

Policy Agenda-Setting and Causal Stories: Examining How Organized Interests Redefined the Problem of Refugee Health Policy in Canada

Programme d'élaboration des politiques et anecdotes :
comment des intérêts organisés redéfinissent le problème
des politiques de santé canadiennes à l'intention des
personnes réfugiées



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Abstract

The development of refugee health policies is significant, given the increased volume of displaced persons seeking refuge in Canada and around the world. Changes to the Canadian refugee health policy, known as the Interim Federal Health Program (IFHP), limited healthcare access for refugees and refugee claimants from 2012 to 2016. In this article, we present a policy analysis using the case of the IFHP retrenchments to examine how political actors on opposing sides of the issue defined the problem using different causal story mechanisms. This analysis reveals that organized interests dramatically changed the problem definition of the IFHP reforms. Following their use of causal stories in redefining the problem, the courts declared that the reforms to refugee healthcare were a form of cruel and unusual treatment. Understanding policy strategies used by proponents of refugee healthcare coverage expansion is important for countries responding to the current, enduring refugee crisis.

Résumé

En raison du nombre de personnes déplacées qui cherchent refuge au Canada et ailleurs dans le monde, les politiques de santé à l'intention des réfugiés ont connu d'importants développements. Les changements apportés à la politique canadienne, connue sous le nom de Programme fédéral de santé intérimaire (PFSI), ont limité, entre 2012 et 2016, l'accès aux services de santé pour les réfugiés et les demandeurs d'asile. Dans cet article, nous présentons une analyse politique, en considérant les retranchements apportés à la PFSI, afin d'étudier comment les acteurs politiques ayant des vues opposées sur la question définissent le problème en utilisant différents mécanismes qui ont recours aux anecdotes. Cette analyse révèle que des intérêts organisés ont profondément transformé la définition du problème dans le cadre des réformes du PFSI. Suivant leur utilisation d'anecdotes dans la redéfinition du problème, les tribunaux ont déclaré que les réformes du système de santé en faveur des réfugiés constituaient une forme de cruauté et de traitement inhabituel. Il est important de comprendre les stratégies politiques employées par ceux qui proposent une expansion de la couverture des services de santé pour les réfugiés afin que les pays puissent répondre à la crise actuelle en matière de réfugiés.

Introduction

The United Nations High Commissioner for Refugees (UNHCR 2019) reports that there are 70.5 million forcibly displaced migrants worldwide, representing the highest level of forced migration since World War II. Following the protraction and persistence of refugee crises around the world, Canada has resettled more than 132,000 refugees and refugee claimants over the past four years, many of whom receive healthcare coverage under the Interim Federal Health Program (IFHP; Government of Canada 2019). The IFHP is a federally funded program established in 1957 that provides comprehensive healthcare insurance for

refugee populations seeking protection in Canada (CIC 2006; IRCC 2017). Before 2012, refugees and claimants received healthcare coverage for physician and hospital visits as well as supplementary care, including optical, dental and drug coverage. On April 25, 2012, the former Conservative government of Canada introduced cutbacks to health coverage provided under the IFHP. These retrenchments separated refugee recipients into categories that provided varying levels of coverage depending on their country of origin and immigration status, significantly limiting healthcare access for this vulnerable population (Campbell et al. 2012; CIC 2012; Table 1).

