverage and high-quality care, national health disparities are a major problem. Refugee experiences of social exclusion in addition to trauma and oppression pre-migration, especially for asylum seekers, result in the limited access to health care services in Canada. The anti-oppressive (social work) theory asserts that group-based power imbalances in a society involve a class of privileged oppressors limiting social goods to create oppressed groups in disadvantaged positions relative to the oppressor group. By analyzing the intersecting barriers to health care services faced by refugees and asylum seekers, this paper will show how the Canadian government situates these groups as an oppressed in relation to Canadian citizens. In this first section, a conceptual and theoretical framework will be provided to analyze the structural barriers. After presenting the significance and background of the study, the second section will examine the barriers to health care access. Several recommendations will be presented in the third section of the paper.

Conceptual Framework

Given the differences in the level of entitlements and support based on refugee status, it is important to define the different refugee classes. Furthermore, it is necessary to use appropriate

terms to avoid any confusion. For an individual to be eligible for refugee status in Canada, they must be recognized as a Convention refugee. A Convention refugee is a person who is outside of their home country and has a well-founded fear of being persecuted for reasons such as race, religion, and political opinion.² In this paper, the term Convention refugee will be used to refer to all types and statuses of refugees. However, references will also be made to asylum seekers. An asylum seeker is a person who is seeking asylum until their claim for protection as a refugee has been accepted. This term is equivalent to ‘refugee claimant’, which is more commonly used in Canada.³

In this paper, access will refer to a definition proposed by Penchansky and Thomas in their article “*The Concept of Access*”; “access is a measure of the ‘fit’ between characteristics of providers and health services and characteristics and expectations of clients, and... this concept includes five reasonably distinct dimensions: availability, accessibility, accommodation, affordability, and acceptability.⁴

For the purpose of this paper, health care will refer to, equitable, quality, affordable, accessible, and effective health services by all levels of care, e.g. primary, secondary, etc., which work to maintain and improve the physical and mental well-being of an individual.

¹ United Nation: Economic and Social Council, General Comment No.14. Substantive Issues Arising In The Implementation Of The International Covenant On Economic, Social, And Cultural Rights. Geneva (2000).

² Citizenship and Immigration Canada, “Glossary”, <http://www.cic.gc.ca/english/helpcentre/glossary.asp>.

³ Canadian Council for Refugees, *Talking About Refugees And Immigrants: A Glossary Of Terms*, Montreal, Canadian Council for Refugees (2015):1.

Theoretical Framework

Refugee health care access can be analyzed through a number of theoretical frameworks. It is important to examine this issue through critical theories to understand the unequal balances of power and therefore, provide suggestions on how to challenge these oppressive structures.

This paper will examine the barriers faced by refugees in accessing health care services in Canada through the anti-oppressive (social work) theory, which questions social divisions and structural barriers in society. According to Mullaly, in a society that is group based, oppressors control social goods and services at the expense of the oppressed. Consequently, in Mullaly's words, "oppression protects a kind of citizenship that is superior to that of the oppressed."⁵ This oppressive power imbalance causes vulnerable groups, such as refugees, to have limited access to health and other social services in society.

The anti-oppressive theory consists of several different concepts and approaches. Firstly, the concept of social divisions explains the differences between groups of people based on inequalities in power and access to resources, individually and collectively.⁶ In relation to the discussion of this paper, immigration class/status is a social division. Secondly, inequalities, such as health inequities, are a consequence of power differentials between groups.⁷ Thirdly, the social exclusion approach is also used to understand the marginalization and oppression of certain groups.⁸ It is important to note that, according to a report by Mikkonen and Raphael,

⁴ Roy Penchanskym and J. William Thomas, "The Concept Of Access: Definition and Relationship to Consumer Satisfaction," *Medical Care* 19, no. 2 (1981): 139.

⁵ Robert P. Mullaly, *The New Structural Social Work* (Don Mills: Oxford University Press, 2007), 194.

