A Socio-Legal Critique on Denials, Delays and Barriers to Care: Health Care Access for Medically Uninsured Migrants in Toronto & Edmonton

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ABSTRACT

The relationship between the denial of health care services for migrants with precarious status and racial capitalism is undertheorized in migration literature. This dissertation begins by problematizing racial capitalism as an emerging dominant ideology and rationality across Canada in order to bring recognition to how the ongoing denial of health care services (including right to life) to migrants with precarious legal status has become normalized and ultimately characterizes public health care as a service that only those viewed as 'belonging' become entitled to. This research employs governmentality as a research method to help investigate the government of migrants in their effort to access health care in Toronto and Edmonton. By researching these 'assemblages of health care barriers', attention is placed on the types of processes and techniques engaged in the government and subjectification of migrants in their efforts to access health care.

An analysis of health and immigration laws as well as interview findings (n=30) with health care workers, civil society members, NGOs and migrant participants across Toronto and Edmonton revealed three findings. First, the techniques of systemic denials for health care by employers, health care institutions and government agencies ultimately work to normalize delays, denials and barriers of care by recrafting who belongs and doesn't belong in the process. Second, the systemic barriers and denials to health care for migrants with precarious status is supported by the dominant political rationality of racial capitalism. Through the legitimization of differentiated forms of labour that are often characterized by race, the denials of rights, such as public health care entitlements become normalized in the process. Third, reform and resistance efforts in support of expanding health care entitlements necessitate mobilization from both within and beyond the law. The limitations of court interventions at this time are documented by tracing Nell Toussaint's legal efforts domestically and abroad to bring about change and calls for the support of a multilevel mobilization strategy when it comes to advocating for expanded health care entitlements. Interviewed participants employed the political framings of (1), firsthand story and rights-based framing, (2), economic framing and (3), consciousness raising of global asymmetries of power in effort to resist the taken for granted racial capitalist regime that underpins the government of health care and the normalization of denied care.

Participant experiences ultimately reveal that the legacies of public health care as an exclusionary system continue to manifest today at the local level and that feelings of belonging and health care entitlements are uniquely intertwined.

DEDICATION

For Téo

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LIST OF ACRONYMS

AHS – Alberta Health Services
AMA – Alberta Medical Association
AHCIP – Alberta Health Care Insurance Plan
BNAA – British North America Act
CBSA – Canada Border Services Agency
CCF – Co-operative Commonwealth Federation
CHA – Canada Health Act
CHST – Canada Health and Social Transfer
CHT – Canada Health Transfer
CPSO – College of Physicians and Surgeons of Ontario
CSF – Canada Social Transfer
DADT – Don't ask, don't tell
EPF – the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act
ESCR – International Covenant on Economic, Social and Cultural Rights
Health Accord – First Ministers Health Accord
HIDSA – Hospital Insurance and Diagnostic Services Act
ICCPR – International Covenant on Civil and Political Rights
IFHP – Interim Federal Health Plan
LHIN – Local Health Integration Networks (Ontario)
Medicare – Canada's publicly funded health care
OHIP – Ontario Health Insurance Program
PCNs – Primary Care Networks
PR – Permanent Resident
SAWP – Seasonal Agricultural Worker Program
TFW – Temporary Foreign Worker

Chapter One.
Introduction|

1.1 Introduction

Canada's labour market benefits from a large flow of temporalized migrants primarily from the Global South to secure its "long-term and immediate social and economic impacts" (IRCC, 2018, I). Increasingly racialized and feminized, this migration flow is also temporalized because worker's immigration permits are limited in location and duration (Foster, 2012). These workers' have frequently been referred to as holding 'precarious status' as this offers a framing of status that is not limited to legalized inclusion or exclusion and it also draws an awareness to the varying degrees of legal status (Goldring & Landolt, 2013). Migrants with precarious status may include migrants with rejected refugee claims, migrants with temporary or expired permits (i.e., student, visitor, or seasonal worker visas) and any migrant who does not have full permanent residency. Even more migrants may become non-status[1] as they struggle with significant socio-economic pressures to leave the country, when faced with lapsed visas or denied refugee claims (Chen, 2017). For example, one interview participant in this doctoral project, a migrant worker living in Toronto, Diego, explains his experience having his application to stay permanently in Canada under the highly discretionary Humanitarian and Compassionate grounds application for his wife and child, stating,

> …those things [applications for status] caused me many, many psychological problems, too much. For me it was too depressing and too frustrating, hear those things and hear the things they say that the reason they deny me is like garbage… that I'm doing my best to stay here, offering service and volunteering many, many places for they say no and then they suggest left my kid here and with a tutor and me and my wife go back home, like you're crazy, I'm never gonna do that (Diego, 06/22).

[1] Non-status refers specifically to migrants who do not have legal permission to reside in Canada, such as those with an expired visa or deportation order. A precarious status migrant may also be considered non-status depending on their circumstances, however not all migrants with precarious status are non-status.

Diego's story provides insight into the experiences of many migrants who come to Canada to work and provide for their families under temporary pathways yet easily encounter difficulties in their legal efforts to stay long term.

Despite the fact that Canada's economic planning relies heavily on such migrant labour, providing health care for migrants has not been met with similar determination in Canada. Significant barriers continue to exist today for migrants with precarious status seeking access to health care in Canada. This has long been an issue in Canada, complicated in part by the patchiness of intergovernmental jurisdictions (Chen, 2017; Marsden, 2018), varying commitments to domestically enforce optional international protocols (ESCR-Net, 2018), increasingly temporalized immigration laws (Foster, 2012; Foster & Luciano, 2020), and public misconceptions of so called 'illegal' migrants (Bauder, 2014). Further challenges arise due to inconsistent service provisions by health care providers not only across provinces, but also among individual health care providers (Mattatall, 2017; Vanthuyne et al., 2013). More research is needed to better understand the broader context in which these health care barriers operate, the ways in which barriers are created as well as any possibilities for resistance.

Across Canadian provinces and cities, health care barriers are particularly significant for uninsured migrants who may resort to underground health care services (Campbell et al., 2014, p. 165), experience worse health outcomes in ambulatory care (Hynie et al., 2016), and experience "clearly inadequate prenatal care" (Wilson-Mitchell and Rummens, 2013, p. 2198). In addition, physicians have widely varying ethical views on whether or not uninsured migrants are deserving of health care (Vanthuyne et al., 2013) and whether or not they will even provide care or charge for their services (Mattatal, 2017). The differences in ethics, protocols, and eligibility rules across provinces and across health care agencies undoubtedly bring chaos, confusion, and gaps in care for

migrants with precarious status in a country with so called 'universal health care.' Migrants with precarious status are more likely to find themselves in and out of being medically insured in their province or territory of residence, which will be described in more detail in Chapter 3 and Chapter 4. My doctoral dissertation aims to empirically investigate how these factors are assembled at the local level in Toronto and Edmonton, and the ways in which they may produce barriers that create uneven access to health care across space.

This dissertation seeks to first and foremost investigate barriers to health care, in an effort to provide a source of resistance against restrictive health policies that deny the application of rights to migrants. The right to adequate health care is considered a human right within the Universal Declaration of Human Rights (UDHR) as well as within General Comment 14: The Right to the Highest Attainable Standard of Health (International Covenant on Economic, Social, and Cultural Rights ICESCR) – core international law obligations to which Canada has signed on to. At the same time, the right to health care is not enshrined in the Canadian Charter of Human Rights and Freedoms. In this dissertation, I argue that the systemic barriers and denials to health care for migrants with precarious status is underpinned by the dominant political rationality of racial capitalism. At the most basic level, racial capitalism can be described as a process whereby capitalism is seen to constantly reproduce itself through differentiated labour in a process that is always in relation to both colonial and racial divides and between those with freedoms and those without (Kundnani, 2020; Kundnani 2023). Racial capitalism then helps explain how racism operates by managing and legitimating differentiated forms of labour (i.e., wage labour, non-waged labour, coerced labour, and surplus labour) (Kundnani, 2020; Kundnani 2023), and in turn, I argue, legitimizes denials to rights, such as the denial to health care for groups of migrants. I show that the technique of systemic denials for health care by employers, health care institutions and government

agencies ultimately work to normalize delays, denials and barriers of care by recrafting who belongs and doesn't belong in the process. While the concept remains undertheorized, Anna Korteweg and Gökce Yurdakul (2024) describe non-belonging as an "… actively constructed space and logic that entails the denial of personhood, where personhood captures one's sense of self, one's capacity to act, as well as the human and citizenship rights tied to this" (p. 293). They further posit that non-belonging is not only the absence of belonging, but rather actively constructed with its own logics, which further creates particular spaces that are in turn actively resisted and negotiated by those made as non-belonging (Korteweg & Yurdakul, 2024). For example, in discussing her lack of health care entitlements in Alberta while on a temporary Open Work Permit for Vulnerable Workers (i.e., visas for workers previously on single-employer visa, who have experienced abuse at their workplace, or by their employer), Lynn raises the topic of belonging, sharing that,

> Yeah, and then my daughter belongs here, we belong here, yeah. It just happened that our problem right now, like the healthcare part, especially for me because I've been in a depression moment that time that I was supposed to be deported and I've been in a counseling session also because after this time then everything, right. There's a lot of need which had been evaluated, especially the undocumented. So that's why we're looking for someone who's an organization that can help us. To be heard or to be seen, for free right because others are scared to walk in the clinic to find out that they are sick. And the number concern also is they cannot pay, it's so expensive, right (Lynn, 08/22).

In discussing feelings of belonging for herself and her Canadian-born daughter, Lynn ties this discussion with the difficulties of having no local clinics in Edmonton that will officially provide ongoing health care for medically uninsured migrants such as herself. Lynn later shares: "that's why I really want to get healthcare; it's just like to be equally treated. No matter what is your status…your gender, you know… And it's really emotional, remember the topic is just that" (Lynn, 08/22). Feelings of belonging and the provision of health care entitlements are uniquely intertwined. To demonstrate this position, I analyze the relevant histories, laws, actors and practices in what I refer

to as "assemblages of health care barriers" to wholistically investigate access to health care in both Toronto and Edmonton.

In doing so, I draw on Brady and Lippert's (2016) neo-Foucauldian 'analytics of governmentality' approach, which uses qualitative methods and focuses on specific times and places in order to investigate 'rationalities', 'techniques', and 'practices' employed by various actors in the government of health access. Turning to the concept of assemblage eschews Foucault's use of dispositif, which has been interpreted as a closure, and instead, helps bring attention to heterogeneity and the open-endedness of practices of government (Brady and Lippert, 2016). The concepts of temporality and waiting are privileged in this analysis, as they come to play a significant role in migrants experiences in their efforts to regularize their status as well as satisfy health care eligibility requirements. This analysis further intentionally privileges the narratives and stories of health care providers, NGO employees, civil society group members and medically uninsured migrants by drawing from detailed interviews. The reason for this privileging is to centre the voices of migrants (i.e., those at the centre of the topic) and those who work in the application of health care laws (i.e., law in action) as well as with migrants (i.e., health care providers). For this reason, interviews with government employees and politicians were out of scope for this research. As a form of resistance against restrictive health policies, I further argue for the support of competing knowledges in these assemblages of health care barriers. Rose and Miller (2008) describe knowledge as not only a group of ideas, but also as a "…vast assemblage of persons, theories, projects, experiments and techniques," "'know-how' that has promised to make government possible," and supports a "intellectual machinery for government" (p. 57-62). Specifically, this dissertation identifies three key competing knowledges or rationalities from participant data, including: (1), firsthand story and rights-based framing, (2), economic framing or cost benefit analysis as well as (3), consciousness raising of global asymmetries of power. Expanding on participant findings, I draw on

Harsha Walia's (2021) seminal work to advocate for the competing rationality that positions precarious migration in Canada as a crisis of displacement and immobility in an effort to challenge the effects and ideology of racial capitalism as a taken for granted practice in the government of migrant health. This competing rationality in turn serves as a form of resistance.

Since access to health care is uneven across Canadian provinces and cities (Foster & Luciano, 2020; Médecine du Monde, 2023; Schmidt, Suleman, Da Silva, Gagnon, Marshall, Tolentine, 2023), I focus on two different ends of the country, Western Canada (e.g., Edmonton) and Eastern Canada (e.g., Toronto) to investigate regional differences or similarities in practice as well as to consider how two different provinces have interpreted the same federal health law, the Canada Health Act (CHA) and how their approaches trickle down to the local level. As I will discuss in more depth in chapter six, a recent analysis of literature covering migrant justice movements in the Global North demonstrates that there has been on average a closing of political opportunities at the national level, with more political openings emerging across other scalar levels and across government agencies (Nicholls & Sorrel-Medina, 2023). As a result, activists often engage in a political field that favors "scalar mobilization strategies" whereby opportunities can be leveraged in more welcoming or accommodating jurisdictions, and then later expanded to less accommodating ones (Caponio & Jones-Correa 2018; Nicholls & Sorrel-Medina, 2023, p. 340).

I chose Toronto primarily due to my existing relationships to the city and my physical presence to the community, making it an ideal and accessible site to undertake this doctoral research. As chapter four will demonstrate, Toronto has multiple free clinics and community health centres that have dedicated funding to support medically uninsured migrants – support that has become much less prevalent outside the Toronto area. Toronto is also home to decades of social movements for migrant justice and has declared itself a sanctuary city at the municipal level, signaling a 'jurisdictional tango' (Ford, 1999) over migrant governance. Municipal "Sanctuary motions" entail a

broad series of practices and directives aimed at providing funded services to migrants with precarious status without the threat of deportation. The Canadian sanctuary city movement has been described as an attempt to alleviate the vulnerability of illegalized immigrants or those with a precarious status in the face of inadequate federal immigration policies (Hannan & Bauder, 2015). Cities with urban sanctuary motions thus present an interesting lens to investigate how migrants with precarious status and health care providers experience the intersection of federal and provincial jurisdiction of immigration and health care in practice. Edmonton has also passed a municipal motion on sanctuary and is home to many migrant workers. Unlike Toronto, Edmonton has virtually no clinics with dedicated funding to provide primary health care to medically uninsured migrants, making it significantly more difficult to navigate access to care locally. Edmonton also has highly active civil society groups and networks aimed at improving social services for different groups of migrants, making it an important site of comparison.

This dissertation is organized by three overarching socio-legal themes – Law in the Books, Law in Action, and Reform and Resistance. I first begin with Law in the Books to investigate federal and provincial health laws and regulations, including how provinces have interpreted the concept of 'universality' in the Canada Health Act (CHA) and examine the eligibility criterion of 'residency' in their respective health acts. Additionally, I consider what barriers to health care exist for medically uninsured migrants at the intersection of health and immigration laws across scalar levels. Second, in order to analyze Law in Action, I investigate how medically uninsured migrants experience or navigate barriers to care, by drawing on interviews in each city with health care providers, civil society group members and migrants themselves. This dissertation concludes with a chapter on Reform and Resistance, where I start by investigating how the experiences of health care providers, medically uninsured migrants and civil society groups may best inform reform strategies. This

research is guided by my theoretical framework, which I refer to as a socio-legal critique on denials, delays and barriers to care.

1.2 A Socio-Legal Critique on Denials, Delays and Barriers to Care

This section provides an analysis of the contributing literatures that collectively help to form the theoretical framework assembled for this dissertation. This research begins with an investigation of curated scholarship on racial capitalism, border and temporalized migration that provides the foundation for problematizing the denial of health care rights of migrants in Canada. Next, drawing upon Critical Legal Geographies' (CLG) conceptual themes, the spatialization of power relations, temporality and waiting are highlighted to help guide my analysis in each case (i.e., Toronto and Edmonton) of local institutional sites such as clinics, hospitals and NGOs, as well as actors such as health care providers, civil society groups and migrants. The concept of waiting includes waiting times and delays for approvals and services imposed upon migrants with precarious status as an instrument of governmental power. Next, governmentality helps to inform both the methodologies and analysis of this research. This includes undertaking a problematization of the denial of rights to medically uninsured migrants, as well as analyzing the government (e.g., authorities, rationalities and practices) that form this assemblage in each location. In addition, socio-legal conceptualizations of jurisdiction and discretion are employed to help investigate the techniques of government at play in the governance of migrant health, for example, the inconsistent application of the criteria for issuing health care cards to infants born in Canada. Lastly, a diverse body of scholarship on migration, citizenship and Indigenous relations in Turtle Island help to situate an ethical basis for conducting this doctoral research. This area of literature emphasizes the importance of supporting Indigenous sovereignty and Indigenous scholarship in tandem with migration related work and serves as a reminder of our Treaty obligations. While this framework assembles literature, theories, and conceptual themes from five disparate areas of work, they ultimately are weaved together to

undertake a more wholistic approach that privileges the stories and experiences of those most impacted by the key issues addressed in this dissertation.