TABLE 1. 2012 Interim Federal Health Program reform information

Interim Federal Health Program group Who is eligible?	Coverage What are they eligible for?
Government-assisted refugees and other refugees who are receiving governmental resettlement assistance in the form of income support, including visa office-referred refugees and refugees coming to Canada through the Joint Assistance Sponsorship Program	Expanded healthcare coverage includes coverage of the following: <ul style="list-style-type: none"> • hospital services, • services of physicians, registered nurses and other healthcare professionals licensed in Canada, • laboratory, diagnostic and ambulance services, • supplemental services (audio care, home care occupational therapy, physiotherapy, dental care, optical care, etc.), • supplemental products (immunizations, medications) and • translation services for health purposes.
Privately sponsored refugees – Resettled refugees while under sponsorship who do not receive and have not received governmental resettlement assistance in the form of income support	Healthcare coverage includes coverage of hospital services, services of a doctor or registered nurse who is licensed in Canada and laboratory, diagnostic and ambulance services, with some limitations. Medications and vaccines only when needed to prevent or treat a disease posing a risk to public health or to treat a condition of public safety concern, such as HIV or tuberculosis (TB).
Refugee claimants who are from a designated country of origin – a country deemed safe by the Immigration Minister	Public health or public safety healthcare coverage includes coverage of hospital services, services of a doctor or registered nurse licensed in Canada, laboratory and diagnostic services and medication and vaccines, only if they are required to diagnose, prevent or treat a disease posing a risk to public health or to diagnose or treat a condition of public safety concern Immigration medical examination
Refugee claimants who are not from a designated country of origin	Healthcare coverage and immigration medical examination
People whose refugee claim has been suspended	Public health or public safety healthcare coverage and immigration medical examination
Rejected refugee claimants	Public health or public safety healthcare coverage and immigration medical examination
Persons for whom the Minister exercises discretion on his own initiative for humanitarian and compassionate considerations or for public policy considerations	Expanded healthcare coverage and immigration medical examinations

Within a month, professional organizations and advocacy groups collectively voiced concerns for refugees' restricted healthcare access. Following their organized protest and legal challenge, the Federal Court of Canada ruled that the IFHP cuts constituted "cruel and unusual" treatment, violating Section 12 of the *Charter of Rights and Freedoms* (CDRC v. AGC

2014). In response, the Federal Government of Canada announced “temporary measures” for the IFHP on November 4, 2014. This program revision was not a full reversal of the 2012 cuts, as ordered by the federal court, but it did restore some health services coverage for refugee women and children.

This policy analysis examines how political actors on opposing sides of the refugee healthcare cuts issue defined the problem to enact policy changes. It is based on the causal stories framework developed by Stone (1989, 2012), resting within the post-structural tradition of narrative policy research. Stone (2012) argued that the process of policy making entails a struggle over the meaning and significance of policy ideas and their influence on values embedded in community life. Disputes over collective community values drive policy debates articulated through relations of power and structures of governance. Subsequently, political discourse and language shape how policy ideas are communicated and translated into practice (Campbell 2002). An examination of the policy discourse will reveal the problem definitions and associated causal story constructions used by various government actors who initiated the IFHP cutbacks and by organized interest groups who called for its reversal. This analysis identifies stories or themes used to frame policy ideas of actors on both sides of the IFHP issue, contributing to our understanding of how political actors control interpretations, assign responsibility and influence policy decisions in refugee policy debates.

Analytical Framework and Methods

Stone’s (1989, 2012) causal stories framework argues that causal ideas are at the core of understanding how difficult conditions or circumstances are transformed into political problems within the policy discourse. This process – referred to as “problem definition” – relies on the ability to attribute cause, blame and responsibility, while being amenable to human intervention (Stone 1989). Causal ideas are theories of causation that frame problems, strategically crafted using stories, symbols and numbers, applied by political actors on different sides of an issue to describe harms, assign responsibility and garner support to propose a policy solution. Throughout the problem definition process, political actors struggle for control over interpretations of the issue and compete to influence which causal idea becomes the main guide to policy (Stone 2012). These ideas are categorized into one of four causal theories that define problems based on the intentionality of the action and predictability of the consequences (Table 2). For instance, intentional causal theory suggests that the problem is derived from a deliberate action that produces expected consequences. Mechanistic causation refers to an unexpected action, such as a mechanical mishap, that leads to predictable outcomes, whereas accidental causal theory suggests that an unexpected action produces unpredictable consequences. Inadvertent causal theory indicates that the problem stems from an intended action resulting in unpredictable consequences.