⁶ Pam Green Lister, *Integrating Social Work Theory And Practice: A Practical Skill Guide* (New York: Routledge), 45.

⁷ *Ibid.*, 51.

⁸ Jane Mathieson, Jennie Popay, Etheline Enoch, Sarah Escorel, Mario Hernandez, Heidi Johnston, and Laetitia Rispel, *Social Exclusion: Meaning, Measurement, And Experience And Links To Health Inequalities. A Literature Review*. WHO Social Exclusion Knowledge Network Background Paper 1. Bailrigg, Lancaster: Lancaster University (2008).

social exclusion is one of the social determinants of health.⁹

Historically, Canada's Eurocentric neoliberal ideology has enabled it to create targeted public policies towards the desirable versus the undesirable newcomers.¹⁰ Despite changes in immigration policies, the undesirable continue to be oppressed by systematic policies and programs. This is evident in the current IFHP, which discriminates against refugees, as they do not experience full access to health care and other social services.¹¹ Thus, in the Canadian context, marginalized groups like refugees experience social exclusion by having limited access to health care and other services.

Based on the idea of social divisions and structural barriers, the anti-oppressive theory provides a holistic approach to understanding the lived experiences of marginalized groups. Specifically, concerned with issues of access and inclusive/exclusiveness, the anti-oppressive theory focuses on the well being of oppressed groups like refugees.

Significance of the Study

Amongst the different categories of newcomers to Canada, refugees tend to be an under-researched group. The majority of the existing Canadian literature focusing on barriers faced by refugees in accessing social services is related to issues such as housing, income, and access to employment. Also, refugees are missing in research that focuses on the health care experiences of newcomers, despite having greater health needs than other newcomers due to their history and their resettlement experience. Furthermore, the limited existing research studying health related

⁹ Juha Mikkonen, and Dennis Raphael, "*Social Determinants Of Health*" Toronto: York University School of Health Policy and Management (2010): 32.

¹⁰ Harold Troper, "Immigration," *The Canadian Encyclopedia* (2001), accessed July 7, 2015, <<http://www.thecanadianencyclopedia.ca/en/article/immigration/>>.

¹¹ Steve Barnes, "*The Real Costs of Cutting Refugee Health Benefits: A Health Equity Impact Assessment*" Toronto: Wellesley Institute (2012).

issues has mainly focused on mental health issues, the health status of children and youth, and pregnant women.¹² While barriers to accessing health care services in Canada may be shared among most newcomer groups, the impact is higher for refugees, given their vulnerable status. The lack of information regarding barriers to general health care services by refugees is problematic, particularly when it comes to the development of effective policies - hence, this paper seeks to analyze and address the barriers to health care access experienced by refugees, and contribute to rectifying this knowledge gap.

Background Information/ Background of the Study

Specific health status and issues will not be referred to in this paper, however, detailed information on refugee health statuses can be found in “The Health of Immigrants and Refugees in Canada” by Morton Beiser.¹³ Additionally, Steve Barnes outlines changes in the new Interim Federal Health Benefit and its impact on specific health conditions in a report.¹⁴ With regards to barriers to health care access, examined in the next section, there are several other barriers that refugees face in accessing health care services which are not analyzed in this paper, such as gender, education, administrative delays in paper work, etc.

According to Beiser and Stewart, compared to other immigrant classes, refugees are more likely to suffer from infectious diseases, general illnesses and mental health issues.¹⁵ Additionally, finding their way through the health care system and facing barriers, including

¹² Marie Mckeary, and Bruce Newbold, "Barriers to Care: The Challenges for Canadian Refugees and Their Health Care Providers," *Journal of Refugee Studies* 23, no. 4 (2010): 534.

¹³ Morton Beiser, “The Health Of Immigrants And Refugees In Canada” *Canadian Journal Of Public Health* 96 no.2 (2005): S32.