Racial Capitalism, Borders & Temporalized Migration

Canada's policy trend toward increasingly temporalized migration is best understood through conceptualizations of racial capitalism, which drawing from Kundnani (2020; 2023), I have defined earlier as a process whereby capitalism is seen to constantly reproduce itself through differentiated labour in a process that is always in relation to both colonial and racial divides and between those with freedoms and those without. Such an analysis of race and capitalism is necessitated to assist in better situating the limits or barriers to health care experienced by migrants with precarious status today. This section draws on theories of racial capitalism as a rationality to help theorize why the application of human rights to migrants in Canada are being openly violated when it comes to health care. In these assemblages of health care barriers, racial capitalism best describes the dominant political ideology in the government of migrant health access. To be sure, this socio-legal theoretical framework does not engage with a traditional Marxist analysis but rather draws on racial capitalism as an increasingly clear rationality made apparent by both state and non-state governments in the administration of temporary migration work permits. Both Cedric Robinson (2020) and Stuart Hall's (1978;1980) work has been foundational to expanding conceptualizations and analyses of racial capitalism across unique local geographies and histories (Toews, 2018), and more recently has been instrumental to understanding neoliberal bordering regimes (Walia, 2021; Kundnani, 2020; Kundnani, 2023) and the racial ordering of migrant labour (Frydenlund & Dunn, 2022).

Racial Capitalism & Differentiated Labour

In the context of South Africa, Robinson (2020) articulates how capitalism failed to universalize society or the labour force, and instead, relies upon elements of pre-capitalist society, resulting in

differentiated labour. Instead of eliminating racism or rationalizing social relations as predicted by Engels and Marx, the "development, organization, and expansion of capitalist society pursued essentially racial directions…." Furthermore, it could "…be expected that racialism would inevitably permeate the social structures emergency from capitalism" (Robinson, 2020, p. 2).

In the Canadian context, the creation and reliance on temporary and employer-tied visas for so called "low skill workers" since 2002 (e.g., Seasonal Agricultural Worker Program [SAWP] and Caregiver Program) can be described as a form of differentiated labour distinct from traditional waged labour and the social benefits that citizens and Permanent Residents get to experience. As Walia (2021) writes, Canada's reliance on its Temporary Foreign Worker Program (TFWP) has quadrupled since its origin, with 98,335 migrant workers entering Canada in 2019 alone, with the majority working in low-wage sector positions (p. 156). Governments have since argued that the TFWP is necessary for temporary labour supply needs, however critics such as Nandita Sharma have (2006) described such needs as actually being based on "…cheapened and politically subjugated labour power" (p. 108, as cited in Walia, 2021, p. 156). The systemic exploitation and differential treatment experienced by migrant workers in Canada with tied-to-employer visas in Canada is well documented (e.g., Nakache & Kinoshita, 2010), with issues expanding: debt-bondages, health care tied to employment, mandatory deductions from payroll for crowded housing (e.g., 16 workers in a four bedroom house), direct or community-specific reprisals upon complaints of abuse, illegal recruitment fees for care workers, application process fees ranging from $1000 to $15,000 for near-minimum wage jobs or change in employment duties and contract length upon arrival to Canada (Faraday, 2014, p. 38-41).

Another example of differentiated and racialized labour practices permitted by the Canadian government involves SAWP workers who initially came to Canada from the Caribbean. These workers are required to have official payroll deductions of 25 percent, permitted by Canadian

authorities, which are then forwarded to the government in their home country for "remittance" costs, a fee that can only be recovered upon completion of contract and return to their home country (Faraday, 2014, p. 43). The risk of losing 25 percent of a near-minimum wage salary is undoubtably a systemic barrier that prevents predominantly Black migrants who are working in unsafe, abusive, or illegal conditions from leaving their positions or reporting their exploitation to authorities, as it could result in a loss of income, housing, health care and could even lead to deportation.

Migrants with precarious status in Canada are often more likely to work in agriculture, warehouses, manufacturing, hospitality, care work, custodial work, and food processing positions where they are more to experience a lack of respect of labour rights, minimum pay, and poor working conditions (Rights of Non-Status Women's Network, 2020). Frequently, they are also among the most dangerous positions where injury may be more likely. In a Toronto based interview, one migrant participant, Diego, shared an experience related to dangerous working conditions, stating:

> I do as much as I can and I say from the beginning, it was really tough, later than I start to reach out on window washer. I used to hang out on the windows from the high top buildings and even that was really risky for me. We used to do it and I say you have to do it because there's not a job, there's not a chance. Once even one partner had an accident, he smashed with the cord they smashed the finger and he has to go to the hospital. So when I saw that I was really really freaked out. I was really really scared because for him was a thousand dollars they billed in the hospital and it was like if I don't have that money what happens to me? Right. What's gonna be next thing? And obviously I don't want nobody knows that I'm here and I don't want to tell the police or the, any hospital or doctor what is my situation, right. Because they'd be at stake here, right. So for me the beginning was really really hard, tough. Struggled too much mentally and physically because I as I say the worst never has been like that in my entire life (Diego, 06/22).

In another interview in Toronto with a migrant participant who is currently undocumented, Aayla, described mostly working in cleaning and factories, and discussed how certain employers will take advantage of undocumented workers without a SIN card, stating, "yeah, because if you don't have it [SIN] you're gonna get a lower wage, you know, like you don't really have much protection as

someone who like does, right…So especially like in the cleaning sectors they are precarious, right" (Aayla, 06/22).

These economic "niches" are not necessarily defined by skill, but rather racialization and immigration status, and perpetuated by non-profit organizations who help "…create pipelines into a racialized labour market niche…," which in the US context has been described as a form of economic pressuring toward refugees into taking low-wage and higher risk jobs to pay off their government debts (Frydenlund & Dunn, 2022, p. 4). Similarly, in the Canadian context, interviewed participants in Alberta discussed the role of non-profit organizations assisting migrants into the meat packing industry as a way to secure a Labour Market Impact Assessment (LMIA). On the one hand, NGOs were viewed as supporting migrants on their path to citizenship, yet on the other, were also seen as brokers for the industry, and at times even disregarded a migrants' preference for work or individual skills. It is worth highlighting that in their recent study on refugee workers working in meatpacking plants in rural Alberta, Bragg and Hyndman (2024) found that working conditions were "dangerous, dirty, and employees found it difficult to enact their rights as workers" (p. 1). Nonetheless, in Canada, bordering processes may begin overseas with third party recruiters. At the territorial border, however, these processes quickly move internally to employers and social service agencies who also participate in bordering work.

Racism & Bordering Regimes in Canada

In neoliberal states, race provides an organizational tool for "…policing surplus populations," which Kundnani (2020) posits, is made evident in state laws and where borders have become a "… key tool for producing spatial boundaries between different kinds of laboring populations and a material aspect of the racist global division of labor under neoliberalism" (p. 1). From this perspective, borders work primarily to support the interests of capitalism. National borders are not defined by fixed territorial lines but rather they work as active regimes engaged in creating spatial boundaries

that produce "social relations of dominance" (Walia, 2021, p. 6). The neoliberal border is described as just as violent as the former Jim Crow laws (Kundnani, 2023) or as Robyn Maynard (2019) documents is a violent regime structured toward "Black disposability" that stems from the transatlantic slave trade (p. 125). For example, Maynard (2019) documents how the continuation of the 2004 Safe Third Country Agreement between Canada and the U.S. has resulted in an increase of "unauthorized" border crossings, making the Canada-US border a grave site. The controversial Agreement applies to refugee claimants who are seeking entry into Canada from the US (or vice versa) at land border crossings. By declaring the US as a 'safe country' for declaring asylum, most refugee claimants are turned back to the US, unless they have a family member in Canada who is a citizen, permanent resident, or on a valid work or study permit. The history of the transatlantic slave trade and its enduring impacts on anti-Black racism in Canada today is important to highlight. For a further example, Barrington Walker (2012) documents how the social history of Black people in Canada has been "inextricably bound to the question of law – more so than any other historically disenfranchised group in Canada, save for its First Nations peoples" (p. 3). Specifically, he documents how throughout Canadian history, anti-Black racism and slavery was supported not only through positive laws but also more passively through the customary recognition of the use of slaves (p. 3). Walker (2012) identifies that the law "…tended to passively support white supremacy by accepting the conditions that allowed it to thrive" (p. 3). This historical tendency for the law to passively support white supremacy continues to play out today with the acceptance of living conditions associated with temporary foreign migrant workers in Canada, where the UN Rapporteur has recently characterized Canada's employer-tied visas as a "…breeding ground for contemporary slavery" (OHCHR, September 6, 2023, p. 1). Employing a racial capitalism lens to bordering regimes also helps draw attention to the fact that it simultaneously denies Indigenous jurisdiction and

borders as much as it steals labour (Toews, 2018), drawing connections between the struggles of dispossessed peoples.

Theories relating to racial capitalism also help unpack why Canadian society and its government might be accustomed to and comfortable with this racialized economic arrangement that offers fewer human rights (i.e., health care) and protections to migrants coming from predominantly the Global South. As previously discussed, under racial capitalism race works to naturalize different types of labour as well as the rights and benefits associated with them. The continuation and survival of racialized and differentiated categories of labour are supported and reinforced through the neoliberal state's veiling of its ideology by means of discourse and imaging of the so called "illegal," "fraud," "bogus," "queue hopper," and "criminal" migrant as well as through Canada's ongoing colonial stories of its "generosity" and "kindness." These discourses and stories in turn help naturalize racialized and differentiated labour and are well documented in official state discourse and media reporting (Diop, 2014). They are, in effect, a process of racial state governance (Walia, 2021). As Owen Toews (2018) elaborates, capitalism today necessitates racial hierarchies, allowing persons who identify as white (or nationally belonging) to align with capitalists for a "share of the spoils," with racialism encouraging them to internalize feelings of inherent deservingness so that they in turn accept standards that are ultimately detrimental to working society at large (p. 18). In addition to helping unpack the constitutive relationship between capitalism and racisms, scholars have begun to draw on racial capitalism as a theoretical lens to discuss how resistance against theses racist practices might be possible.

Resistance

Racial capitalist scholars ultimately share similar visions for resistance, proposing "…an opening out to other struggles while maintaining the specificity of one's own" (Kundnani, 2020, p. 1) and that

"…our futures—and our freedom—are bound up in one another's" (Maynard, 2019, p. 144). More specifically in the Canadian context, this requires supporting movements that support Indigenous struggles as well as migrant justice (Toews, 2018; Walia, 2021). For more Marxist oriented racial capitalist thinkers, resistance will come from opposition to capitalism by all labourers (i.e., waged, non-waged, coerced, and "surplus") (Robinson, 2020). For Walia (2021), issues stemming from the Canadian border cannot be solved simply by domestic policy changes alone and must be analyzed "within globalized asymmetries of power" (p. 4). In their keynote lecture at the Global Labour Research Centre, Walia (2021) advocates for "no border politics," which they caution is not simply about an opening of the border, but rather about more widely dismantling systems of exploitation, such as policing, prisons, and banking, as much as it is about expanding the freedom of movement. Finally, it is necessary to investigate racial capitalism at the global level in order to develop effective strategies that will work to dismantle it (Hall, 1980). To understand the current crisis of displacement and mobility, the role of Canadian corporations overseas must be considered. For example, in a 2014 report submitted to the Inter-America Commission for Human Rights looking at the role of mining corporations in Latin America found that the role of Canadian corporations in multiple countries resulted in violent deaths, forced displacement, adverse health conditions, fraudulent acquisition of land, adverse local economic impacts as well as the criminalization of social protests (Working Group on Mining and Human Rights in Latin America, 2014).

Ultimately, racial capitalism as a theoretical lens helps contributes to this doctoral project by disrupting and interrogating the naturalization and racialization of differentiated labour. Racial capitalism offers an explanation of the rationality that underpins the government of migrant health as well as the discourses that work to normalize barriers and denials to care. The denial of public health care for migrants residing in Canada is tied to provincial rules that outline arbitrary employment conditions that vary from one province to the next, while ignoring other factors such

as residency length or community ties. It is also a helpful lens to disrupt this seemingly colourblind policy and interrogate the immigration policies that make migrants more likely to fall into precarious status to begin with, particularly when so many of their needs and legal status are tied to a single employer, including access to housing, eligibility for health care and new LMIAs. Finally, the question of resistance against restrictive policies on health care and racial capitalism itself is explored further in chapter six "Reform & Resistance," where competing rationalities that work to challenge the effects of racial capitalism are investigated and identified.

Critical Legal Geographies

Critical Legal Geographies (CLG) help investigate the constitutive nature of law, society, space and time. Viewing law as always spatialized and temporalized, these approaches help "…ground the law in the "world" and in assemblages of socio-spatial-material relations" (O'Donnell, Robinson & Gillespie, 2020, p. 4). Nicholas Blomley (2003) brought attention to this constitutive nature of law and space, explaining "A legal category such as 'citizen' is meaningless without the spatial category of 'territory.'.. The challenge is to find a conceptual language that allows us to think beyond binary categories such as 'space' and 'law'" (p. 29-30). Here, CLG scholarship provides a useful analytical perspective that power, both legal and extra-legal, is exercised through spatial and temporal governance, guiding my analysis of laws and interviews to privilege both space and time. There is no unified approach to conducting legal geography-based studies, and some scholars have questioned if legal geography neologisms (e.g., 'nomospheres' or 'chronotopes' etc.) are necessary to investigating analyses of spatialized power relations (Valverde, 2014). However, irrespective of CLG's many neologisms, guiding conceptual themes can be drawn from this scholarship, given its useful approach to spatial and temporal governance. Furthermore, pairing it with critical race theory and governmentality offers a more wholistic approach to this investigation of health care accessibility for

migrants with precarious status. It is worth noting that, according to Antonia Layard (2019), "..we are in the earliest days of academic understanding of how race and legal geography explicitly interact" (p. 238), despite some key concrete investigations into race and space (Ford, 1999; Razack, 2002). Scholars have also begun to employ critical legal geography approaches to their investigations of migrant illegality (Flores et al., 2019), and public health issues (Williams, 2020), providing a useful analytical approach to investigate health care access for migrants with precarious status. In this section, separating spatialized power relations from temporality helps to illustrate their distinct merits, although, in practice it is not possible to position them as separate, as they are always both constitutive elements of law working together. Finally, while uniquely tied to legal geography scholarship, questions of scale and jurisdiction are addressed in section four of this chapter—*Jurisdiction, Discretion & Street Level Bureaucrats*.

Spatialized Power Relations

Today, scholars continue to conceptualize borders as fluid and relational. Most recently, Walia (2021) interrogates borders as spatial and material power structures, functioning through "shared logics of border formation — displacing, immobilizing, criminalizing, exploiting, and expelling migrants and refugees…" (p. 2). Walia (2021) argues that state discourses that depict a "migrant invasion" and "migrant crisis" are employed to increase deportations and detentions, creating an "imagined crises" at the border (p. 3). Instead, Walia offers a helpful reframing of mass migration, which she calls a "…crises of displacement and immobility, preventing both the freedom to stay and the freedom to move" resulting from capitalism, conquest, and climate change (p. 3). Walia's (2021) language of migration as a crisis of displacement and immobility is helpful to frame precarious status in Canada, as well as to help ethically justify the legitimation of health care rights to migrants.

Looking to interdisciplinary scholarship in migration studies more broadly, migrant illegality has widely been described as a spatialized condition itself, where national borders are rendered visible and reproduced in the accessibility of social services such as health care institutions (McDonald, 2012). In their governmental analysis of Toronto's sanctuary city movement, Jean McDonald (2012) found that service providers were engaged in governing the local population through a variety of policies and practices, ultimately playing a role in the making and unmaking of migrant illegality through their government of belonging and membership. Even at the city level, access to services remained uneven from one social service office to the next (McDonald, 2012). Similarly, through their investigation of the spatiotemporal logics of "chaos and crisis" in contemporary state practices of migration governance, Alison Mountz and Nancy Hiemstra (2014) demonstrate how sovereign power is reconfigured through newer geographies of border enforcement, such as the internal expansion of policing (p. 383). This scholarship helps bring this analysis of health care access and migrant governance to spatial and institutional settings, such as hospitals, medical offices and community clinics. Such an approach is imperative, as the localized context and organizational structure may influence the spatialization of law and shift the provision of care to migrants from one location to the next.

Ultimately, accounting for space helps to illustrate how precarious status impacts mobility and access to certain places (i.e., clinics etc.) and how boundaries of state sovereignty and national borders can be reproduced in medical offices. More and more, medical professionals in the Global North are being identified as gatekeepers of health law in the provision of health care for 'undocumented' migrants (Greenbrook, 2020). This framing is not intended to pose blame or identify individual health care providers as ethically good or bad, but to interrogate the socio-legal system that allows for the denial of care to medically uninsured migrants from one medical office to the next, or from one care provider to another.