TABLE 2. Stone's (1989, 2012) theory of causal stories framework

Actions	Consequences	
	Intended	Unintended
Unguided	Mechanical cause ^a <ul style="list-style-type: none"> Intervening agent Machines 	Accidental cause ^b <ul style="list-style-type: none"> Fate Natural disaster
Guided	Intentional cause ^c <ul style="list-style-type: none"> Oppression Blaming the victim 	Inadvertent cause ^d <ul style="list-style-type: none"> Unanticipated harmful side effects of policy

a Mechanistic causation – unguided action(s) resulting in predictable consequences.

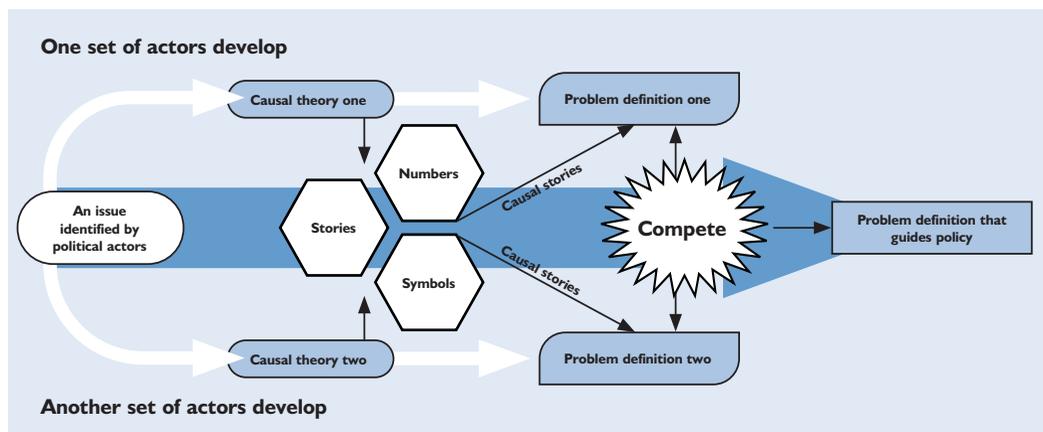
b Accidental causation – unguided action(s) with unpredictable consequences (such as fate, the absence of human control).

c Intentional causation – guided action(s) leading to intended consequences (involving complete human control).

d Inadvertent causation – guided action(s) leading to unintended consequences.

Causal theories create the resulting problem definition using stories, symbols and numbers in the political discourse (Figure 1). According to Stone (1989, 2012), stories are composed with heroes, villains, problems and solutions and categorized into those involving either change or power struggles. *Stories of change* include *stories of decline*, which depict changes for the worse or stymied progress, whereas *stories of rising* depict successful transformations. *Stories of power* include those of *control* or *helplessness*, which represent the gain or loss of power, respectively. Symbols can include powerful literary devices, such as synecdoche and metaphor, as well as ambiguity, which synchronize motivations and values that fuel collective action. In this context, a synecdoche is defined as “a small part of the policy problem, used to represent the whole” (Stone 2012, p. 159). Numbers are descriptions of the world, derived from measuring and counting a problem, that support stories and symbols based on their interpretations (Stone 2012).

FIGURE 1. The problem definition process – transforming political issues into policy problems