¹⁴ Steve Barnes, *The Real Costs of Cutting Refugee Health Benefits: A Health Equity Impact Assessment*, Toronto: Wellesley Institute (2012): 4-6.

¹⁵ Morton Beiser and Miriam Stewart, “Reducing Health Disparities” *Canadian Journal Of Public Health* 96 (2005): S4.

cost, language, culture, coverage, etc., may further increase their health needs. As already mentioned, refugees are likely to have greater health issues given their history and resettlement process. Refugees may arrive with serious existing health problems, (e.g. Tuberculosis) which are not diagnosed during the pre-arrival screening.¹⁶ This is not only problematic for the individual but for the general public as well. Consequently, it is imperative that they have access to health care in order to prevent the spread of diseases.¹⁷ In the General Comment No.14, the Committee on Economic, Social, And Cultural Rights (CESCR) asserts that every individual has the right to the utmost standard of health¹⁸, therefore, states must ensure that health services are available, accessible, acceptable, applicable, and of good quality to the entire population, including refugees.

Barriers

This section will examine the intersecting barriers that result in social exclusion and oppression of refugees and asylum seekers in Canada.

a. Funding and Coverage

The most significant issue associated with the funding of health care services in Canada is the tripartite government structure (federal, provincial, and municipal). All three levels of government differ in their responsibilities and therefore, there is an issue of lack of coordination regarding which government level is responsible for the health and welfare of refugees.¹⁹ As stated by Mckeary and Newbold, “health care access is affected by the complexities and

¹⁶ Beiser and Stewart, S4.

¹⁷ Beiser S32.

¹⁸ United Nation: Economic and Social Council, *General Comment No.14*. Substantive Issues Arising In The Implementation Of The International Covenant On Economic, Social, And Cultural Rights. Geneva (2000).

challenges of health insurance for refugees, which reflects a bureaucracy that impacts on health access as various levels of government are responsible for different components.”²⁰

In Canada, if it has been decided that a refugee claimant is eligible for a hearing, they may be entitled to health care under the Interim Federal Health Program (IFHB).²¹ Similar to provincial and territorial insurance coverage for Canadian citizens and permanent residents, the IFHB, originally provided “temporary health insurance to refugees, protected persons, and refugee claimants in Canada” that are not covered by other health insurance plans.²² Other services were also provided, such as medications, emergency dental care, and vision care. However, on June 30th, 2012, the federal government made changes to the IFHB. These changes would limit, and in some cases eliminate, access to health care services for all refugees.²³ All refugees, excluding government-sponsored refugees, lost their access to medication, vision, and dental coverage. They are only covered for the following conditions; issues of public health concern, including communicable diseases, and issues of public security concerns, including psychotic conditions that pose a danger to others.²⁴ People from designated countries of origin (DCOs), refugee claimants from countries Minister Jason Kenney deems safe and thus should not be producing refugees, no longer have any health coverage including for emergency care.²⁵

The Canadian government feels that by limiting access to health care, it will prevent refugees from coming to Canada.²⁶ However, refugees flee their countries in fear of being persecuted, so it is misguided to believe that access to health care is a priority during the process

¹⁹ Mckeary and Newbold, 531.

²⁰ Ibid., 535.

²¹ "Health Care for Refugee Claimants." Refugee Rights in Ontario. November 6, 2014. Accessed July 2, 2015. <http://refugee.cleo.on.ca/en/health-care-refugee-claimants>.

²² Barnes, 2.

²³ Ibid., 2.

²⁴ Canadian Doctors for Refugee Care, “The Issue” (2015) <<http://www.doctorsforrefugeecare.ca/the-issue.html>>.

²⁵ Barnes, 2.

of deciding in which country they will seek safety. According to Doctors for Refugees, “refugees previously received nothing more than what the lowest income Canadians who receive social assistance do” and now receive much less.²⁷ The government disregards the systematic barriers refugees face in accessing health care services even when they are available. Furthermore, these beliefs and actions only further complicate matters and violate the inherent human rights of refugees. The policy changes reaffirm the social work theory about how the distribution of resources among different categories of people is oppressive and exclusionary.