Temporality & Waiting

There is no doubt that, at the time of writing migration studies, along with the social sciences more broadly, is undergoing a temporal turn as made evident by conference themes (e.g., IMISCOE 2022 Migration and Time) as well as recent publications privileging time (e.g., Waiting and the Temporalities of Irregular Migration by Jacobsen, Karlsen, and Khosravi, 2021). In critical legal geography scholarship, there has been a trend to focus more on spatial elements, often limiting temporal analysis to that of historical analysis. Mariana Valverde (2015) also cautions scholars to not restrict temporal analyses to that of histories alone, and to engage with temporalities of all kinds. Jacobsen et al., (2021) suggest that, while significant efforts have been made to unpack how complex and layered temporalities shape migration governance, work in this area necessitates further conceptual development in its approach to time. In order to address this need, they draw on Hage (2009) and advance conceptualizations of 'waiting' as an analytical lens in their work on "irregular" migration, using it both as a social phenomenon that increases irregular migration as well as a perspective to investigate migration practices (Jacobsen et al., 2021). This research draws on conceptualizations of time and waiting to help investigate how temporal elements of health care access are shaped by legal and extra-legal power relations. There are multiple conceptualizations of waiting that may be fruitful in analyses of migration governance, including waiting as an exercise of state power (Auyero, 2012) and waiting as multiple and relational (Jacobsen et al., 2021).

In their work on Argentinian citizens waiting in hospitals and welfare offices, Javier Auyero (2012) found that the state uses waiting as an exercise of power, meant to impose subordination through the processes of producing uncertainty and arbitrariness (e.g., public employees giving contradictory messages, suddenly cancelling waiting periods, the veiling of human actions). 'Poor' people are thus conditioned through these daily lessons and are required to accommodate to the

state's instructions, learning their political subordination in the process. Drawing from both Auyero's (2012) concept on the politics of waiting, as well as a governmentality approach, waiting can therefore be seen as a technique of government. Taken from this perspective, this research analyzes how both state and non-state actors employ waiting in specific ways in the governance of migrants, which is made observable through provincial health care residency requirements, application processing times and visa requirements to name only a few examples. Furthermore, this work investigates how waiting for health care eligibility, work contract renewals, or limited community clinic hours impacts the day-to-day experiences of migrants accessing health care.

In their conceptualization of waiting as multiple and relational, Jacobsen et al., (2021) draw on Çağlar (2016) to highlight the risk of othering that researchers take when they conceptualize migrants as holding distinct temporalities. They also draw on Ramsay (2019) to emphasize the fact that "precarisation" which stems from global capitalism, has made "crisis" the new norm for many and is not necessarily distinct to migrants (p. 4). Relatedly, Synnøve Bendixsen and Thomas Eriksen (2018) problematize how 'waiting' has been conceptualized as a homogenous condition, documenting through ethnographic fieldwork how 'irregular' migrants experience waiting in a variety of ways. Analyzing waiting as multiple and relational, Jacobsen et al., (2021) look beyond viewing waiting only as an exercise of state power as is the case with Auyero (2012) and instead focus on the production of waiting by "legal regimes, cultural norms, and power relations" (p. 9-10). Drawing on this conceptualization of waiting as multiple and relational, enables an investigation of how waiting for health care is experienced by migrants, how this waiting is relationally assembled, and how the experience of waiting may differ across geographical boundaries (Jacobsen et al., 2021). From a relational perspective, I investigate the roles that various actors play in the production of the politics of waiting experienced by migrants in their attempts to access health care.

In the Canadian context, migrants with precarious status are subjected to both *waiting for* and *waiting on*.[2] Not only are medically uninsured migrants made to wait significantly more for employers, government agencies, limited clinic hours, visa processing, residency waiting periods and more, they are also made to wait on Canadian citizens through their labour, which is largely characterized by agricultural work, the hospitality industry, meat packing, driving, care work, and customer service industries. Here, waiting serves two purposes, the act of waiting on eligibility and status as well as waiting in terms of providing a service. These parallels of waiting are recurrent themes in throughout this research.

Finally, in this dissertation, time is not reduced only to an element of history (i.e., how have state immigration and health policies shifted over time, or how has race been produced over time in the Canadian context and what role this plays in the application of human rights to migrants with precarious status), but time is also a necessary conceptual tool to help analyze the current context of health care access and how it is shaped by both legal and extra-legal influences. By joining CLG perspectives more broadly to a governmentality analysis, the privileging of space and time will be most fruitful to investigating health care access across Toronto and Edmonton.

Governmentality and the Law

This research draws on a neo-Foucauldian 'analytics of governmentality' approach (Brady & Lippert, 2016), which uses qualitative methods and focuses on specific times and places, in order to investigate 'rationalities', 'techniques', and 'practices' of government to better understand how barriers to health care for migrants with precarious status are created. From this approach, power is neither totalising nor absolute, which allows for the state to be de-centered and instead emphasis is focused on the multitude of governing agencies, institutions, and authorities. Furthermore, a de-

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[2] I would like to thank my committee member Dr. Amar Bhatia for recommending this specific lens of waiting.

centering of the state (as a unified entity) and the implementation of a governmentality analysis does not minimize the state's role of inflicting harm onto migrants (i.e., as some migration studies governmentality critics have argued). It does, however, allow for investigations of contemporary government practices and power across different spatial and temporal locations. With governmentality, power and authority are not considered self-evident, and work needs to be done to reveal the taken-for-granted power relations that are constructed through ideological work (Dean, 2010), such as identifying relevant political rationalities at play (e.g., racial capitalism). According to Dean (2010), different rationalities of government will employ different technologies and techniques that produce certain forms of practice which aim to create specific norms and shape desired actions. For example, tying single-employer closed work permits to provincial health care entitlements, authorities (e.g., federal immigration programming, provincial ministries of health etc.) utilizes these assembled techniques (e.g., laws, regulations, and program requirements) to incentivize migrants to avoid changing work positions or not to report on abusive conditions, where if they do, they may be penalized by losing access to health care.

This dissertation also draws in part on an analytics of governmentality approach to guide methodologies and investigate Toronto and Edmonton as assemblages of health care barriers. The use of qualitative methods such as observational methods and interviewing with an analytics of governmentality approach allows for a "...closer, and context-specific analysis" which Brady and Lippert (2016) have described as an "ethnographic imaginary" (p. 13). Unique distinctions within the analytics of governmentality or analytics of assemblage approach include the use of 'assemblage' in place of Foucault's 'dispositif', 'apparatus', or 'regimes of practice' (Li, 2011). Turning to the concept of assemblage eschews Foucault's use of dispositif, which has been interpreted as a closure, and instead, helps bring attention to heterogeneity and the open-endedness of practices of government.

For Li (2011), the use of assemblage brings focus to the labour required to bring heterogenous elements together and emphasizes that this requires continuous work.

From a governmentality perspective, the role of law can be seen as offering a language that shapes and frames strategies of government (Rose & Valverde, 1998). At the same time, 'law' as a single, unified form of government does not exist. Instead, Nicholas Rose and Mariana Valverde (1998) propose "legal complex" to account for an assemblage of legal practices, codes, authorities, texts, discourses, and norms (p. 542). It is necessary to de-center law and instead focus on problematizations or social issues that have formed at the intersection of both legal and extra-legal practices and discourses (Rose & Valverde, 1998). Law may help facilitate creating boundaries for where people may act upon economic (or other) interests. Nonetheless, governmentality privileges an analysis of the various tactics employed in general rather than the work of specific laws (Wickman, 2017). At the same time, specific regulations in federal and provincial laws and programs identified in this research serve as techniques of government in the regulation of migrants.

It is also widely recognized that Foucault's governmentality does not provide adequate theoretical means to analyze resistance. Nonetheless, contemporary governmentality scholars have noted that individuals have some level of choice, even if limited, in responding to the efforts of government in creating their desired norms of action. From this perspective, resistance may occur when individuals are able to differentiate between their practice of self and practices of government (Dean, 2010). For example, migrants with expired work visas may apply for a stay of deportation or seek under-the-table employment options when ordered to leave Canada, or physicians who may forgo payment and provide care to uninsured migrants despite restrictive provincial policies and professional directives directing them to profiteer. With power relations widely dispersed within day-to-day life, and rationalities and techniques of government engaged in moral-based activities that

shape both behavior and thought, the ability to distinguish between practices of self and of government may be difficult – potentially hindering possibilities of resistance.

Ultimately, drawing on governmentality foregrounds specific issue at heart, that is, the problematization – health care barriers and the denial of care experienced by migrants across Canada. This investigation then moves beyond relevant laws, encompassing the larger tactics, practices and techniques in the government of health care provisions and the application of rights to migrant with precarious status. Additionally, attention is further focused on identifying competing knowledges that are engaged in disrupting the discourses that work to normalize barriers to care, while unveiling the rationality of racial capitalism in the process. Since contemporary approaches to governmentality are focused more on the 'how' of government, it is consequently helpful to weave it into this Socio-Legal Critique on Denials, Delays and Barriers to Care with other socio-legal concepts that can assist in addressing 'why' of the issue. Governmentality as a guiding method will be discussed further in the methodology section, nonetheless, it is helpful to highlight governmentality's role as both a theory and method.

Jurisdiction and Discretion

Theories of jurisdiction and discretion are fundamental to investigating not only 'where' and 'how' law happens, but when paired with a governmentality approach and critical race theories, they can assist in unpacking the 'why' law happens. This next section draws on a governmentality-based approach to the conceptualization of jurisdiction and discretion. From this perspective, concepts of jurisdiction and discretion not only aid in understanding how health care eligibility is recrafted across jurisdictions, or what institutional or actor-level discretion might look like (Pratt & Templeman, 2018). These concepts further aid in larger analyses of power when jurisdiction and discretion are viewed as techniques of government.

Jurisdiction

Building from a governmentality approach, Pratt and Templeman (2018) describe jurisdiction as a productive technology, that holds "power and authority to speak the name of the law" (Dorsett & McVeigh, 2007, p. 5). They draw from Shiri Pasternak's (2014) work and posit that jurisdiction may be crafted and recrafted, highlighting the role of jurisdiction as a productive technology, and a level of craft, or technique (Pratt & Templeman, 2018). The work of legal authorities in producing migrant subjects can be viewed as a performative technology within the 'game of jurisdiction' (Dorsett & McVeigh, 2012) – a game which is played not only across scalar levels but within legal systems (Valverde, 2015). As a technique of government, jurisdiction is actively re-crafted and is constantly engaged in re-configuring practices that re-produce both sovereignty and territory (Pratt & Templeman, 2018). A small shift in jurisdiction may instantly change how migrants with precarious status are governed, and the material consequences in the case of health care access are at times matters of life and death (Marsden, 2018).

Taken from this conceptualization of jurisdiction as a productive technology of government, health care sanctuary can be viewed as a game of jurisdiction, where competing legal orders are crafting administrative jurisdiction over migrant health, from one community program or scalar level to the next. From this perspective, this research investigates the crafting of administrative jurisdiction over migrant health as evident in Canada's health care laws and policies across scalar levels. By focusing this research at the municipal level in Edmonton and Toronto and across Alberta and Ontario, contradictions between administrative jurisdictions become more visible. While definitions of sanctuary may fluctuate among scholars or among local contexts, for Bosniak (2018), all iterations of sanctuary entail an effort to contain the scope of the state's bordering procedures. As such, the role of sanctuary is to render jurisdictional "bulwarks," "forcefields," or "firewalls" between the local society and national immigration enforcement (Bosniak, 2018, p. 18). While the

administration of public health care is regulated largely at the provincial level, it is useful to investigate how some local institutional sites have become sites of health care sanctuary or 'jurisdictional bulwarks' (Bosniak, 2018) against restrictive policies. In my investigation of health care access across locations, I draw on conceptualizations of discretion in tandem with jurisdiction as they are always operating in relation with one another.

Discretion

Socio-legal conceptualizations of discretion help investigate how discretion is located in and intersecting with legal rules (Pratt & Sossin, 2009). Within a governmentality approach, discretion can be seen as a technique of government that produces social power (Pratt & Sossin, 2009). In her seminal analysis of discretion, Anna Pratt (2005) problematizes Ronald Dworkin's broadly cited doughnut analogy, which presumed discretion to be a lingering by-product of the law (i.e., like the hole in a doughnut, only existing by virtue of being surrounded by the doughnut). Instead, Pratt (2005) depicts discretion as a powerful form of government. As a form of government, discretion actively manages social concerns within immigration law and practice. This approach challenges previous legal conceptualizations of law and discretion as a fixed binary and instead privileges social forces.

As noted by Sarah Marsden (2018) in her reporting on health care access in British Columbia, a visit to the emergency room by a non-status migrant could result in a deportation. An act of sanctuary by administrative hospital staff or health care providers who use their discretion to provide care without engaging policing agencies, can be considered as a jurisdictional "bulwark" between local actors or authorities such as the Canada Border Services Agency (CBSA). The decision and discretion to provide health care services or not, can also be understood through the lens of Dorsett and McVeigh's (2007) game of jurisdiction, where jurisdiction is constantly being

crafted and engaged in re-producing sovereignty and territory (Pratt & Templeman, 2018). For example, my analysis of interviews demonstrates how health care staff may indeed be actively engaged in the re-crafting of jurisdiction and the re-producing of sovereignty when they hold the discretion and power to engage in border enforcement or the provision and denial of services. In Sweden, the role of physician's discretion in providing care to medically 'undocumented' migrants have been described as gatekeepers of the law (Greenbrook, 2020). Undoubtedly, in the face of conflicting health care laws across jurisdictions that arguably violate medical ethics of equitable care, the discretion of health care providers has become a powerful source of social power. Whether intentionally or not, they are often engaged in crafting sovereignty, citizenship and belonging with their decisions.

A review of this literature demonstrates how the power of discretion works differently across scalar levels as well as local sites. How does discretion in the access of health care differ between Toronto and Edmonton, or from one health care provider or health care institution to the next? By employing a conceptualization of discretion as a technique of power, this research investigates how discretion is deployed when migrants attempt to access health care and to which effects, as well as which authorities, rationalities, and practices of government have been assembled to create these techniques.

Migration and Indigenous Relations

In an effort to move toward more ethical approaches to conducting research that is situated within the global displacement and mobility crisis (Walia, 2021), scholars working within settler-colonial contexts such as North America have more recently been working through challenging topics including "Decolonizing' the treaty right to be here' (Bhatia, 2013), 'the politics of allyship with Indigenous peoples' (Nobe-Ghelani & Lumor 2022), and 'migration as decolonization' (Achiume,

2019) to name a few. These ongoing questions and potential pathways to ethical approaches will undoubtedly continue to shift and adapt over time. As this work takes place in Canada, also known by many Indigenous peoples as 'Turtle Island" (e.g., the Algonquian name for North America), it is important to recognize that Canadian citizenship has always been tied to the ongoing colonization of Indigenous land and peoples (Lawrence & Dua, 2005; Walia, 2014). This approach is not only limited to ethics and theory, but has substantial material affects for Indigenous peoples and health equities. This research thus necessitates not only acknowledgement to the land but also the lived realities in which it is conducted on. The material lives of medically uninsured migrants and Indigenous peoples, although they cannot be collapsed into the same experience or history, share different yet similar health inequities that demands our attention. For example, at the height of the COVID-19 pandemic, Sefanit Habtom and Megan Scribe (2020) write on mutual aid possibilities from the perspective of shared experiences within white settler society. Looking at possibilities as called on by Tiffany Lethabo King (2020) to "…remake reality and its relations on more just terms" (p. 209), Habtom and Scribe recommend a reflection on "…the violent conditions bringing Black, Indigenous, and Black-Indigenous peoples together and collaborative paths forward" (p. 1) as they referenced disproportionate COVID-19 impacts for Black and Indigenous peoples. In effort to consider opportunities for reform, resistance and new possibilities, and in line with this approach, this dissertation seeks to better understand the shared experiences of health inequities for uninsured migrants and Indigenous peoples alike, which in itself may be seen as a form of violence.

This diverse body of literature contributes to my dissertation by drawing on the contentiously labeled and frequently debated 'decolonizing methodologies', as it provides an ethical approach to my project that helps guide my methodologies as well as provides an ethical legitimation (i.e., Achiume's (2019) "migration as decolonization") for the provision of health care services for migrants with precarious statuses. This literature further helps conceptualize the law's hegemonic

nature in the production of race across time and space, particularly as it relates to migrants, Indigenous peoples, rights and belonging. Such a conceptualization is fundamental when considering potentials for reform, resistance, and policy recommendations to improving the application of human rights to migrants with precarious status.