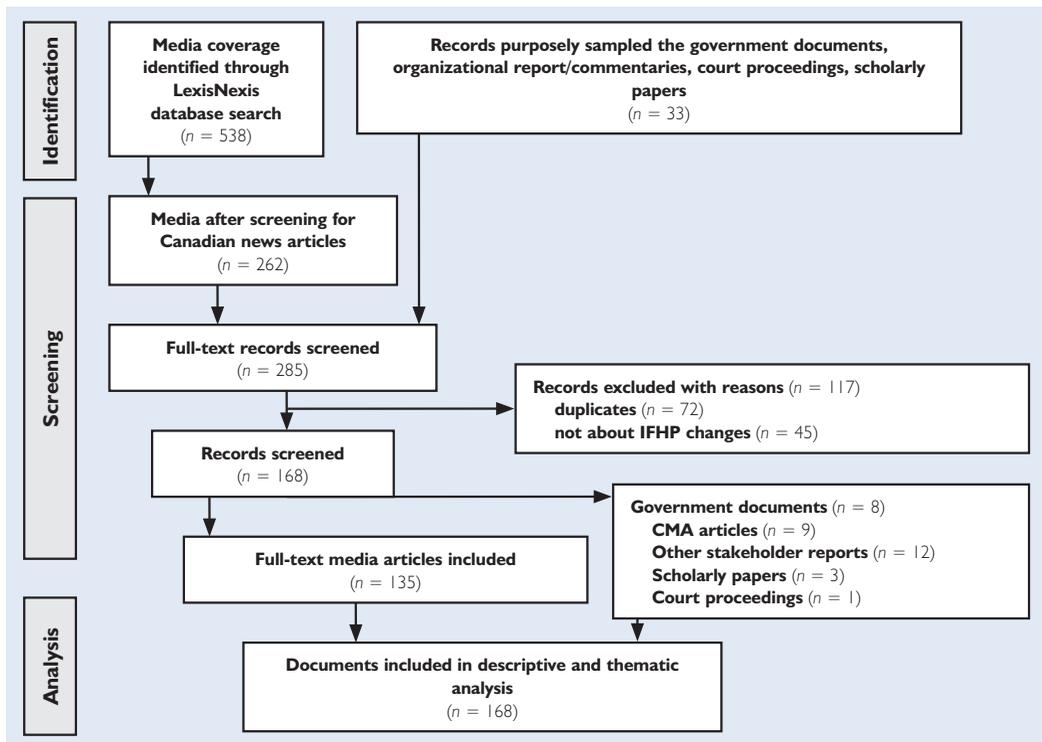
The problem (re)definition process occurs when at least two different groups of political actors develop causal theories, composed of mechanisms (stories, symbols and numbers) that frame divergent problem definitions, which compete against each other to gain precedence on the political agenda and guide policy-making processes.

We used the policy case of the IFHP retrenchments in 2012 and their partial reversal in 2014 to examine how each problem definition process was constructed and how different

causal mechanisms were used to define the problem by political actors on opposing sides of the issue (Yin 2009). An interpretive policy analysis of government documents, organizational reports, academic papers and a court proceeding was conducted. These documents were retrieved from ProQuest databases, PubMed, governmental and organizational websites and Google Scholar and examined to abstract different problem definitions of the refugee health policy reforms. In addition, news media articles on refugee health policy in Canada were searched using the LexisNexis database. Keywords included a combination of “Canada,” “health policy,” “refugee,” “healthcare,” “coverage” and “IFHP.” The database search retrieved English-language newspaper articles only.

Canadian media reports ($n = 262$) were identified, and 135 articles were included in this study (Figure 2). News media coverage spanned nine provinces, of which 84% of articles were published in the top 10 newspaper sources (Appendix 1, available online at longwoods.com/content/26126). Documents ($n = 33$) published after the 2012 IFHP changes and before the introduction of the “temporary measures” to the IFHP in November 2014 were included. A content analysis was employed using a constant comparative approach to abstract themes of problem definition and causal stories, drawing on inductive discursive analysis techniques (Glynos et al. 2009). Triangulation of sources was conducted by assessing the consistency of data themes abstracted from the variety of documents analyzed in this study, strengthening the credibility and trustworthiness of the results (Patton 1999).

FIGURE 2. Media and document search strategy



Results

Causal theories were used by political actors on opposing sides of the issue to convey different representations of the problem of IFHP cutbacks: governmental actors used *intentional causation* and organized interests used *inadvertent causation*. This section examines each of these causal theories, deconstructing the causal stories used within each and revealing strategies used by political actors to gain support for their interpretation of the problem.