As a result of the IFHB changes, refugees will face greater financial barriers to accessing health care services and thus, they will become more vulnerable.

b. Language and Interpretation Issues

Language difficulties and the need for interpretation is one of the most significant barriers to accessing health care services for refugees. Compared to other newcomers, refugees tend to have greater issues with English, depending on their country of origin.²⁸ Making sure information given to patients is understandable can be a real challenge. For example, in a report made in 2010, the Winnipeg Regional Health Authority states that language difficulties increase the risks of “misdiagnosis, poorer patient understanding of his/her condition and adherence to prescribed treatment, lower satisfaction and confidence, and differences in prescribed treatment.”²⁹ Additionally, according to Mckeary and Newbold, language difficulties may also affect follow-

²⁶ Canadian Doctors for Refugee Care.

²⁷ Ibid.

²⁸ Mckeary and Newbold, 529.

²⁹ Winnipeg Regional Health Authority “*Understanding The Health And Health Issues Of Immigrant And Refugee Populations*. Part Two: Developing An Evidence-Informed Response (2010): 77.

up instructions or prescriptions, which are typically in English.³⁰ Therefore, errors in understanding may have implications for the provision of health care to refugees.

Interpretation and interpretation services are also problematic and affect health care accessibility. Provincial health care coverage does not cover translation services, so it is the responsibility of the patients, or community health centers to pay for the translation costs. For the social service community health care agencies, this causes many difficulties concerning their budgets and limited resources, in order to ensure interpreters are available to accompany patients to mainstream medical centers.³¹ This lack of translation services may also delay care when the need for it is serious. On the other hand, there are other risks and issues associated with having an interpreter present, such as client confidentiality. When medical information is no longer just between the health professional and the patient, the presence of an interpreter may further stress trust relationships.³² Moreover, Mckeary and Newbold argue that “the lack of consistent professional interpreter that follows a client through the system may mean that refugees need to re-tell their story via multiple interpreters, further increasing the potential to compromise confidentiality and using valuable time in a provider’s office.”³³ When interpreters are not available, family, friends or other untrained individuals may be used as interpreters, which can be very problematic as they may wrongly translate medical terms and advice, thus leading to misunderstanding and misdiagnosis.³⁴ Overall, not only is there a shortage of professional interpreters but too little attention is paid to the issues of interpretation in general further raising the language barrier for refugees.

³⁰ Mckeary and Newbold, 530-531.

³¹ Mckeary and Newbold, 530.

³² Ibid.,531.

³³ Ibid., 531.

³⁴ Ibid., 531.

c. Culturally Competent Care

Availability does not necessarily mean accessibility. For many refugees, accessing health care is more than just finding a provider. It is about finding a provider who understands and who has practice located in an area comfortable to the refugee patient. In Canada, there are many issues involved with providing culturally competent care. Not having specialized training to address the cultural divide amongst refugees can be an issue. According to Mckeary and Newbold, many medical centers do not offer specialized knowledge and the dominance of Western biomedicine fails to acknowledge social and cultural basis of health.³⁵

d. Lack of Information

Many refugees lack information on what services they are entitled to and the procedures involved in gaining access to these services. Furthermore, according to the Canadian Council for Refugees, the IFHB document is difficult to read.³⁶ Many health care providers also lack information and therefore, may mistakenly tell the patient that they are not covered. As a consequence, refugees are forced to pay for services or refrain from getting the services they need.³⁷ With the changes to the IFHP, many refugees and health care providers have noted that there is a major confusion surrounding IFHP eligibility.³⁸ The new IFHP contains a complex set of categories and entitlements. Refugees and asylum seekers face challenges in navigating the health care system, and with the changes to the IFHP, service providers now also face confusion

³⁵ Mckeary and Newbold, 532.