The concept of decolonization has always held many divergent definitions – particularly so in recent times. For Haudenosaunee professor Beverly Jacobs (2017), decolonization for Indigenous peoples at the most practical level refers to "taking our power back" and "…true partnerships, whether those partnerships are with Canada, with our non-Indigenous allies, between Indigenous men and women, or in all relationships" (p. 50-51). For professor Jeffrey McNeil-Seymour (2017), who is a member of Tk'emlúps te Secwepemc First Nation, decolonization is "… a process that is truth-speaking, heart-centred…" (p. 56). The concept of decolonization in the Canadian context has expanded to multiple localities. Particularly after the release of the Truth and Reconciliation Commission and its 94 'Calls to action', discourses around decolonization are commonly heard in post-secondary institutions and social service sectors. The expansion of decolonization and its conceptualization has not been supported by all scholars. For Unangax̂ writer and professor Eve Tuck and K. Wayne Yang (2012), 'decolonization' is primarily about repatriation of Indigenous land and life and should not be used as a metaphor (as they suggest it has become) to improve other social issues in society and human-rights based issues. Furthermore, they fear that, "…the decolonial desires of white, nonwhite, immigrant, postcolonial, and oppressed people, can similarly be entangled in resettlement, reoccupation, and reinhabitation that actually further settler colonialism" (Tuck & Yang, 2012, p. 1). Read in isolation, this work may suggest that the resettlement of migrants may contribute to reoccupation of Indigenous lands and further settler colonialism. While rejecting this interpretation of resettlement to Canada, drawing on Tuck & Yang's (2012) work can provide more specific requests to scholars working in Canada. One of their concerns with the expanded use

of decolonization is that it often is used without recognition of Indigenous peoples, their struggles for sovereignty, or without reference to Indigenous intellectuals doing work in this area (Tuck & Yang, 2012). At the time of writing, ten years after Tuck and Yang's (2012) work, scholars and community organizers working on issues related to migrant justice have taken various approaches to support Indigenous sovereignty efforts in tandem. One of these approaches has been to explore the concept of decolonization within migration studies which continues to hold multiple possibilities today.

Looking to decolonization as a source of ethical guidance may provide many practical implications and calls for concrete actions. Nobe-Ghelani and Lumor (2022) propose critical reflexivity at both sectoral and individual levels, which they define as "… examining how power relations operate in a given context and how we become complicit in the process of marginalization and oppression as we conform to pre-existing discourses" (p. 121). One of the ways in which they propose this takes shape within the refugee-serving sector is by centring the settler colonial violence and colonial dynamics that create refugee migration in the first place. Doing so they argue helps to shed light into the many ways that colonialism operates across contexts and regions as well as in interrelated and connected ways.

Another way of reflecting on decolonization in this work is to draw on its expanded usage as posited by E. Tendayi Achiume's (2019) reconceptualization of 'migration as decolonization.' Achiume (2019) challenges how the "First World" (i.e., European colonial powers and settler colonies) positions so-called economic migrants as "political strangers," whose movement is characterized by preference and agency (p. 1529). From an international and domestic law perspective, the First World's exclusion of economic migrants, or migrants who don't meet the narrow 'refugee' recognition, has been justified as a "…righteous matter of sovereign self-determination" (Achiume, 2019, p. 1515). Ultimately, Achiume (2019) argues that the First World

nation-states have no right to deny Third World migrants (i.e., migrants coming from nations that were colonized by European nations between mid-eighteen and twentieth centuries) due to "…distributive and corrective justice implications of the legacies of colonialism" (p. 1517). From this perspective of justice in immigration, migration from the Third World to the First ethically speaking must be seen as an "…entitlement to neocolonial imperial membership on grounds of political equality" (p. 1520-1521). Migration as decolonization necessitates supporting the self-determination of migrants (i.e., political equality with First World citizens), and thus provides an ethical justification and legitimation of membership, rights and belonging to migrants (e.g., including healthcare). Another way that scholars have supported Indigenous sovereignty rights together with migrant justice has been to investigate how Indigenous laws, such as treaties, as well as Indigenous authority may address or guide immigration to Canada.

Looking to settlers 'treaty right to be here', Bhatia (2013) asks "…how does the relational acknowledgment of our treaty right to be here (to have any rights at all) address the concerns raised by racialized settlers and migrants from the global South?" (p. 57). Drawing on many Indigenous writers to discuss the 'treaty right to be here', Bhatia (2013) articulates that the treaty relationships that underpin physical presence on the land of Turtle Island continues to exist today. For example, he shares Harold Johnson's (2007) relational approach to Cree law,

> Kiciwamanawak, my cousin: that is what my Elders said to call you. When your family came here and asked to live with us on this territory, we agreed. We adopted you in a ceremony that your family and mine call treaty. [...] At Treaty No. 6 the Cree adopted the Queen and her children. We became relatives (as cited in Bhatia, 2013, p. 55).

This treaty relationship today is often characterized by both settlers as well Indigenous peoples through stories and teachings of the Two Row Wampum Belt living treaty (also known as Gä•sweñta' in Onondaga), which represents a commitment for a peaceful coexistence amongst settlers and Indigenous nations. In the Haudenosaunee telling of this living treaty obligation, it is reported that,

> Together we will travel in Friendship and in Peace Forever; as long as the grass is green, as long as the water runs downhill, as long as the sun rises in the East and sets in the West, and as long as our Mother Earth will last (Onondaga Nation, 2022, p. 1).

It is clear that 'the treaty right to be here' among settlers, newcomers and Indigenous peoples is an ongoing and living legal commitment that deserves respect from all parties. This work serves as a reminder that Canada is a legal pluralist country, that our treaty obligations continue to exist, and are particularly salient in this doctoral project when it comes to questions of resource sharing (e.g., health care, social services etc.) and mutual respect (e.g., equitable labour protections, freedom of movement etc.) for all. To respect our treaties, as informed by Indigenous legal orders, Bhatia (2013) concludes "'we' must all be treaty people who are here to stay, in relation to one another, with territories, burdens, bowls, dishes, and spoons shared between all our relations" (p. 64). Taken from the perspective of treaty obligations, Canada's increasing temporalization of immigration programs that exploits the labour of racialized migrants necessitates serious reform.

This dissertation draws on these teachings from decolonization and migration studies literature in effort to support Indigenous sovereignty as well as shine light on issues that impact both migrants and Indigenous peoples. In tracing the history of universal health care in Canada, I highlight how universal health care has always been linked to racial exclusion since its origin, documenting its early exclusion across provinces from Indigenous peoples, both in social movements as well as legislation. In doing so, I hope to move beyond land acknowledgements and draw on Indigenous scholarship to provide a more holistic history on the evolution of universal health care in Canada.

In summary, this theoretical framework weaves together a diverse body of socio-legal scholarship to help investigate how immigration regimes in the Canadian context simultaneously exploit groups of migrants for economic gain, while also denying them access to rights to health and life. Underpinned by the rationality of racial capitalism, this governmental framework helps

demonstrate how these practices that are enacted by state actors, employers, and health care institutions work to deny access to care, while also recrafting notions of belonging in the process. This governmental framework further provides a lens to help identify the key practices of government at play in the provision and denials of health care to migrants with precarious status and to which barriers and effects. These practices are highlighted throughout interview findings as shared by health care professionals, civil society group members, and migrant workers themselves. Interview findings and personal narratives also help highlight how the technique of discretion and the technique of jurisdiction is employed by multiple state and non-state actors in these assemblages of health barriers (*see chapter four and five*). Distinguishing racial capitalism as an emerging dominant ideology and rationality across Canada helps to bring recognition to how the ongoing denial of health care services (in turn including right to life) to migrants with precarious legal status has become normalized and ultimately turned health care into a service that only those viewed as 'belonging' become entitled to, both legally and morally. In order to disrupt this norm, this very issue requires reform and resistance across scalar levels in order to uphold what Bosniak (2007) refers to as 'ethical territoriality plus' – the full recognition of rights based on one's geographical presence to the land. In effort to advocate against restrictive health policies, in chapter six – *Reform and Resistance,* presents arguments for the support of competing knowledges in these assemblages of health care barriers that build on the rationality that positions precarious migration in Canada as a crisis of displacement and immobility.

1.3 Chapter Overview

In chapter two, "Setting the National Context," I first provide a brief overview of Canada's federal health laws, including a brief history on funded health insurance in Canada, the evolution of universal health care and the Canada Health Act today as it pertains to medically uninsured migrants.

Following a review of Canada's health laws, I review some of Canada's early immigration exclusions in effort to set the national context for exclusionary policies today. This section is followed by a brief introduction to some of Canada's temporary immigration programs, such as the Temporary Foreign Worker Program (TFW) and the Seasonal Agricultural Worker Program (SAWP). An analysis of health and immigration laws and programs are necessary to help contextualize the national context and structures that allow many migrant workers to find themselves as residents of Canada yet medically uninsured across provinces.

In chapter three, "Methodologies: Assemblages of Health Care Barriers," I provide a detailed account of my research methodologies, including my research questions as well as case selection. Second, this chapter expands on the 'analytics of governmentality/ assemblage' (Brady & Lippert, 2016) approaches to explain how it helps guide my research stages, including my analysis of laws and relevant texts (i.e., law in the books) as well as qualitative interviewing and the importance of privileging narratives with the law (e.g., law in action). Finally, this chapter discusses interview recruitment (n=30), data, coding, and analysis and concludes by discussing limitations, gatekeeping and deductive disclosure.

In chapter four, "Toronto/ Tkaronto" I investigate the status of health care access for migrants with precarious status in Toronto, with particular attention to barriers to access and denials of care. This section includes a review of Toronto's immigration history, current demographics, and local social movements for urban sanctuary. Starting with law in the books, I investigate key legislative changes in provincial health care from the 1970s to the present in order to demonstrate that regulations were never set in stone, frequently changing over time. I provide an analysis on how the Ontario government has interpreted the CHA and taken an increasingly narrow interpretation of 'resident' to deny access to health care for many migrant workers. Next, this chapter provides an analysis of 18 interviews and highlights findings related to hospital billing and facility fees; varying

standards of care and pre-mature risk of death; interprovincial billing issues; medical specialists and profiteering; Covid-19 and temporary billing codes; discrimination, racialization and impacted service delivery; language and translation concerns; and the local governance of immigration status. Specifically, examples from these categorized findings demonstrate that racial capitalism helps legitimize denials to rights, such as the denial to health care for groups of migrants. This process takes place through multiple steps. Namely, systemic denials to rights for health care by employers, health care institutions and government agencies work to normalize delays, denials and barriers to care by recrafting who belongs in the process. To conclude, the discussion weaves together interview findings with a socio-legal critique on denials, delays and barriers to care.

In chapter five, "Edmonton/amiskwaciwâskahikan," I investigate the status of health care access for migrants with precarious status in Edmonton, with particular attention to barriers to access and denials of care. First, I briefly review the City of Edmonton's immigration history, demographics, social movements (e.g., Mckenna Law), and municipal motions in support of its status as a Sanctuary City. This helps to provide a contextual grounding that encompasses how local beliefs about belonging and membership may be recoded at the service provision level or local level. Starting with law in the books, health care spending, policy and provincial-political branding are reviewed, covering the "Klein era" to the present. Health care eligibility based on immigration or employee status is investigated, as well as the regulation of fees by professional bodies. Moving to law in action, this chapter provides an analysis of 12 interviews and highlights findings related to the following themes: reasons for becoming medically uninsured; lack of services available in Edmonton; common issues of fear, delayed care, and financial constraints; out of country billing, lower standards of care and denials of care; and the local governance of immigration status. Findings demonstrate that medically uninsured migrants may be subjected to a lower standard of care compared to the rest of society, as a result of their immigration status and lack of health insurance.

In turn, this experience negatively impacts feelings of belonging for medically uninsured migrants. To conclude, the discussion weaves together interview findings with a socio-legal critique on denials, delays and barriers to care.

In chapter six, "Reform & Resistance," in part one, I focus on interview findings to highlight the experiences of migrant participants (n=6), health care professionals and civil society members (n=24) as well as investigate efforts for reform through the legal system. In part one, this chapter considers legal mobilization and investigates the past successes and failures with attempts to utilize the law as a technique for change (i.e., Toussaint v. Canada), Canada's non-compliance with customary international law (*pacta sunt servanda)* and issues with the 'grounds approach' to human rights (Eisen, 2013; Hodes, 2020). Lisa Vanhala (2021) describes legal mobilization more broadly as "…any type of process by which individual or collective actors invoke legal norms, discourse, or symbols to influence policy, culture, or behavior" (p. 1), noting that high-profile litigation efforts, such as the case of Toussaint v. Canada, is only one aspect of legal mobilization. In part two, I draw on Nicholls and Sorrell-Medina's (2023) conceptual work on migrant activism. This chapter first looks at key framings or competing rationalities on discourse pertaining to funded health care for medically uninsured migrants, including: (1), firsthand story and rights-based framing, (2), economic framing or cost benefit analysis as well as (3), consciousness raising of global asymmetries of power (Walia, 2021). Additionally, interview findings are analyzed to discuss the strategy of political opportunities whereby participants discuss the need for multilevel mobilization strategies. Participants shared the importance of the strategy of "winnable battles," starting with a more politically acceptable win, such as health care for government sponsored refugees or for uninsured pregnant women, and then expanding mobilization efforts to other areas and issues after securing initial wins. Finally, the power of organizational support, individual actors, and mutual aid networks

are discussed as being influential components to migrant justice movements in support of health care rights.

Lastly, in chapter seven, "Conclusion," I review the key contributions of this dissertation to the field of socio-legal studies, which includes (1), the documentation of denials, delays and barriers to health care for medically uninsured migrants at the local level in both Eastern and Western Canada, and (2), the identification of racial capitalism as the dominant political ideology that underpins the denial of health care rights to medically uninsured migrants in Canada. These findings suggest that the improvement of health care entitlements for migrants with precarious status is dependent upon overcoming this ideology and making space for competing knowledges and rationalities. This chapter further reviews key findings of this doctoral project across chapters, addresses limitations encountered with field work, and provides a reflection on the key similarities and differences across Toronto and Edmonton. This chapter concludes with implications and recommendations for future research.

Ultimately, this dissertation investigates temporalized migration and restrictive health care policies as techniques of government in the regulation of migrants with precarious status. Through the political rationality of racial capitalism and its associated discourses, Canadian society continues to accept these social orders as natural and taken for granted. Through techniques of jurisdiction and discretion, each scalar level of government systemically avoids accountability for ensuring migrants maintain access to health care. The results of these health care barriers in Edmonton and Toronto are investigated in-depth through interview findings in chapter four and five and the results are dire. Chapter six investigates possibilities of reform and resistance to this significant issue. Having provided a chapter outline in this section, the following chapter, "Setting the National Legal Context" provides an overview on the relevant national context necessary to situate this doctoral project, including Canada's federal health laws and immigration trends.

Chapter Two.
Settling the National Legal Context |

2.1 Introduction

In order to investigate health care access at the local level in Toronto and Edmonton, it is necessary to first investigate the national context, such as federal laws and program that also govern this issue. This chapter begins with a brief overview of Canada's federal health laws, such as the Canadian Health Act and its early origins with publicly funded health care across Canada. Following an overview of publicly funded health care in Canada and the limits of the Canada Health Act, this chapter concludes with a brief overview of early immigration exclusions in Canada leading up to today's increasingly temporalized immigration programs. Ultimately, this chapter argues that Canadian society has historically tolerated differentiated health care standards based on race, identity, and notions of belonging.

2.2 Canada's Federal Health Laws

In this section, contemporary discussions on access to public healthcare programs in Canada are contextualized by its federal governance structure and historized alongside the settlement and displacement of Indigenous lands. First, the British North America Act (BNA Act), later renamed the Constitution Act (1867), sets out the division of powers between the federal and the provincial governments. The areas that are deemed exclusively federal jurisdictions in s.91 are either expensive or of national interest, leaving provinces or local governments jurisdiction over other areas (Deber, 2017). Nowhere in the 1867 Constitution Act are local governments mentioned, neither is "healthcare" referenced. Nonetheless, section 92 of the Constitution outlines some exclusively provincial responsibilities, including subsection 7 which refers to "The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the province, other than Marine Hospitals," which are the exclusive jurisdictions of the federal

government according to s.91(11). While courts have often ruled that provinces hold primary jurisdiction over health care (Deber, 2017), most recently, *Carter v. Canada (Attorney General) (2015)* found ruled that "Health is an area of concurrent jurisdiction; both Parliament and the provinces may validly legislate on the topic" (p. 1). Second, as articulated by Esyllt Jones (2019), in Canada the social movement for public healthcare in the 1940s was "…not without its oversights, silences, mistakes, and bigotry." Jones concluded "…it is impossible to read a history of Canadian health care without acknowledging exclusion, segregation, and experimentation upon Indigenous bodies in the name of medicine" (p. 20).

In line with my CRT guided methodologies, this section briefly historicizes publicly funded health care in Canada, leading to a current day mapping and analysis of shared jurisdictions over health as it relates to migrants with precarious migration status. It is important to highlight that only a partial history is provided here, as a full historical analysis could be the subject to an entire dissertation given its scope and importance. As it is not possible to include a full legislative and social history of the evolution of public health care in Canada, key moments of significance are underscored as guided by my theoretical framework: a socio-legal critique on denials, delays and barriers to care. This section also outlines two opportunities where the federal government could take the lead by helping make health care more accessible to medically uninsured migrants, including by 1), providing incentives in its bilateral agreements with provinces and territories, and by 2), employing Ministerial discretion to expand the Interim Federal Health Program (IFHP) for resettled refugees (i.e., federal funded health care for refugees), to include migrant workers who find themselves medically uninsured as a more immediate intervention.