Causal Theory One: Intentional causation as a defense of the federal position

Federal government actors identified the issue of increasing refugee claims from European Union “democracies” that were rejected by the refugee determination system in Canada (Campion-Smith and Keung 2012; Appendix 2, available online at longwoods.com/content/26126). They transformed the issue into a political problem by framing the submission of failed asylum claims as the willful illegal action of fraudulent asylum seekers in Canada, which justified the implementation of the 2012 IFHP cutbacks. In this causal story, intentional causation is used to defend the federal government’s position of withdrawing or limiting healthcare coverage to certain groups of refugees, whereby the problem’s cause is assigned to an intended outcome resulting from guided, deliberate action. In turn, IFHP cutbacks were portrayed as a means to deter false refugee claims, contain costs and ensure fairness to Canadians.

Causal story strategies using intentional causation

DETECTING FALSE REFUGEE CLAIMS

The causal story portrayed by governmental actors is one of power and control, as the retrenchments are framed as a solution to “stop the abuse of Canada’s generous and overburdened healthcare system by bogus refugees” (Keung 2012a). According to then Prime Minister Stephen Harper, healthcare benefits were removed “if we had clearly bogus refugees who have been refused and turned down” (Gulli 2015). In this case, a symbolic device, the *synecdoche*, is used to convey that “bogus refugees” define the entire problem and policy response. However, labelling all claimants who were refused refugee status as “bogus refugees” represents only part of the story. As a result, the IFHP cuts not only eliminated coverage for failed claimants, it also limited healthcare access for claimants awaiting a decision on their claims as well as for privately sponsored refugees (Table 1).

One year following the implementation of the IFHP reforms, the then Immigration Minister Chris Alexander stated that “Under the old, broken refugee system, abuse was commonplace. Thanks to our reforms, we’ve seen the number of asylum claims from safe countries fall by 87%” (Alexander 2014). The Minister presented a *story of rising* in which progress was made as a result of the policy response. Despite the use of numbers to justify this *story of change*, “numbers in policy debates cannot be understood without probing how people produced them,” (Stone 2012, p. 159). Therefore, *ambiguity*, which is essentially the

capacity to have multiple meanings, underlies the origin of these numbers, urging the question of whether these figures were produced as a result of the IFHP cutbacks or whether they were generated as a result of the changes to the refugee determination system that same year (Bhuyan et al. 2014).

CONTAINING COSTS

Under the intentional causal problem definition, governmental actors present the causal story that increased intake of fraudulent refugees costs the healthcare system, and the IFHP cuts are a cost-containment measure. According to governmental actors,

the cost of the IFHP continued to rise as a result of ... the increasing number of people eligible for IFHP coverage. For example, there were 105,326 people eligible for IFHP benefits in 2003, whereas, there were 128,586 people eligible for benefits in 2012. ... the IFHP cost Canadian taxpayers \$50,600,000 in 2002/2003 and almost \$91,000,000 in 2009/2010. As a consequence, cost containment was a driving principle underlying the decision to reform (CDRC v. AGC 2014).

This causal *story of decline* reveals that with increasing numbers of refugees, there were harms in the form of increased costs to taxpayers. Political actors strategically used numbers to assert that the rising cost phenomenon was occurring frequently, even though “overall expenditure on the IFHP is a tiny fraction (0.04%) of the percentage of total health expenditure in Canada” (Stall 2012).

Governmental actors used symbolic devices, such as the *container metaphor*, to convey that the IFHP costs were overflowing and needed a container to prevent spillover. Moreover, Stone (2012) indicated that *stories of decline* serve as the impetus for *stories of control*. As such, governmental actors used the empirical argument of containing costs to set the stage for the *story of control*, whereby they emphasize that the IFHP reforms would “ensure that tax dollars are spent wisely,” saving taxpayers money (Keung 2012b).