³⁶ Canadian Council for Refugees, “*Refugee Health Survey By Province And By Category*. Montreal: Canadian Council for Refugees” (2015): 3.

³⁷ *Ibid.*, 3.

³⁸ Sonal Marwah, *Refugee Health Care Cuts In Canada: System Level Costs, Risks And Responses*, Toronto: Wellesley Institute (2010): 8.

and difficulties. Again, it can be seen that such barriers leave these vulnerable groups to a system that is oppressive.

e. Economic

Financial difficulties, especially after the 2012 IFHP changes, also serve as a significant barrier to health care access for refugees and asylum seekers. Refugees in Canada are often faced with unemployment because they cannot find work due to language barriers.³⁹ Asylum seekers/refugee claimants are more vulnerable when they are unable to obtain work permits. Not only does their inability to work contribute to poverty or low-income status but this leads to detrimental impacts on their physical and mental well-being.⁴⁰

f. Shortage of Health Care Services

The unavailability of health care services is also a systemic barrier for many refugees in Canada. Mckeary and Newbold argue that there is a shortage of primary care providers and as a consequence refugees are forced to be put on waiting lists.⁴¹ This situation becomes more problematic when providers are reluctant to accept new refugee patients, even those with pressing health needs, due to the array of challenges they bring, such as complicated insurance coverage and language barriers. Additionally, many health care providers are unwilling to accept new patients to avoid lengthy appointments and expenses that drain on physician resources.⁴² In Mckeary and Newbold's research, many respondents stated their inability to access appropriate

³⁹ Mckeary and Newbold, 538.

⁴⁰ *Ibid.*, 538.

⁴¹ *Ibid.*, 533.

⁴² *Ibid.*, 534.

services due to the unavailability and inaccessibility of primary care providers.⁴³ As a consequence, refugees are forced to use walk-in clinics or Community Health Centres (CHCs), where they receive inferior and inadequate care, further limiting the resources available at the centres.⁴⁴ According to a worker at a CHC in Ontario, in 1998 the number of patients at the centre was 215 and within several years, this number increased to over 10,000. This increase has resulted in all 55 CHCs to have wait lists for access to primary health care services.⁴⁵

g. Isolation

Social, physical and cultural isolation are also barriers to health care access for refugee and asylum seekers in Canada. Newcomers acquire assistance regarding available services, accessibility, processes, and rules from their established communities. However, many new refugees often find themselves segregated within communities, leading to discomfort, isolation and fear.⁴⁶ Isolation is further complicated by transportation availability. Refugees and asylum seekers, being unfamiliar with the city, often find it difficult to get around.⁴⁷ Furthermore, transportation requires economic resources and knowledge of the system. According to Mckeary and Newbold, refugees often miss their appointments due to transportation challenges or other factors.⁴⁸ Isolation is also further complicated by gender. Based on a qualitative research conducted by Marry et al., the majority of the women reported that they felt isolated because they were separated from their family and friends and had no access to child care.⁴⁹ Besides not

⁴³ Ibid., 533.

⁴⁴ Ibid., 533.

⁴⁵ Ibid., 533.

⁴⁶ Mckeary and Newbold, 539.

⁴⁷ Ibid., 539.

⁴⁸ Ibid., 539.

⁴⁹ Ibid., 539.

knowing where to get the services, they also had difficulties transporting themselves to and from the services, and felt that they had no one to help with this.⁵⁰

Recommendations

Several recommendations will be made to ensure that refugees, of all statuses, have equal access to health care services. Taking into consideration the various barriers to health care services, all actors in all levels need to review and adjust health care policies so that health care is responsive and accessible to refugees and asylum seekers.

a. Individual

As presented in this paper, language difficulties tend to be the most significant barrier to accessing health care services for many refugees in Canada. Language training programs need to be made available and accessible to all refugees, even though it will take time to learn English and/or French. Also, trained, confidential health interpreters are necessary and must be provided to all refugees at no cost until the refugee is able to communicate for his/herself. Another way of addressing language barriers is by matching refugee patients with providers that speak the same language.