Brief History on Publicly Funded Health Insurance

The creation and expansion of publicly funded health care is, in part, linked to Canada's desire to increase its settlement across Turtle Island. However brief, this early history linking racial exclusion to the foundation and creation of public health care in Canada is important to encapsulate, as it helps to historicize contemporary exclusions to Canada's Medicare today, particularly for racialized and illegalized migrants that this dissertation seeks to problematize. With an increase in immigration, Canada saw that in order to expand settlement beyond a few centralized cities, it would need to ensure that medical care would continue to be accessible for the success of its national project, particularly in the prairies (Deber, 2017). For example, Saskatchewan saw a rapid increase in (documented) population from 91,279 in 1901 to 895,992 in 1941 (Deber, 2017, p. 53-56). In Canada, the creation of publicly funded health care (Medicare) is often attributed to the election of premier Tommy Douglas in 1944 (i.e., the first ever democratic socialist government in North America), where Saskatchewan first began to expand funded hospital care across the province. It is important to note that Tommy Douglas is known to be inspired by the work of his friend James Shaver Woodsworth, who was first elected as the leader of the Co-operative Commonwealth Federation (CCF) in 1933 (The Douglas Coldwell Layton Foundation, 2024; Morley, 2021). In Woodsworth's (1909) highly racist book, *Strangers Within Our Gates or Coming Canadians*, he analyzes the character traits of Black Canadians who were largely descendants of slavery at the time and Indigenous peoples in a joint chapter. He later moves on to a concluding chapter on titled "Assimilation" where he outlines a plan to assimilate Indigenous peoples and non-white immigrants alike with white Canadian society by targeting the use of schools and labour unions to do so. This background is helpful for setting the context of how Indigenous peoples continued to be excluded from Canada's early health care plans. Nevertheless, the transnational social movements that underpinned this era are also of great significance to this history, demonstrating that mobilization has changed the way in which Canadians thought of access to and funding of health care.

The history of public health care is linked to racial exclusion from the start. As Jones (2019) writes, beginning in the 1920s, socialized health care in Soviet Russia became a significant source of inspiration globally. Following the publication of "Red Medicine: Socialized Health in Soviet Russia" by Sir Arthur Newsholme of England and Whales and John Adams Kingsbury of the United States (1933), which spoke about "polyclinics," the creation of large health care centres near families and workplaces, similar models began to expand across European countries (Jones, 2019, p. 21-31). In 1935, two Canadian physicians, Frederick Banting and Norman Bethune, traveled to the Soviet Union to attend an international conference on health and medicine, and returned inspired by 'socialized health' (Jones, 2019). Around the same time, the League (e.g., The State Hospital and Medical League), founded in 1936, was beginning to study, organize, and lobby for "socialized medicine as state medicine" in Saskatchewan (Jones, 2019, p. 136). Individuals could join the League for 25 cents, and clubs or municipalities could join for five dollars. In 1936, the League sent its members a survey asking them to report any illnesses they had over the past five years and the expenses they occurred and then published these findings. It is within this history that public health care and its link to racial exclusion becomes evident.

Jones (2019) posits that the League generated its publications without any input from Indigenous peoples, operated with a "colonialist mentality," and included only non-Indigenous residents of Saskatchewan due to their status as "citizens and ratepayers" (p. 140). At this time, Indigenous peoples with signed treaties were not recognized as Canadian citizens under Canadian law, however, non-status and Metis peoples were also ignored by the League's activism efforts. Operating within the same geographical region now recognized as Saskatchewan and Alberta, at a different scalar and jurisdictional level, the story of how Treaty No. 6 (1876) legally mandated a federal obligation to provide a 'medicine chest' for Cree, Assiniboine, and Ojibwa communities across the plains is of significance here.

Treaty 6 is of great significance to Canada's health care history because it marks one of the only Western-numbered treaties where the federal government formally enshrined its legal obligation to provide funded medicine to Indigenous peoples, agreeing "That a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the direction of such agent." As told by Maureen Lux (2018), the federal obligation to provide a medicine chest in Treaty 6 subsequently became central to Indigenous peoples' claims for health equity in Canada. Despite this social and legal commitment, the federal government abrogated its obligations to provide a medicine chest in 1919, when it began charging medical costs to the Mistawasis Band.

In 1935, George Dreaver, the chief of Mistawasis successfully sued the Canadian state and recovered costs that were previously charged to the Band for medical care (Lux, 2018). Lux (2018) documents how, despite this successful win, Indigenous peoples across regions were made to continue to pay for their healthcare as a signal of their successful assimilation. Unfortunately, the breaking of treaty responsibilities by the Canadian state is all too common, as John Burrows (2002) describes, "…in almost every treaty negotiation one can detect dishonesty, trickery, deception, fraud, prevarication, and unconscionable behaviour on the part of the Crown" (p. 113).

Shifting back scalar and jurisdictional levels, while Saskatchewan began to expand publicly funded hospitals under the Tommy Douglas government (i.e., representing the Co-operative Commonwealth Federation (CCF) party, founded by a group of farmers, academics, and union allies) (Morley, 2006) in 1947, the province created North America's first ever universal hospital insurance program, with Alberta and British Columbia soon following with assistance from the federal 'National Health Grants Program' (Deber, 2017). It wasn't until 1957 when the federal government committed to paying for half the cost of publicly funded health care programs for interested provinces if they met specific federal requirements on licensing, inspections, budgets,

planning, and most importantly, "…make insured services available to all on uniform terms and conditions" (Hospital Insurance and Diagnostic Services Act [HIDSA], 1957).

By 1961, all Canadian provinces joined in creating publicly funded hospital services, marking the first-time provinces and the federal government would work to create national health care standards (Canadian Museum of History, 2010). Despite legal obligations to provide health care and hospital services "available to all on uniform terms," Lux (2018) documents how "The Indian annexes, Indian wings, and basement wards, demanded by community prejudice and inadequately funded by the state, actively shaped inequality and constructed an image of Aboriginal people as less worthy of care" (p. 21). Here the naturalization of differentiation becomes evident, despite the government's early shift toward more modern-day treaties and self-government agreements at this time, in all these new health care commitments, Indigenous peoples were still seen as less worthy of care. As I noted earlier in my discussion of the effects of waiting, this naturalization of differentiation plays out in this context by Indigenous peoples waiting significantly longer (years) to gain more equitable access to care compared to the Canadian society at the time.

Evolution of Universal Health Care

A brief history of universal health programming and policy in Canada is essential for better understanding the patchy nature of health coverage for migrants with precarious migrants today. The exclusion from 'universal' health care, which different groups of migrants' experience today, is not a new phenomenon that only arises with the development of temporalized immigration programs, but a continuation of its original design linked to racial exclusion and inclusion. As Carmella Murdocca (2010) writes, public discourses that often unequivocally connect disease and racialized others have "…served to fuel colonial anxieties about being overrun by the colonized—or worse, mixing with them." (p. 391). Historically, this connection is made particularly salient by the

separation of Indigenous peoples from non-Indigenous Canadians in public hospitals in "Indian annexes," or as well documented in published debates by local municipalities over their legal obligation (or lack of) to admitting Indigenous patients throughout the 1950s (Lux, 2018). This brief history on the origin of public health care helps lay the groundwork for a socio-legal analysis of Canada's contemporary health care laws across jurisdictions and how they govern access and the mobility of migrants with precarious status.

Ensuing the emergence of publicly funded hospital insurance programs across all provinces in 1961, Canada began to see more significant advancements in universal health care law and policy. The following is a brief timeline of significant legal developments in Canada's public health care regime:

- In 1966, at the federal level, the Medical Care Act was introduced by the Liberal government and passed with the support of the New Democratic Party to introduce a "…universal, prepaid, government-sponsored scheme" for public health services. Notably, the Conservative and Social Credit Opposition rejected the Act, accusing it of indulging in "the false philosophy of the welfare state" (Canadian Museum of History, 2010b). This act title was shortened and in conjunction with the HIDSA, both became known as 'Medicare.'

- By 1971, all provinces established a single-payer health care plan, with health care financially administered in each province by a single public agency (e.g., Ontario Health Insurance Plan and Alberta Health Care Insurance Plan).

- In 1977, the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act (EPF), replaced the Medical Care Act as well as the HIDSA, offering transfer payments (i.e., fiscal federalism) from the federal parliament to provinces for health care funding, based on population size (Government of Canada, 1991).

- In 1982, Canada revised its constitution to include equalization payments in section 36(2): "(2) Parliament and the government of Canada are committed to the principle of making equalization payments to ensure that provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation." (Constitution Act, 1982).

- In 1984, the Canada Health Act (CHA), solidified more concrete terms and conditions which provinces would be required to meet in order to continue to receive transfer payments for insured health services, including services provided by hospitals or physicians. Under the CHA, provinces were required to provide health care to all provincial residents, including Indigenous peoples living on or off reservations (Lux, 2018).

- In 1996, the EPF was rolled into the new Canada Health and Social Transfer (CHST), which included transfer payments for not only health care, but for post-secondary education as well as welfare programs.

- In 2002, all provinces and territorial counterparts (except Quebec) agreed to a "Health Act Dispute Avoidance and Resolution" process, which allows for the federal Minister of Health to discuss, clarify, and dispute interpretational issues of the CHA, including the establishment of fact-finding committees. As part of this process, Health Canada publishes annual reports on how governments have met the CHA criteria and satisfied requirements for transfer payment eligibility (Health Canada, 2022).

- In 2003, at the federal level, Canada introduced the First Ministers Health Accord (the Health Accord), an action plan dedicated to improving "…timely access to quality care for all Canadians," in which starting in 2004, the government would increase transfer payments on health spending by 6% per year (i.e., $16 billion over 5 years for a Health Reform Transfer, and $14 billion in Canada Health Transfer etc.) (Government of Canada, 2006b).

- In 2004, the federal government reverted the CHST into two separate funds, the Canada Health Transfer (CHT) and the Canada Social Transfer (CSF), to "…enhance transparency and accountability and ensure predictable annual increases in health transfers." (Government of Canada, 2006, p. 1). Arguably, Canada's federal cash transfer is the only way it can truly influence provincial spending on health care.

- In 2014, the Health Accord expired after its initial ten-year period. Under the Progressive Conservative federal government at the time, prime minister Stephen Harper elected not to renew the Health Accord and allow for its cessation. After 2016-2017, provincial CHT's amounts would be tied to inflation, but no less than 3% annually (Deber, 2017).

- In 2017, under the Liberal federal government, prime minister Justin Trudeau signed bilateral agreements with each province and territory, unlike the previous Health Accord which included one shared and universal plan for all jurisdictions. All provinces and territories further agreed to a "Common Statement of Principles on Shared Health priorities." Each bilateral agreement established a plan for allocating federal funding to: (1), home and community care, (2), mental health, and (3), addiction services. Bilateral agreements were set to renew 2021-2022 for a remaining 5 years of federal funding (Government of Canada, 2022). To date, there is no evidence to suggest that this shift to bilateral agreements is significantly more beneficial than traditional multilateral agreements.

Canada's division of powers over health care, the creation of federal-provincial transfer payments and the creation of the CHA are significant to understanding the legal context where claims for the legitimization of human rights and improved health care access for migrants may be made possible. Since their origin, transfer payments from the federal government to provinces for

health care funding have never been without some strings attached. Jurisdictional boundaries, authority and leadership over health care is blurred at best, translating across scalar levels at different points in time, despite its current general recognition as chiefly "provincial jurisdiction." In the next section, an analysis of the CHA will argue that provinces may be in violation of its 'universality' principle, which is a chief obstacle for expanding access to migrant health care today.

Canada Health Act (CHA) Today

The Canada Health Act (CHA) is Canada's federal legislation dedicated to governing publicly funded health care insurance. The CHA has five conditions that provinces must satisfy in order to receive federal transfer payments described supra. First, that of public administration – provincial health insurance plans must operate on a non-for-profit basis. Second, comprehensiveness – provinces must ensure that all insured services are provided by medical practitioners and hospitals. Third, universality – provinces must "…entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions." Fourth, portability – provinces must not have eligibility waiting periods longer than three months to gain access to the public insurance plan. Further, the principle of portability governs how provinces respond to publicly insured residents visiting other parts of Canada. And lastly, accessibility – provinces must:

> provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons (Government of Canada, 1986).

The primary goal of the CHA is "…to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial

or other barriers" (Government of Canada, 1986). While the goal of the CHA makes no distinction based on immigration status, it later defines a resident as:

> **resident** means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province; (*habitant)* (Government of Canada, 1986).

It is this vague resident qualifier of "lawfully entitled" or "does not include a tourist, a transient, or visitor" that provinces have in turn relied on to exclude many groups of migrants from accessing publicly funded health care in their own provincial legislation. Nonetheless, as scholars have argued, this common provincial interpretation of resident likely violates the CHA itself (Chen, 2015). They contend that provinces have established strict 'residency' requirements as a means to override the universality principle of the CHA to limit entitlements (Chen, 2015; Flood & Chen, 2010; Marsden, 2018). The universality principle mandates that all medically necessary health care services are required to be readily available to "insured residents" on unified bases. From this perspective, using the CHA's universality principle may be a suitable legal argument for resisting restrictive eligibility guidelines that prevent medically uninsured migrants from accessing Medicare.

This limited reach and detail of the CHA has further meant that provinces have adopted rules and regulations that vary significantly from one province to the next. One of the reasons for the inconsistent health care provisions across provinces can be attributed to the tradition of the federal government's lack of 'strings attached' health care in their provincial transfers. This issue was heightened under the Harper government in 2011 when they signaled that they wanted to be 'out of the business of health care' and even failed to renew the Health Accord (Wellesley Institute, 2016). I argue that the federal government could take the lead in helping make health care accessible to all residents by providing incentives in its bilateral agreements, which already include some "strings attached" type of healthcare funding, such as funding dedicated to specific services like mental health programs. Nonetheless, provinces may choose to resist such efforts and eschew them as

violation of Canada's division of powers, since provinces have now legally defined residents in their respective health care laws for decades.

Legally speaking, the federal government can also withhold transfer payments if it finds that provinces are not meeting the mandatory CHA principles. Most recently, in 2021, the federal government announced that it was withholding millions in transfer payments from New Brunswick over its overly restrictive access to medical abortions, later confirming that $140,216 was actually withheld (The Canadian Press, July 27, 2021). This recent precedent demonstrates that if the federal government finds provinces are violating the CHA, they can in fact act by limiting or withholding transfer payments where there is a political will. The federal government, namely the Minister of Immigration, could also exercise discretion to expand its Interim Federal Health Program (IFHP) for resettled refugees (i.e., federal funded health care for refugees), to migrant workers who find themselves medically uninsured as a more immediate intervention.

In this section, I have reviewed the CHA and its relevance in governing health care access for migrants with precarious status. Ultimately, the CHA is very brief in its description of "residents," allowing provinces to create their own interpretation. As I will analyze below in the following chapters, provinces have also added their own immigration requirements for health care eligibility. While health care jurisdiction is determined by the archaic design of the Constitution, its federal structure may offer a more responsive policy framework influenced by the province's local populations and their aspirations. In the following section, I briefly highlight some of Canada's programs in relation to temporalized and precarious migration.

While this section is outlined some of the early history of publicly funded health insurance in Canada and the CHA today, it is important to briefly highlight some of Canada's early exclusionary immigration laws to help set the context, particularly given the importance of the intersection of these two areas of law for uninsured migrants today.

2.3 Early Immigration Exclusions

It is important to highlight that Canada's earliest immigration laws contained very limited restrictions, and overtime became significantly more exclusionary. For example, the Immigration Act of 1869 prioritized safe passage to Canada with few exclusions (Canadian Museum of Immigration, 2024). Nonetheless, and shortly thereafter, Canada introduced its first of many race-based exclusionary acts with the Chinese Immigration Act of 1885. This act introduced a 'head tax' for Chinese migrants to Canada, starting with a $50 duty per person at its origin, leading up to $500 per person in 1903 (Canadian Museum of Immigration, 2024, p. 1). Early 1990s migration screening and policies in Canada have been described as ableist and exclusionary based on race.

Sarah Adjekum and Ameil Joseph (2023) document how Canada's early immigration procedures employed eugenics-based screening, requiring physical and mental fitness for migrants entering the country, with discovery of illness or disability becoming grounds for deportation. Around this same time, Canada introduced the Continuous Journey Regulation in 1908, which prevented migration to Canada by sea unless the journey could be made in one single trip without stopping along the way. This regulation was put in place specifically to limit immigration from Asia, particularly China, Japan and India (Canadian Museum of Immigration, 2024). This regulation was challenged multiple times, notably with the arrival of the Komagata Maru in 1914 to the Vancouver harbor, where hundreds of migrants from India (parts now considered Pakistan), who were considered British Subjects at the time, were denied entry to Canada under this regulation. Most passengers were not permitted to ashore and remained confined to the ship, only to ultimately be turned away. Unfortunately, many passengers were imprisoned and killed upon return to British India (Johnson, 2006).