ENSURING FAIRNESS TO CANADIANS

Governmental actors normatively argue that the cutbacks are a means to ensure fairness to Canadians. According to Alexis Pavlich, Immigration, Refugee and Citizenship, Canada spokeswoman,

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 (Keung 2013a; Komarnicki 2014).

Again, political actors use synecdochical labels such as “illegal immigrants” and “bogus refugees” to represent all who were affected by the reforms. Moreover, “gold-plated healthcare

benefits” is an *evocative metaphor* used to generate anger among Canadian citizens for having received fewer healthcare benefits than refugees. According to Stone, “the emotional impact of symbolic devices can make it harder for audiences to recognize and question the underlying factual assumptions” (Stone 2012, p. 177). In this case, the public overlooks the plight of refugees, who flee their homelands seeking refuge from endemic violence. The fact that refugees receive coverage “equivalent to Canadians on social assistance” (Payne 2014) was omitted by actors in this problem definition. Advocates describe the government’s response to refugees as one that excludes refugees as “aliens who are treated with suspicion, not as guests needing help” (Stanbrook 2014). This label presents refugees as the other, an inhuman entity, undeserving of the social support and healthcare coverage that was previously provided to them.

Causal Theory Two: Inadvertent causation and the mobilization of organized interests

Organized interests transformed the issue of limited healthcare access for refugees into a political problem, in which the IFHP cuts were defined as “both inequitable and possibly inhumane in light of the extreme hardship and mistreatment many [refugees] have already experienced” (Arya et al. 2012, p. 1876). In contrast to the government’s framing, interest groups used the theory of inadvertent causation to re-define the problem as one of guided action by the government with unintended consequences, “inadvertently introducing new system-level barriers to healthcare” (Arya et al. 2012, p. 1876). The IFHP reforms created suffering for refugees, generated ethical dilemmas for healthcare providers, threatened public health and downloaded costs to provinces, healthcare institutions and taxpayers. These organized interests included health professional associations, refugee-serving organizations, provincial governments and refugees who organized to instigate the legal challenge (Sanders 2012). See Appendix 3, available online at longwoods.com/content/26126.

Causal story strategies using inadvertent causation

PRODUCING PREVENTABLE SUFFERING FOR REFUGEES

The causal story depicted by organized interests is one of helplessness, in which tensions are portrayed explicitly on the assumption that situations were better in the past and have changed for the worse (Stone 2012). According to academic, media, legal and interest group reports (Barnes 2013; CCR 2013; CDRC v. AGC 2014; Raza et al. 2012; Seeking Solutions 2013; Sheikh et al. 2013), advocates conveyed that the situation before the reforms provided better access to healthcare for refugees, during which they received services equivalent to those received by Canadians on social assistance. In particular, organized interests conveyed how the IFHP reforms caused suffering for refugees on several accounts, for example, “Since the federal cuts, people with cancer cannot access chemotherapy, pregnant women are denied prenatal care, and diabetic children are not entitled to insulin medication.” (Payne 2014). These *stories of helplessness* are *synecdoches*, representing parts of the whole problem.

Some of these stories are represented in the media as “horror stories” (Stone 2012). According to Dr. Buchman, who treated a 72-year-old failed refugee claimant,

Her tumors were very large and disfiguring. Her chest wound was open and bleeding and infected. She was not eligible for cancer treatment ... we needed to find a place to accept her and allow her a peaceful, comfortable, dignified death (Keung 2014a).

Horror stories generate fear, as expressed by healthcare professionals: “Watching our patients become ill as a direct result of this policy has left us feeling desperate. We frankly fear for the lives of our patients” (Kraeker and O’Shea 2012). These *stories of helplessness* and horror are symbolic representations that allow people to identify with refugees, particularly the hardships and suffering endured as a result of the limited access to healthcare created by the IFHP reforms.