b. Community and Institutional

As it has been shown, CHCs are very important for many refugees who have limited or no health care coverage. However, CHCs are experiencing many resource shortages and therefore need to be supported to maintain and improve their ability to provide health care assistance to refugees.⁵¹

⁵⁰ Lisa A. Merry, Anita J. Gagnon, Nahid Kalim, Stephanie S. Bouris. "Refugee Claimant Women And Barriers To

Health care services and staff personnel need to be redesigned and trained to ensure that services are culturally competent and accessible. Health care providers need to be aware of important cultural differences and issues affecting care. Refugees, like any other group of people, want “individualized, nonjudgmental care – assessment of their concerns that are not based on stereotypes.”⁵² Moreover, refugees need information and support concerning health care systems. Education on rights, eligibility, and coverage should be provided at all levels.

c. Provincial

The situation varies among all provinces in Canada. According to Marwah, since the changes in the IFHP in 2012, provinces, such as Ontario and Quebec, have begun to reduce the gap in health care access for refugee claimants.⁵³ These new provincial programs provide health care coverage for refugees who are not eligible for IFHP or other health care. However, to be eligible for some of these provincial services, refugees are required to wait three months from the day their claimant application is accepted by Citizenship and Immigration Canada. Therefore, it is important that all provinces refrain from the waiting period and continue to adopt and improve provincial health care coverage for all refugees and asylum seekers.

d. Federal

With regards to the IFHP, the federal government needs to reverse the cutbacks to ensure fair health care access for all refugees and asylum seekers in Canada.

Health And Social Services Post-Birth”, *Canadian Journal Of Public Health* 102 no.4 (2011): 287

⁵¹ Marwah, 15.

⁵² Winnipeg Regional Health Authority, 87-88.

Conclusion

Accessible and high quality health care services are basic human rights and a social determinant of health. This is particularly important to bear in mind when thinking about the situation of refugees, as they are more likely than other types of asylum seekers to arrive in countries with existing health problems. Besides waiting the three-month period to be eligible for health care coverage, depending on their status, vulnerable and socially excluded refugees and asylum seekers experience many challenges and barriers during settlement. These disadvantages, such as a lack of access to health care services, significantly affect their health. The following are some common barriers faced by refugees who have been identified by scholars and policy influencers: status, coverage, language, interpretation, economic, lack of information, and problems with navigating the system. Despite Canada's promise of universal health coverage, it is evident that health and health care disparities are pressing issues for marginalized and oppressed groups like refugees and asylum seekers. And with the recent cuts to the IFHP and the limited resources of the CHCs, due to the overwhelming number of refugee patients, the ability of refugees to access services has also been additionally affected. The anti-oppressive theoretical framework and related concepts and approaches within it, have been useful in examining and understanding how exclusion and oppression is rooted in the current reality for refugees in Canada. To have high quality and accessible health care for refugees, the Canadian government and all other key actors need to eliminate oppression on the basis of immigration status, as well as gender, race, age, etc. Changes at other levels are also necessary. As it has been shown, it is important to understand that availability does not necessarily mean accessibility, especially for refugees.

⁵³ Marwah, 14.

In conclusion, this paper provides a thorough breakdown of accessibility issues faced by refugees and asylum seekers not only in Canada, but internationally, which adds value to the field of International Studies. With the current influx of refugees, it is important to evaluate Canada's role in dealing with the health care concerns of these refugees. This information can be used to deal with future studies of Canada's role in relation to the international refugee crisis and how Canada will manage a large number of refugees while maintaining, and improving, accessible health care services to all refugees. Furthermore, this paper may be used in studying other countries dealing with the same issues. Overall, by studying and understanding barriers faced by refugees and asylum seekers in accessing health care services, we take one step closer to creating a more humane society, not only domestically but also internationally.

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