Other notable exclusionary acts included the Order in Council of 1911, which

explicitly banned Black migrants from entry to Canada due to being deemed unsuitable to the country's climate and requirements (Canadian Museum of Immigration, 2024). This order came to fruition at a time where Black farmers were looking to leave the United States for Canada. While this ban did not end up being implemented into the country's immigration act at the time, the ordinance was nonetheless passed and accompanied by significant efforts to deny Black migrants legal assistance in Canada. Other notable exclusionary restrictions included the banning of Chinese immigrants from 1923 to 1947 under the dubbed 'Chinese Exclusion Act.' The examples are too many to list, nonetheless, it was not until 1962 where Canada finally removed overtly race-based discrimination from its immigration laws. These early exclusionary immigration laws are helpful for setting the context for the exclusionary policies today, where only some are seen as deserving of health care.

2.4 Canada's Temporary Immigration Programs

It is necessary to analyze health care laws alongside immigration laws and programs to fully contextualize the structures that allow for many migrant workers to find themselves both residents of Canada and medically uninsured. While immigrants in Canada's permanent immigration streams obtain health care coverage upon establishing residence in their respective provinces (usually after a waiting period), individuals in Canada's temporary immigration streams are not so fortunate.

Canada has operated the Temporary Foreign Worker (TFW) program since 1973, and its Seasonal Agricultural Worker Program (SAWP) since 2002, allowing Canadian employers to hire non-Canadians on a temporary basis due to local labour shortages. It is widely acknowledged that migrant workers coming to Canada under these programs are almost entirely from Global South countries. The TFW Program allows for work permits typically 1-2 years in length whereas SAWP visas are valid for a maximum of 8 months. Since 2014, the former stand-alone Live-in Caregiver

Program no longer requires migrants to 'live-in' and has since been merged into the TFW Program's other streams for low wage or high wage positions (Government of Canada, 2024).

Even though they are not legally permanent residents, in Ontario, migrants with SAWP visas receive health care coverage under OHIP (Ontario Health Insurance Plan) upon arrival. For all other categories of migrant workers in Ontario, employers must provide private health insurance for the first three months and then switch to OHIP coverage upon meeting waiting period criteria. Alternatively, in Alberta, migrants with SAWP and TFW visas must access private health insurance from their employers. For all other migrant worker visas, AHCIP (Alberta Health Care Insurance Plan) is only provided for workers who enter Canada with a minimum active six-month work permit, yet at the same time, they must intend to be working for twelve months and maintain an active work permit in order to maintain coverage. However, due to the patchy and inconsistent rules across migration programs and health care entitlements, migrant workers may find themselves laid off work for disclosing health issued and in turn, lose access to employer or provincial health care coverage.

Recently, Kerian Burnette, a 42-year-old Jamaican woman living in Nova Scotia as a migrant worker was recently fired from her job strawberry picking when she was diagnosed with cervical cancer. Like many other migrant workers across Canada, and in line with my interview findings, she has disclosed being denied treatment for her cancer due to losing health care coverage and in 2022, collected a debt of $81,000 after two surgeries (CBC News, August 14, 2023). At the time of writing, the federal government has granted Burnette access to IFHP to cover her health care needs. The expansion of IFHP by the federal government from resettled refugees only to migrant workers who find themselves medically uninsured is a welcomed move. At the same time, this Ministerial discretion is not consistently employed when requested, resulting in uneven access. While there is no

public data on total requests for IFHP for migrant workers who are medically uninsured, interview findings suggest this is relatively rare.

These visa programs typically require employers to demonstrate that they are unable to hire a Canadian citizen for the position through the application of a Labour Market Impact Assessment (LMIA) to Employment and Social Development Canada who ultimately grant permission to hire a migrant worker. Since 2013, a LMIA fee of $1000 is charged to employers for each application and subsequent position. A brief submitted to Parliament by the Migrant Mother's Project posits that the creation of these new fees has led some employers to download these costs to migrant workers (House of Commons, 2016, p. 9). My interview findings also echoed this concern, and since migrant workers cannot apply for a LMIA themselves, they may find themselves suddenly unemployed and ineligible for health care if their employer delayed or forgot to submit a LMIA application, leaving them in a precarious position with few options.

Migrant workers in Canada through the SAWP or TFW program are legally tied to a single employer, meaning there are significant barriers in place that reduce or restrict their mobility in the Canadian labour market. For example, migrant workers are required to apply and pay for a new visa in order to change employers, which often requires a waiting period in addition to case processing. To complicate their situation further, migrant agricultural workers, particularly on SAWP visas, often live on farms with their employer. As such, quitting a position due to exploitation or abuse could result in homelessness, as it is unlikely that a migrant worker could legally access a new position without a waiting period due to bureaucratic processes. Canada increasingly relies on temporary work visas with numbers increasing every year. In 2022, Canada processed 1,164,000 work permits compared to only 630,000 in 2021 (Government of Canada, 2023). Similarly, in 2022 Canada finalized 919,000 study permit applications – a 29% increase from 2021 (Government of Canada, 2023). This increase of student visas in Canada has also led to a marked increase in student worker

exploitation, as documented for example by community groups, such as the Naujawan Support Network (NSN) – a collective of international students and immigrant workers based in Brampton and the Greater Toronto Area. Founded in 2021, NSN has recovered more than $650,000 in unpaid wages for exploited workers through their actions (Motla, 2023, October 6, p. 1). NSN states that their group receives roughly 40 to 50 new requests for support on a monthly basis, where they provide legal advice and guidance on how to counter exploitation (Motla, 2023, October 6, p. 1) To be sure, these statistics are not meant to criticize increasing immigration to Canada, rather to emphasize that by significantly increasing reliance on temporary programs, it is reasonable to assume more migrants will find themselves medically uninsured in Canada due to the intersection of federal immigration programs with provincial health insurance policies.

Reliance on employer-tied visas has been characterized more and more as a form of indentured labor. Most recently, Jamaican workers living in the Niagara region and working under the Seasonal Agricultural Worker Program (i.e., two hours south of Toronto), published an open letter in the summer of 2022 after the death of one of their colleagues, stating that "As it currently stands, the Seasonal Agricultural Workers Program (SAWP) is systematic slavery" and that "They [employer] physically intimidate us, destroy our personal property, and threaten to send us home" (Raza, 2022, August 20). In an interview with Lynn, now based in Edmonton, she describes her experience with her employer when she first immigrated to Toronto, stating:

> But my first encounter with my employer is not really good. He just like because I don't know the community at that time because I'm just new here, it's happened that an employer did not follow what's written in the contract. Just a lot of labor dispute, it's supposed to be 40 hours a week, it gives us only 20 hours. And apart from that is that if the restaurant is slow. They used us to go to their farm, like to cut trees, that is not part in our labor contract. Yeah, and then the other ones that like, our first winter experience is just that we don't have safety winter gear to wear. So we're shaking outside in the winter at that time (Lynn, 08/22).

Lynn's experience is unfortunately all too common, with many migrant workers being tied to single employer visas and as a result, are in a difficult position where it is finically difficult to leave due to the gap in time required to find a new employer and apply for a new visa.

To consider a final example, in response to the death of three Mexican migrant workers during COVID-19 and the reports widely circulated by migrant worker groups naming their concerns over workplace safety, competing authorities such as the Canadian Federation of Agriculture (2023) were quick to characterize these concerns as "unsubstantiated" and offer a counter narrative on "…how this program works for everyone" (p. 1). Concerns over the exploitation of migrant workers through temporalized migration programs are well documented (Faraday, 2014) and the "focus on the current program and ways to improve it" was recently the subject of a parliamentary report titled "Temporary Foreign Worker Program" (House of Commons, 2016, p. 1) – signaling that the material effects of these programs continue to demand our concern and attention.

2.5 Conclusion

This chapter concludes by summarizing the problematization of how health care rights for migrants with precarious status in Canada emerged. A historical review of public health care in Canada has demonstrated that racial exclusion has been present since its conception, documented in the exclusion of Indigenous peoples by civil society groups and local governments alike in early health care programming, planning and advocacy. Canadian societies have thus always tolerated differentiated health care standards based on race, identity and notions of belonging over time. This is historically marked through constant changes in public policy both provincially and federally. Beginning with the League's mobilization throughout the 1930s in Saskatchewan, or the federal governments violation of Treaty No. 6 medicine chest agreement, to the 2012 Harper restrictions and claw backs of the Interim Federal Health Program for refugees, or the denial of health care

provisions for migrant workers who don't satisfy restrictive provincial eligibility requirements today – discrimination in so called universal health care provisions has existed since its origin.

Federalism and an archaic division of jurisdictional powers further characterizes these assemblages of health care barriers, where the federal government controls the majority of increasingly temporalized migration programs and where provinces in turn determine their health care entitlements. With a growing reliance on temporary migration programs and single employer-tied visas, the number of migrants living in Canada who find themselves in-between work visas and thus medically uninsured is therefore reasonably expected to continue to rise. In chapter four and five, I further investigate how provinces have interpreted the CHA and what this looks like for migrant workers of various temporary migration categories as provinces add immigration-based criteria to their health care policies.

Efforts to legally mobilize for migrants with precarious status to have the right to access health care for have been unsuccessful. For instance, courts have ruled that immigration status is not 'immutable', eschewing any systemic barriers that may prevent access to full immigration status (Chen, 2017), and by extension access to health care. Courts have essentially argued that migrants simply need to change their immigration status and they will then be eligible for health care. While domestic legal efforts have not been successful, they may present an opportunity to bring more visibility to counter narratives, discussed further in chapter six addressing reform and resistance. Having introduced the national legal context for health care access for medically uninsured migrants in Canada, the following chapter "Methodologies | Assemblages of Health Care Barriers" describes the research methodologies employed in this doctoral research.

Chapter Three.
Methodologies | Assemblages of Health Care Barriers

3.1 Introduction

This chapter provides an overview of methodologies used to conduct the empirical research for this dissertation. The first section of the chapter presents the research questions, followed by a rationale for conducting a local comparison of health care barriers for medically uninsured migrants in two Canadian cities. This rationale includes the basis for specific city selection (case selection), that is, Toronto and Edmonton. Second, governmentality is reviewed to assist with organizing the research method stages, spanning a discursive analysis of laws and relevant texts (law in the books) as well as qualitative interviewing and the importance of narratives or stories with the law (law in action). The third section focuses on the qualitative analysis, beginning with interview recruitment, as well as interview processes and data collection, followed by coding and analysis. Key challenges in designing and conducting the comprehensive approach undertaken are described, including limitations impacting the research, such as COVID-19, geographic and professional positionalities, gatekeeping, and deductive disclosure.

There are a wide range of distinct approaches to socio-legal methodologies, which are fundamental to investigating in instances when "…your research question is one in which you need to draw conclusions beyond what the law is" (Webley, 2019, p. 59). Most empirical socio-legal research beings with a well-defined research question that aims to investigate how specific laws or legal systems interact in society. As previously indicated, my research questions are organized by three themes, including:

1. Law in the Books: How have provinces a) interpreted the concept of 'universality' in the CHA and b) defined the eligibility criterion of 'residency' in their respective health acts? What barriers to health care are created for medically uninsured migrants at the

intersection of provincial and federal laws?

2. Law in Action: How do medically uninsured migrants and health care providers experience and navigate barriers to health care in practice?

3. Reform and Resistance: How can the experiences of health care providers, medically uninsured migrants, and civil society groups better support legal reform? What legal and extra-legal strategies are societal actors utilizing across territorial borders in their efforts to improve access to health care and legitimize the human rights of medically uninsured migrants?

These research questions were designed based on an identified gap in sparse Canadian literature that investigates health care access for medically uninsured migrants across Canadian cities and builds on important scholarship that has begun to analyze these issues, including the fact that a large proportion of research conducted to date is based primarily in Montreal (Cloos et al., 2020; Braband and Raynault, 2012b; Vanthuyne et al, 2013). Much of the existing research has documented a serious concern with the provision of health care services for medically uninsured migrants, with the majority of health care providers and administrative staff (n=237) surveyed expressing that access to health care is a privilege (Vanthuyne et al, 2013) and 50 percent of medically uninsured migrants reporting their health as negative (Cloos et al, 2020). Further research is necessitated to better understand how barriers to health care for medically uninsured migrants are manifested at the local municipal level across Canadian regions.

3.2 Local Comparison & City Selection

Undertaking a comparative study at the local level (city level) introduces a valuable site for comparison. Global migration trends are ultimately defined in local contexts. According to Julieta Nicoloa (2019) "...it is a fact that local areas lie at the heart of the complex relations between globalization, regional integration processes and public policies" (p. 74). While immigration laws and health laws are influenced by international laws and are crafted and defined at federal and provincial

levels, they are acted on in practice at the local level. Regional health authorities, health care institutions, and health care providers are tasked as the final temporal site in which health laws are interpreted and acted on in practice, making the local level an ideal site for comparing barriers to health care. The differences in health care eligibility and access across scalar levels and jurisdictions also requires serious consideration and helps to paint a broader picture of the barriers encountered across regional boundaries in Canada, Western Canada (e.g., Edmonton), and Eastern Canada (e.g., Toronto).

The common theme that connects each site of comparison is the fact that health care provisions are ultimately governed by the Canada Health Act and its principles of universality. All migrants with precarious status across provinces are also governed by national-level immigration laws and programs (and in some cases provincial nominee programs). At the same time, respective public health insurance program regulations differ from province to province, as well as community health programming. Both cities of Toronto and Edmonton hold unique political, cultural, and social differences irrespective of both being within Canada. To investigate health care access within one Canadian city only, would limit our understanding on the status of health care provisions for migrants with precarious status across the country. Likewise, to undertake a province-wide comparison would prove difficult within a doctoral dissertation project given the complex local histories, programs, and social movements across regions that vary widely even among neighbouring regions.

Toronto was first selected for this study due to my existing local relationships with social service agencies from my experience as a professional social worker working in the shelter system and also due to being my current place of residence. Edmonton was subsequently selected to be considered for this study. Toronto and Edmonton are both the largest city, or second largest city in the case of Edmonton, in their respective provinces. Also, of importance in my selection, each of

these cities has adopted some form of sanctuary motion at the municipal level, suggesting the existence of local social movements in support of migrant rights. Given that this research would have to take place digitally due to COVID-19 and the temporary but lengthy university bans on in-person research, it was necessary to select cities that were large enough to have some existing community programs or services for medically uninsured migrants. However, upon starting this research, it soon became evident that Edmonton has no official medical clinic for medically uninsured migrants. Nonetheless, I found it to be a city rich in community support and unofficial medical service provisions. Alberta and the prairies more generally were found to have less existing academic literature on the topic of health care access for migrants with precarious status compared to other provinces such as Quebec and Ontario, making Edmonton, Alberta an important local site to include, particularly given the fact that academic research may become a site of evidence if referenced in court challenges on denials of health care for medically uninsured migrants.

The local immigration histories and the public health histories at the provincial level paired with current day service provisions for medically uninsured migrants differ greatly at each site of comparison. This comparison is not designed to highlight one city's or province's response as better or worse than the other, but to wholistically understand the differences and the contributing factors that create barriers to care or opportunities for change in both locations. I am also eschewing assumptions that best practices from one locale may then be easily transferred to a new location. Comparative criminologist David Nelken (2010) proposes a comparative methodology focused on stretching the imagination of what else is possible, as well as focusing on differences as much as similarities across space and time. To that extent, I hope to identify and share strategies of resistance and/or policy solutions from both locations in an effort to help reduce barriers to care.

3.3 Governmentality as Method

As previously described in chapter one, this research employs governmentality as a research method to help investigate the government (i.e., processes, techniques, discourses, and rationalities) of migrants in their effort to access health care in Toronto and Edmonton. By researching these 'assemblages of health care barriers' in both cities, I focus my attention to the types of processes and techniques engaged in the government and the subjectification of migrants in their effort to access health care. I described the discourses that work to normalize barriers and denials of care and explained how racial capitalism best describes the veiled political rationality that contributed to the naturalization and racialization of differentiated labour. In line with governmentality scholarship, I employ the concept of government as a verb, which is the mobilization of individuals to govern themselves, which can occur both within and external to the policy field. While this dissertation does not involve an ethnographic study, this specific approach to governmentality employed is referred to by Brady and Lippert (2016) as an "ethnographic imaginary" perspective – which ultimately holds strong methodological value as described further in this chapter.

Analysis of Laws and Local Histories

Drawing from this "ethnographic imaginary" approach (Brady & Lippert, 2016), I begin my research with a systematic discursive analysis of laws and materials available from archival research (provincial and federal immigration and health laws, regulations, case law and international protocols), including local immigration histories and key municipal motions. This analysis allows first, for a deeper understanding of recent historical changes in health care and immigration programs, laws and regulations, specific institutional lexes, as well as jurisdictional and scalar divisions of power. In Chapter 3 and Chapter 4, an analysis of local histories and provincial health laws helps to establish

the legal governance (i.e., practices of government) of migrants' health entitlements in each city and province (law in the books).

To help set the national context, the creation of universal health care in Canada is traced from its origin to the present in Chapter two, noting the ways in which exclusion has always been an element of Canada's 'universal' health system as well as the ever-changing and evolving nature of health care laws in Canada. The work of Canadian and Indigenous health and public health historians (Deber, 2017; Jones; 2019; Lux 2018; Simner, 2020) as well as immigration historians (Troper 2003; Noh & Kaspar, 2003; Anisef & Lanphier, 2003) is particularly essential to this multi-scalar analysis.