GENERATING ETHICAL DILEMMAS

A corresponding *story of helplessness* conveyed by organized interests in their problem redefinition is the loss of control by physicians and other healthcare workers in administering refugee care. According to Ontario’s former Health Minister, Dr. Eric Hoskins,

Cuts to the Interim Federal Health Program left refugee claimants unprotected and put our doctors in an untenable position, forcing them to choose who should be treated (Keung 2014b).

The ethical dilemma of placing healthcare providers in a position to deny providing care for a vulnerable group of people was a frequently discussed issue by the health provider community. According to advocates, “Healthcare workers should be deciding what care people need based on their illness – not their income or refugee status” (Hayes 2012).

THREATENING PUBLIC HEALTH

According to organized interests, the IFHP cutbacks harmed not only refugees but also the public. A causal *story of decline* is presented in which the reforms place the public at risk of developing communicable diseases. According to one interest group,

Even though treatment for a select list of public health conditions remain covered [for refugees], the testing needed to diagnose these conditions often isn’t, paradoxically. This results in a failure to protect either the public or the patient (Stanbrook 2014).

Again, powerful literary devices are used to portray the negative outcomes of retrenching diagnostic services, to generate fear and mobilize action. An example of the use of the *synecdoche* appears in the following statement from Dr. Gruner of the Canadian Doctors for Refugee Care:

If they've got a cough, it could be tuberculosis but we're never going to know because they're not going to the doctor ... But they are going to the playgrounds, the schoolyards, the shopping centres, putting the rest of us at risk (Levitz 2013).

DOWNLOADING COSTS

Organized interests argue that the reforms generate harm through the IFHP cutbacks because they download the cost of refugee healthcare from the federal level to healthcare organizations, provinces and, simultaneously, taxpayers. A causal *story of decline* is portrayed, where taxpayers lose money if refugees are not cared for. According to advocates, because the reforms limit access to preventive and primary care,

when a person with uncontrolled diabetes ends up in the emergency department ... Canadians will bear the burden of these policy changes through their taxpayer supported provincial health plans (Arya et al. 2012, p.1876).

The *story of decline* is further supported by empirical evidence in the form of numbers and facts, reported by hospitals that were absorbing the healthcare costs for refugees. According to media reports, "Sick Kids absorbed \$131,615 in outstanding costs," and "the University Health Network ... expects to foot a bill of \$800,000" as a result of the refugee healthcare cuts (Cauderella and Evans 2014; Evans et al. 2014; Keung 2013b).

One scientific study at the Hospital for Sick Children in Toronto, which examined emergency department (ED) admission rates six months before and after the IFHP cutbacks, demonstrated that the number of ED admissions among children doubled from 6.4% to 12.1%, with clinical significance (Evans et al. 2014). Empirical research facilitates the gain of political support when causal theories are successfully appealed to in scientific studies (Stone 1989). Thus, organized interests voiced the causal story supported by numbers and scientific evidence that the IFHP reforms limited refugees' access to preventive care, which subsequently increases ED visits, and costs to provinces and taxpayers.

Discussion

The IFHP policy case reveals important insights into the role and subsequent impact of causal stories in defining and re-defining policy problems. Our results demonstrate a dramatic change in the way that the IFHP reform was initially justified and then later represented using different causal theories and accompanying strategies to portray them. The causal stories, in turn, had considerable shaping effects on resulting policy decisions by (1) changing

interpretive social constructions of refugees, (2) garnering political support through both empirical and normative arguments, (3) assigning responsibility for the problem and (4) challenging or protecting the existing social order.

To control the interpretive frame, governmental actors defended the implementation of the reforms using intentional causal theory, depicting refugees as bogus and blaming them for deliberately submitting false claims to undermine the refugee determination system. The negative constructions generated by governmental actors fuelled a discourse of othering where providing refugees with healthcare generated the perception of “unfairness” or unequal healthcare opportunities among Canadian citizens, motivating public support. Governmental actors assigned blame by portraying the negative consequences of high healthcare costs on the supposed fraudulent actions of refugees. This analysis demonstrates that intentional causal theory was used as an instrument of social control to maintain existing global patterns of dominance over refugee reception, in which most Western host countries contain population movements to the global South, within regions of origin, and unevenly share the responsibility of refugee resettlement (Gottwald 2014).

To counter these stories, organized interests redefined the problem of the IFHP reforms using the theory of inadvertent causation, attributing the unintended effects of government action as the cause of suffering for refugees. Problem redefinition generated a normative shift, in which refugees were portrayed as doubly victimized, fleeing persecution only to endure intolerable suffering through restricted healthcare access. These social constructions humanized refugees through stories of relatable healthcare hardships in Canada, conveyed through select narratives of suffering or health decline following the reforms. Beatson (2016) argued that both governmental actors and advocates used simplistic framing strategies that other refugees as either bogus or the victim. The author recommends that future advocacy entail a human-rights-centred approach that shifts “the emphasis on access to healthcare from charity to obligation,” legitimizing refugees as healthcare users while protecting them from fluctuating populist sentiment (Beatson 2016, p. 131). Our analysis reveals that in addition to changing the interpretive frame depicting refugees, causal stories are an important component of gaining political support through normative and empirical arguments. Following the IFHP cutbacks, normative arguments structured around core community values raised political awareness and public concern about the equity of refugee healthcare access, efficiency of the healthcare system and liberty of healthcare providers to appropriately practise. The assignment of blame on unintentional policy consequences placed accountability on the federal government to rectify not only refugee access to primary care but also the high burden of costs assumed by healthcare institutions and provincial governments. On the empirical level, costs for taxpayers were no longer solved by the reforms but were caused by them.

Moreover, shifting the location of responsibility from refugees to government action restructured alliances among refugee-serving groups, contributing to the growing mobilization of healthcare providers, advocacy groups, legal organizations, provincial governments

and even a few refugees themselves. The causal stories implicitly appealed for a redistribution of power, whereby organized interests explicitly requested the federal government to cease producing harm, or the “cruel and unusual treatment” of refugees, a dominant belief supported by the Federal Court in their decision that the IFHP reforms violated the *Charter of Rights and Freedoms* (CDRC v. AGC 2014). Holtzer et al.’s (2017) policy analysis recognizes the influence of external drivers such as the legal venue of the courts and the 2015 federal election that created opportunities for alternative causal stories to enter the political discourse. In addition to causal stories and external drivers, factors such as organized interest group interactions and institutional mechanisms that contributed to the full reversal of the IFHP retrenchments in 2016 require further investigation.

Limitations

There are several limitations to this study. First, a limitation of this study relates to the minimal exploration of interest group and institutional mechanisms for policy change. Second, although an examination of the way causal stories are used by political actors is valuable to understand the problem definition process and respond to the problematization of key issues, it is difficult to attribute select causal pathways to complex settings, such as politics. Finally, a limitation of this study involves the focus on English-language media sources only, which may have excluded important perspectives that were only covered in French-language news media.

Conclusion

Understanding causal story mechanisms used by advocates of refugee policy expansion is essential for those contesting restrictive measures implemented in response to enduring refugee crises around the globe. Restrictive refugee policy proponents construct migrants as the problem, portraying them as deviants eroding the regulated systems of host nations. The resulting political discourse situates moral responsibility and economic costs on refugees. By using Stone’s causal stories framework, this analysis reveals strategies for organized interest groups to contest populist and anti-immigrant ideologies in the problem re-definition process. Ultimately, changing the policy in question involves transforming the interpretive framework by redefining the problem, composed of causal stories that generate empirical and normative strategies to dismantle opposing arguments, shift accountability and challenge the existing social order.

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Conflict of Interest

None identified.

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