While a systematic discursive analysis of identified texts is helpful in mapping the relevant groundwork of legal complexes and assemblages of health barriers in each province (Alberta and Ontario), it does not fully account for the practices and experiences of various actors in-action (e.g., health care providers, migrants with precarious status, etc.) nor does it fully account for the issues and conflict surrounding access to health care. Nonetheless, the narratives of individuals directly experiencing being medically uninsured or those engaged professionally in providing or denying care are fundamental to better understanding these techniques of government. The next section outlines the qualitative interviewing methods employed to analyze access to health care of medically uninsured migrants.

Qualitative Interviewing & Narratives

Unlike more traditional Foucauldian approaches to governmentality that eschew sociological interpretations, this research treats individuals' narratives "...equally as a source of insight into problematizations, rationalities, and technologies for governing" (Howard, 2016, p. 137). This key emphasis on individual narratives as a significant source of insight in understanding access to health

care for medically uninsured migrants is instrumental to my doctoral research methodology. To better investigate the experiences of health care access for medically uninsured migrants, I employed in-depth interviews with health care providers, civil society groups and migrants across both cities (n=30) (i.e., law-in-action). Eighteen interviews were conducted in Toronto (health care providers: n=15, migrants n=3) and twelve in Edmonton (health care providers: n= 5; NGO employee and/or civil society group member: n=4; migrants =3).

The use of qualitative methods is paramount to investigating the law-in-action and reform/resistance research questions, providing more depth and insight to a systematic discursive analysis. Since narratives and meaning derived from interviews are instrumental in identifying acts of resistance and potentials for reform, my analysis requires diverging from a traditional Foucauldian concept of discourse, which methodologically discredits any interpretive work. Interviews help to address how health care providers perceive the ethical obligation of providing non-emergency care, how they interpret the laws that govern their work, and the administrative steps they utilize when resisting restrictive policies that deny care. Health care providers are also best positioned to provide strong insights into provincial legislative changes on health care funding and programs as well as helping to detail necessary histories that contextualize present day access to care. Interviews with migrants who are medically uninsured are foundational to this study, as they are best positioned to share their personal, lived experiences with accessing or attempting to access health care services in Edmonton and Toronto, including the barriers or issues they experience as a result of restrictive health policies (e.g., "nothing about us without us" research principle). Interviews with migrants are also important to examining the realities of immigration law and programs and how they connect and disconnect with provincial health law in ways that are not always apparent to health care professionals.

Recruitment

Interview subjects included medically uninsured migrants, health care providers (i.e., nurse practitioners, physicians, specialists, coordinators etc.), NGO staff, and civil society group members. Local politicians were not interviewed for this project, as the aim was to highlight the experiences of those who work more closely and regularly with migrants as well as medically uninsured migrants themselves. This section outlines how subjects from each group were recruited for this project.

My previous work experience with medically uninsured migrants in a Toronto drop-in centre, as well as volunteer service in several NGO's that worked with refugees helped provide me with local institutional knowledge as well as a professional network to engage in interviewing for this project. Prior to commencing interviews for this doctoral project, I had completed roughly 30 research interviews for another Canada-wide immigration law project, which assisted me greatly with forming professional relationships that conveniently overlapped with this doctoral research. This external project also included coding two-hour long interviews with migrants living in Alberta and Southern Ontario, which provided me with a strong base of knowledge regarding some of the specific issues migrants experience with employers, health care, immigration applications, housing, and local communities. Due to limitations in the project's multi-university ethics certification, I was unable to draw references or quotes from these interviews for my doctoral research. These experiences and professional relationships nonetheless provided an instrumental knowledge base for beginning this dissertation.

A letter summarizing this doctoral project's intent and need for interview participants was emailed and faxed to health care organizations requesting interview participation. Dozens of organizations and individual health care providers were contacted over an 8-month period. Different types of health care institutions were contacted to capture a variety of responses and perspectives, such as Family Health Teams, Community Health Centres, and volunteer or NGO-based clinics.

Unfortunately, no Family Health Team responded to participate in this project, which is not unexpected given that most do not have funding for medically uninsured migrants. A flyer was also circulated on twitter; however, no new interviewees were recruited through this method. Through snowball method, participants often volunteered to share information about this study to their colleagues internally or externally at other organizations. Civil society organizations were identified through public knowledge of their organizing efforts, and often recommended sources by health care practitioners. Notably, response rates were faster and easier to organize among Edmonton participants in comparison to Toronto. This is not surprising given the size of Toronto in comparison to Edmonton and the higher amount of research projects being undertaken on migrant health at this time.

While my doctoral project primarily included interviews with health care providers and NGO employees, special ethical considerations were required for recruiting migrant participants and conducting interviews with medically uninsured migrants (n=6). Due to the sensitive nature of interview topics (i.e., precarious migration, risk of deportation etc.), additional preparedness and considerations were imperative as discussed in the next.

3.4 Interviews

Interviews With Migrant Participants

Migrant participants were an integral group in my research. Research methods included conducting these interviews over Zoom and utilizing an external audio recorder to record the meeting audio only. Conducting interviews over online programs such as Zoom and recording audio only when compared to conducting interviews in person presented new challenges and opportunities throughout the pandemic. Drawing from Spies et al., (2019) Skype Preparation Checklist and Clark-

Kazack's (2017) Research Guiding Principles, the following steps were undertaken. First, due to safety considerations and fears which medically uninsured migrants may have, some participants could feel uncomfortable conducting interviews while using the video function. Participants were given the option to start the meeting with audio only and one participant chose this option. Zoom meetings were also password protected to prevent uninvited guests from joining. Prior to starting interviews, relevant referrals were collected from participants' local communities (i.e., local agencies that provide relevant resources, health care NGOs, counselling hotlines). In the event that an interview's discussion elicited an emotionally challenging response, a handout sheet was prepared for circulation. Ultimately, the wellness of research participants was prioritized over the research objectives of this project in interviewing.

A clear power imbalance exists between a Canadian citizen-doctoral student with white privilege studying issues that impact migrants with precarious status while simultaneously being the recipient of government grants (e.g., SSHRC, OGS, etc.) to do so. This project required the ongoing work to maintain awareness of my own positionality and biases as well as ongoing work to develop mutual trust with all participants. There is an unfortunate tendency for certain marginalized communities to be over-researched while simultaneously they are under supported. Research funding was requested and granted by the university to provide all migrant participants in this project with $35 cash instead as an honorarium for their time, instead of more commonly presented gift cards for their participation in 25-to-45-minute interviews.

Migrant participants were asked open-ended and broader questions about themselves, starting first with their own story and journey, sharing whatever details that felt important from their perspective first, and then moving into more specific questions about health care access. Interview findings were enlightening, imparting a variety of stories and techniques that participants utilized as

they navigate access to services locally, which are shared in following chapters (see Appendix A for a full list of questions).

Interviews with Health Care Providers

When it comes to health care provisions for medically uninsured patients, previous research indicated that the personal ethics and decisions of individual care providers played a significant role. For example, when looking at the attitudes and ethical beliefs of health care providers in Calgary, Mattatall (2017) surveyed medical staff who provided health care services to uninsured women delivering babies between 2013-2016. Survey findings indicate large discrepancies between whether or not providers charge for their services, and whether or not providers believed they were ethically responsible to provide non-emergency care for uninsured persons. For example, 78 percent of obstetricians accepted uninsured patients for maternity care, with only 58 percent charging (Mattatall, 2017, p. 1019). These substantial differences in ethical views and the way health professionals practice care are thus an important element for understanding the assemblage of health care access for medically uninsured migrants. Health care providers (n=20) were asked questions about their experiences providing care to medically uninsured migrants, the layout or structure of their organization in terms of procedures (e.g., discretionary funds), ethical views, as well as any changes they would recommend (see Appendix B for full list). One of the most impactful elements of interviews with health care providers includes stories that were shared about their work with uninsured patients and the challenges they encounter with respect to providing care and navigating public health policy.

Interviews with Civil Society Groups and NGOs

Interviews with civil society group members and NGO employees (n=4) included more than four individuals, since many other interviewees such as physicians or midwives were (or previously were) participating in civil society group organizing or migrant justice advocacy and therefore could have been categorized under either category. Nonetheless, interviewees in this category work closely with migrant workers in Canada, often including migrants who are medically uninsured or navigating private health insurance through their employers. Interviewees were asked about their organization and the work that they do, any health care access issues they are privy too through their work as well as their opinions on how to create change or improve conditions for medically uninsured migrants (see Appendix C for full list). Many interviewees in this category shared unique insight into the day-to-day issues that migrant workers experience, having provided direct support in a variety of ways, from hospital drop offs to campaigning around specific issues.

3.5 Qualitative Coding & NVIVO

While each research project has a set of specific techniques for the collection, evaluation and analysis of data, Nowell et al., (2017) posit it is ultimately the researcher's responsibility "…to assure rigour and trustworthiness" (p. 2), which can be facilitated through a detailed reporting on the methodologies that are employed. Every interview conducted was audio recorded, professionally transcribed by the same transcriber for consistency, and added to NVIVO software to be qualitatively coded. Interview coding (n=30) was in part informed by the theoretical framework outlined in my chapter one, which combines scholarship on racial capitalism, critical legal geographies, governmentality, jurisdiction and discretion, migration and Indigenous relations, as well as governmentality. Since data collection and analysis was constantly occurring simultaneously while interviews were in process (Maher et al., 2018), a preliminary coding template was established before commencing coding based on emerging themes and topics from my interview notes, theoretical

framework, and initial legal analysis. Examples of codes derived from my theoretical framework include codes such as: space or scale, time, racial capitalism and reform and resistance to name a few. Interview notes led to the creation of codes based on common themes or topics of discussion, such as: rationale for providing care, rationale for not providing care, racism or biases, advocacy, COVID-19, language and translation, important quotes, recommendations, law & policy (child codes for various jurisdictions), and migrant experiences (e.g.., child codes: health care access, fear, threats, positive experiences, finance, death) to name a few. New codes were added throughout the coding process when a new theme or topic of importance appeared to emerge.

Coding with NVIVO helped to organize important passages by theme, aiding the analysis of health care accessibility for medically uninsured migrants across locations. Additionally, Toronto and Edmonton transcripts were coded under two separate projects with the same initial coding framework to allow for a clearer analysis of local differences, and to avoid data from one location clouding analysis in another. This was particularly important since more interviews were conducted in Toronto. The use of qualitative coding provided a highly organized method for organizing participants narratives, allowing for a clear analysis of law-in-action, resistance and potential for reform. As well, doing so provided an insight into the problematizations, rationalities and techniques of government used in the assemblage of health care for medically uninsured migrants. A methodological decision informed by Brady and Lippert (2016) was made to include significant quotes and passages from interviewed participants to allow their narratives to speak for themselves, and to provide as much context as possible to their experiences throughout this dissertation. Upon the completing of coding for each city in NVIVO, narrative passages were re-read and analyzed code by code simultaneously, while writing each chapter and addressing core research questions. It is important to specify that interview quotes were not edited for style, language or grammar, in effort

to respect the participant's choice of words and individual style of speaking.

3.6 Limitations & Discussion

"Gatekeepers" and Relationship Building

Ultimately, conducting interviews with medically uninsured migrants for this dissertation was more difficult due reduced direct connections since leaving my previous role as a social worker in a Toronto drop-in centre, where I worked with medically uninsured migrants. Often, academic researchers external to migrant communities rely on various "gatekeepers" to help facilitate interviews, such as NGOs, civil society groups or community leaders, which creates an additional level of considerations for maintaining confidentiality. At the same time, there are complications to relying on gatekeepers to help facilitate research. As Stachowski (2020) warns, gatekeepers can become seen as the face of the research they are circulating, and thus, involuntarily become associated with the project. As a result, in order for gatekeepers to be comfortable sharing a research project, they must trust the intentions of the researcher, to ensure that no potentially unethical conduct by the researcher may impact their local reputation.

Since I initiated research interviews with health care providers and social workers first, I reached out to previous service provider interviewees who were best positioned to share the research poster developed for a call for research with their service users, members, or community connections who were medically uninsured. Details of the poster indicated that interviews with migrant participants would last approximately 30 minutes, and participants would be compensated with a $35 e-transfer. I formally requested university funding to be able to pay migrant participants, which if unused, would remain with the university. In my request to circulate my call for research participants to gatekeepers, I also noted that I was committed to sharing an executive summary of

my findings distinct from my dissertation and have received offers from a knowledge translation specialist to help facilitate this process.

I received two different reactions from gatekeepers when requesting their assistance in circulating my call for research participants with medically uninsured migrants. Those working directly in the health care industry and with medically uninsured migrants frequently offered to share the poster without hesitation, often expressing their appreciation for the research project and sharing sentiments to its importance. One major limitation they noted was my lack of translation services, which understandably impacted how many people with whom they could share the research call with as a limitation of this study. In comparison, two other gatekeepers reported that "migrants are not lab rats" (of course I agreed). Gatekeepers who, to my knowledge were most hesitant to share the call for research participants expressed their concern that academic researchers and NGO employees were getting rich from migrants, and in one instance noted that a payment of $35 for the 30-minute interview was "not very much." In these interactions, I explained that research incentive payments would be returned to the university if they were unused. I attempted my best to communicate how I understood this doctoral research to be important, particularly the ability to document denials of health care services in a Canada-wide study. Nonetheless, it was my perspective that trust unfortunately was not adequately developed with some gatekeepers as email requests were left unanswered, limiting the reach of the call for research participants in specific communities. Due to a strong dislike for academic researchers that was communicated directly by some gatekeepers, it is possible that my positionality was a barrier from the beginning. As one participant referring to migrant workers put it:

> … you have to protect them, because speaking out comes with a cost and for advocates who are working tirelessly right now, you know, do they want to participate in yet another research thing or another consultation where they've been burned every time. That's hard until there's trust, there's long term. So, it's about who do you get who has that trust is all… (NGO 2, Edmonton, 02/22).

These interactions likely stem from a history of research that has not adequately safeguarded or respected migrant participants. As a result, interviews with health care providers (n=23) were relied on more heavily in this project, with gatekeepers ultimately helping to facilitate interviews with migrant participants (n=6) whose insights and experiences are paramount to this project.

Deductive Disclosure with Small & Connected Communities

Maintaining confidentiality, anonymity, and privacy with participants is particularly important as migrants with precarious status may fear risk of detention, loss of jobs, status, or deportation if their identities and personal details are not adequately protected (Stachowski, 2020). In efforts to prevent deductive disclosure, researchers working in small migrant communities have opted to change the name of the location of their work, create pseudonyms, or intentionally change some information about the participants (Stachowski, 2020). At the same time, changing details of data can lead readers to feel unsure of the significance of the changes or influence how the validity of findings is interpreted (Kaiser, 2009). Additionally, research participants may not be comfortable with their identities or personal details being altered in research. While not ideal, at times, researchers may need to leave data unpublished in effort to avoid deductive disclosure if altering details is not possible.

While conducting interviews with migrant participants, I asked each individual if they had a pseudonym they would like to use in my research. I asked that the pseudonym not be a nick name, or a name by which others may recognize them by. Some participants indicated no preference, however one participant asked that their nick name be used. In this situation, an alternative pseudonym was ultimately used. Otherwise, this participant could be identified through deductive disclosure and in a worst case, her identification could potentially impact her future immigration hearings.

Due to the small number of migrant interviews (three in each city) and the reliance on gatekeepers to help facilitate connections, the only way to completely avoid deductive disclosure is by both withholding some details of their stories (e.g., specific doctors names, specific legal challenges reported by the media, exact ages and exact length of residencies). Ultimately, no substantive details were changed to limit concerns around the validity of interpretations, and instead, I opted to withhold some details only where necessary.

In the case of health care providers, all names were withheld, even in cases where participants consented to have their names used. Due to the small, connected nature of this field of study, publishing some participants names, may lead to the deductive disclosure of other interviewees who were not named. Additionally, some specializations of service providers were also withheld to avoid deductive disclosure. In some circumstances, in order to provide greater assurance of privacy I asked interviewees throughout the interview process the following, "I understand you consented to share this information; however, I want to confirm if it's okay to discuss or quote you on X given the sensitive nature of the topic."

This chapter has provided a detailed overview of the different methodological procedures utilized in effort to best addresses the core research questions. In essence, an analysis of laws and local histories, combined with qualitative interviews have enabled an empirical investigation of how health care access is assembled at the local level, and the ways in which barriers are produced and create uneven access to health care across space in Toronto and Edmonton. Ultimately, the narratives of research participants are privileged to the highest degree, which becomes more visible in chapters four through six where law in action is investigated.

Chapter Four.
Toronto | Tkaronto |

4.1 Introduction

This chapter investigates health care access for migrants with precarious status in Toronto, with particular attention to barriers to access and denials of care. A brief review of the City of Toronto's immigration history and its current demographics is first provided before exploring health care laws "in the books" versus health care services in "action." It is in this early Canadian history that racial capitalism as a rationality or logic of government becomes increasingly evident, since the state's federal policies relied on explicit racialized calculations in its development and expansion of Canada's society at the time. Next, Toronto's social movements and municipal motions supporting its status as a Sanctuary City are discussed. The purpose of this contextual grounding is to encompass how local beliefs about belonging and health may be recoded at the service provision level or provincial level. CRT scholarship further emphasizes the importance of investigating how racial hierarchies have been produced spatially across scalar levels, while a racial capitalist lens helps us view the gradual shift of Toronto's population as a reflection of the changing and precarious nature of Canada's labour needs. As such, it is important to consider Toronto's immigration history and acknowledge that its local borders are not historically fixed.

As public health care is operationalized provincially, this chapter also provides a curated review of key legislative changes from the 1970s to present. This review helps bring to light first, that there has always been resistance against Ontario's restrictive health care laws, and second, that public health care rules and regulations have never been set in stone, frequently changing over time. This section begins to address the first research question for the law-in-the-books theme, investigating how Ontario's health laws have interpreted the CHA and defined residency for OHIP eligibility, and the ways in which narrow interpretations may result in denied care. Techniques of

government are identified here to highlight how competing governing authorities are involved in changing rules for different categories of migrants at the provincial level, signalling at times inclusion and more often exclusion for migrants with precarious status.

This chapter also explores what access to health care for migrants with precarious status looks like today, including the different types of institutional sites as well as key findings from interviewed participants (n=18). This investigation reveals how a cultural norm has formed that positions' both the denial of health care and the increase in charging for care for medically uninsured migrants as acceptable practice. CLG themes of space and time are privileged in this analysis. Specifically, they help to investigate the consequences of waiting and delayed care, as well as how federal and provincial health care laws have been spatialized locally, ultimately shifting boundaries of state sovereignty across medical offices in the process. Further, drawing on the law-in-action theme, this section also addresses the enforcement of the criterion of residency and eligibility across different health care institutions, as well as how health care providers and migrants report barriers to accessing health care services in practice. This section ultimately demonstrates how the technique of systemic denials for health care by employers, health care institutions and government agencies ultimately work to normalize delays, denials and barriers of care by recrafting who belongs and doesn't belong in the process. Empirical findings are also highlighted, particularly the effects of governmental power in these assemblages. Key themes include inconsistent hospital billing, large down payments, and facility fees; different standards of care and pre-mature risk of death; interprovincial billing; medical specialists and profiteering; Covid-19 and temporary billing codes; discrimination, racialization and impacted service delivery; language and translation; and the governance of immigration status. The chapter concludes with a summary of key findings and posits that the systemic barriers and denials to health care for migrants with precarious status is supported by the dominant political rationality of racial capitalism.

4.2 City of Toronto/ Tkaronto

In effort to disrupt Canadian national mythologies (Razack, 2002) and to support ongoing treaty obligations, this section begins with recognition of the Indigenous territory in which Toronto is situated. The City of Toronto is also known by the Mohawk term Tkaronto, meaning "the place in the water where the trees are standing" and is the traditional territory of the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples. Today, Toronto hosts many Indigenous peoples, including the Inuit and Metis. The city is governed by the Dish with One Spoon Wampum Belt Covenant, a treaty that was originally made between the Haudenosaunee and Anishinaabe, however, all newcomers were subsequently included into this treaty. The "dish," sometimes referred to as a "bowl" is said to represent the territory whereas the "spoon" represents the peoples living on the land and using its shared resources with mutual respect, friendship, and peace. Historically, Toronto was a "place of bounty," a "seasonal meeting place," and a place for "trade and ongoing council" for many Indigenous Nations, however, as artist Ange Loft (2021) of Kahnawà:ke Kanien'kehá:ka Territory describes, "Toronto did a lot of forgetting to become what it is today" by renaming rivers in French and English as well as updating its maps (p. 17). Toronto has also been subject to the Toronto Purchase Treaty No. 13 (Treaty 13), in 1805 when the Mississaugas at the Bay of Quinte and the Mississaugas of the Credit purportedly "sold" their lands of the Toronto Purchase Treaty to the City. Nonetheless, according to the Mississauga of the Credit First Nation (2017), many years after the official sale, the sale deed was found blank and without description of the land "purchased" by the Crown, throwing its entire legitimacy into question (p. 1). It wasn't until 2010, twelve years after the Mississauga of the Credit First Nation first filed a lawsuit against the Crown for unlawfully acquiring their land, that the Government of Canada finally agree to a settlement of $145 million (Mississauga of the Credit First

Nation, 2017). These Indigenous roots are important to this research because Indigenous and immigration populations, both which are substantial in size and growth in Toronto, share similar struggles. As such, their histories impact significantly Toronto's cultural, political and social character.

Brief History & Demographics

As previously discussed in chapter one, racial hierarchies are understood to be produced spatially across scalar levels. As such, it is important to consider Toronto's immigration history and acknowledge that its local borders are not historically fixed. Further, borders are understood to work primarily in the interest of capitalism through "social relations of dominance" (Walia, 2021, p. 6), therefore it is necessary to investigate how this developed historically leading toward the present-day economic arrangement whereby fewer human rights and protections are recognized for migrants with precarious status. During the era of Confederation to the turn of the century, federal immigration policy streamed non-British and non-American immigrants, many of them Eastern Europeans, who were allowed to enter Canada, away from city centres like Toronto, and into rural and labour-intensive disciplines, such as mining, lumbering, and construction (Troper, 2003). Migration of others, mainly Black, Jewish, and Asian people, was either barred or strictly regulated. For example, Walker (2012) documents how in 1793, Upper Canada introduced a gradual emancipation act through the legislature, which prevented any new slaves from being imported, and required that children born into slavery were to be made free by age of twenty-five (p. 16). Nonetheless, members of the legislature at the time were slave holding members. Therefore, this gradual emancipation act did nothing to free any slaves. Nonetheless, Walker (2012) highlights that it was "…unparalleled in British North America and served as a catalyst for the withering away of the

institution elsewhere" (p. 16). In the Post-Upper Canada era, Benjamin Drew (1856) documented how most Black people living in Toronto at the time were refugees fleeing slavery and indentured labour from the United States. Drew (1856) estimated that of Toronto's population of forty-seven thousand at the time, roughly one thousand were Black people. While Drew (1856) documents the testimonies and first-hand stories of ten Black men living in Toronto following horrific experiences of bondage and forced labour in the South, Walker (2012) also documents that despite the British Empire's abolition of slavery in 1834, that the abolition of white supremacy and the law's role in securing racial hierarchies were maintained in practice.

During this era, Toronto's population was largely of Anglo-Saxon heritage, although by the early 1920s, racialized immigrants started to seek out jobs in Canadian cities and xenophobia steadily increased. Toronto served as the location for many of Canada's economic industries' centered administration and commercial centres, making it unlike major US cities at the time that saw their immigration levels increase at much higher rates (Troper, 2003). Prior to WWII, most racialized immigrants to Toronto settled in a few neighbourhoods such as the Kensington Market area. However, as Troper (2003) documents, these neighbourhoods were considered an "area apart from the city, in the city but not really an organic part of its urban core" (p. 22). When Canada reopened to immigrants after WWII, Canada's federal immigration policies demonstrated a clear prohibition against so called undesirable immigrants from Southern and Eastern Europe as well as migrants of Jewish, African, or Asian descent, based on the rationale that migrants of these ethnic or national backgrounds were allegedly unable to contribute to service industries or that training would be too costly to the Canadian economy (Noh & Kaspar, 2003, p. 317).

By the 1960s, Toronto's geography began to see more distinct racially segregated neighbourhoods, in part due to kinship networks and practices of offering room and board to newcomers but also due to systemic discrimination in housing (Murdie & Teixeira, 2003; Noh &

Kaspar, 2003). At the same time, the pool of Europeans wanting to come to Canada dried up as their economies recovered, talk of human rights began to take hold, and the race-based immigration prohibitions at the federal level began to evolve. Federal regulations in 1962 for the first time reduced the significance of race as the major consideration of selecting independent immigrants, substituting skill, education and training instead, although preferences for certain countries of origin continued to apply to family migration (Troper, 2003, p. 40). The 1967 regulations, the precursor to the 1976 Immigration Act that formally instituted the point system for independent immigrants, finally removed all race-based criteria from Canada's immigration laws. In addition, major changes to the adoption of multiculturalism as official government policy (first in 1971) (Troper, 2003, p. 45) attracted yet more immigrants to Canada's biggest city.

As migration to Toronto began to increase to even higher levels in the following decades, with 42 percent of the population born outside of Canada in 1996 (rising to 51.5 percent a decade later 2016), Toronto adopted the moto "Diversity: Our Strength" in 1997 and amalgamated its six constituent municipalities in 1998 (Anisef & Lanphier, 2003, p. 3; City of Toronto, 2017, p. 5; Ahmadi, 2018, p. 64). Toronto's amalgamation was widely recognized as part of the Harris administration's (Ontario premier Mike Harris, Progressive Conservative Party, 1995-2002) cost saving measures. Nonetheless, as Donya Ahmadi (2018) posits, such discourse on the one hand demonstrates popularity among city residents for the terminology of diversity, while on the other hand, diversity as adopted by the City can be viewed as an "instrumentalist" approach, supporting only "desirable" diversity that can be measured in profit and economic gains (p. 64-65). Such an instrumentalist approach to diversity is documented in inner-city neighbourhoods which benefited from both city-based and private sector-based development plans, with more racialized and lower income neighbourhoods, such as Jane and Finch receiving insufficient attention and policy interventions (Ahmadi, 2018). Highly racialized inner-city neighbourhoods that have been the centre

of redevelopment projects from the City of Toronto have often resulted in the forced displacement of residents who, in the case of Regent Park for example, had found their community to be a "…well-connected neighborhood with a great downtown location" as well as having a "…mutual understanding based on the shared experience of poverty, and political strength based on shared struggles" (August, 2014, p. 1323). This history is strongly reminiscent of Halifax's destruction of Africville a few decades prior.

Jumping forward to today, Toronto now has one of the largest immigrant populations in all of Ontario, with 1,286,140 or 46.6 percent of the population born outside of Canada (City of Toronto, 2022, p. 1). Based on the past 10 years, Toronto also has the largest number of recent immigrants relative to Canada as a whole, at 29.4 percent. In 2016, Toronto was home to 17.5 percent of all recent immigrants, compared to its population which comprises 7.8 percent of Canada's total population (City of Toronto, 2017, p. 4), making Toronto among the top chosen cities for resettlement among newly arrived migrants. Among Toronto residents, 55.7% of the population identified as being racialized in the 2021 Census, with the top three largest groups being South Asian (14 percent of total 2021 population), Chinese (10.7 precent), and Black (9.6 percent) (City of Toronto, 2022, p. 2). Toronto also has the largest Indigenous population in Ontario. In 2016, 46,312 individuals identified as Indigenous, though agencies working with Indigenous peoples estimate that the local Indigenous population is closer to 70,000 residents (City of Toronto, 2017), representing roughly 1.7-2.6 percent of the total Toronto population. In 2021, this data shifted to 5,870 people identifying as solely Indigenous ancestry, with 24,150 individuals identifying as a combination of Indigenous and non-Indigenous ancestry (City of Toronto, 2022, p. 2), representing a large decrease in Indigenous populations between 2016 and 2021 of close to 10,000 people. It is possible that this data is skewed based on less self-reporting of Census data during the COVID-19 era.

Toronto's distinct demographic, political and social histories have helped shape and inform its local social movements, as well as health care and social service needs which are funded at the provincial level. Toronto is thus a useful starting point before unpacking the status of health care services for uninsured migrants today. As the largest city in the province of Ontario, and indeed in Canada, representing roughly a third of its total population, it stands to reason that Toronto's local actors, social movements, population needs, and health care institutions have had a significant influence on policy making and funding decisions at the provincial level.

Social Movements & Municipal Motions

Local histories are helpful for identifying new possibilities for reform at the local level through investigating past successes or failures. Toronto has been the home to decades of social movements lead by multiple religious organizations, as well as civil society groups organizing around migrant justice issues, from church sanctuary and school access for non-status youth to city-wide level municipal motions. This local history is essential to understanding local movements in support of medically uninsured migrants today, whereby reform and resistant becomes possible through the dismantling of systems that create exploitation and by expanding the freedom of movement for migrants with precarious status in Canada (Walia, 2021).Contemporary sanctuary city motions of the 21st century typically have their histories rooted in church sanctuary movements, for example, when churches grant residency and shelter to migrants facing active deportation orders typically on denied refugee claims. Although the Arizona church sanctuary movement that occurred in the early 1980s stemming from liberation theology is well documented, Randy Lippert (2005) explains that in the Canadian context, church sanctuary can be traced back to 1983, but due to the lack of documentation, the movement's origins are more obscure. Canadian churches, however, were

known to apply screening procedures and norms similar to those of the IRB when considering offers of sanctuary, arguing that they were upholding misinterpreted and wrongfully applied refugee law (Reehag 2009).

In 2004, the City of Toronto was first presented with the request for a complete Don't Ask Don't Tell (DADT) motion – also commonly known as an Access Without Fear (AWF) motion -- from 23 local community groups (Solidarity City Network, 2016). This request was initially rejected. The City of Toronto circulated a new poster in lieu of an official motion, titled "The City of Toronto provides services to residents regardless of immigrant status," listing services such as museums, festivals, and waste transfer. The poster also incorrectly identified the Toronto Police Services as an accessible service for migrants with precarious status (see Appendix D). McDonald (2012) documents how at the time, in the early 2000s, No One is Illegal Toronto (NOII), a migrant justice focused civil society group, began providing its advocacy focus on the city itself, whereas other group chapters had been previously focused more heavily on national level policies. In partnership with the Ontario Secondary School Teacher's Federation and local community members, and under the slogan of "Education not Deportation," the DADT campaign was able to secure a declaration from the Toronto District School Board (TDSB) that all schools would remain spaces of sanctuary zones (p. 140). This TDSB policy was made possible through strategic and consistent focus from the DADT campaign and was adopted shortly after the publicization of two high school students who were arrested at their school and subsequently deported (McDonald, 2012). It is important to note that the TDSB sanctuary policy experienced backlash from the local Toronto Police Services Board, as well as the Canada Border Services Agency. Nonetheless, this early sanctuary policy win helped set the context for further sanctuary policies that followed.

Leading up to the City of Toronto's interests in adopting new sanctuary motions, No One is Illegal (Toronto) member Chowdhury asserts,

> On the question of municipal politics, no we don't think it has a role to play in winning these changes. In fact, that's the very notion we are trying to fight against… Sanctuary City is about building ways of living that allow us to horizontally make decisions with collective communities, on the ground…(Nail et al., 2010, p. 1).

Or as group member Hasan states,

> …the opportunity is to change the imagination of Canadian society… What we are doing is creating a new form of power and political organizing that can, if done properly, radically reshape what it means to actually take on radical struggles inside neoliberal economies (Nail et al., 2010, p. 1).

A civil society member from a different civil society group in Southern Ontario, whom I had previously interviewed in 2016, discussed the importance of gaining a municipal motion, stating "Phase one, get the title. Phase two, deal with whatever that means after, implementing, and monitoring" (Anderson, 2016, p. 27). These passages demonstrate the complexity and multiplicity of views held among civil society groups on the role of government level changes when it comes to migrant rights in Ontario.

The City of Toronto's first sanctuary motion adopted in 2013 demonstrates the symbolic nature of its reach as well as the "game of jurisdiction" (Dorsett & McVeigh, 2012) over migrant rights across scalar levels and the struggle for authority between governments. On February 20th, 2013, Toronto passed motion CD 18.5, titled "Undocumented Workers in Toronto" by "re-affirming its commitment to ensuring access to services without fear to immigrants without full status or without full status documents" (p. 1), arguably becoming the Canada's first de jure Sanctuary City. As described by Mariana Valverde (2015), jurisdiction is a game that is always being played, both across scalar levels but also within legal systems. Because the City of Toronto has no jurisdiction over universal health care, it sent "requests" to the province asking that they ensure migrants gain access to health care and emergency services. The City also signaled a desire for more intergovernmental collaboration and asserted opinions on federal immigration policies. Critics were correct to point out the motion's limited reach. It is a stark contrast from previous U.S. based

sanctuary ordinances such as San Francisco's (1989) City and Country of Refuge ordinance, which explicitly rejected cooperation with federal immigration enforcement. Back in 2006, the City of Toronto also entered one of its first Canada-Ontario-Toronto Memorandum of Understanding (MOU) on Immigration (i.e., the only municipality at the time to entre such an agreement) and later signalled this same continued desire for intergovernmental collaboration over immigration with its most recent MOU signed May 3, 2018. Praznik and Shields (2018) document that this first MOU did little to shift power relations, with the federal government maintaining jurisdiction over immigration, yet it assisted with information sharing and consultations.

On June 10, 2014, the City of Toronto passed its second Sanctuary City motion, CD29.11, titled "Access to City Services for Undocumented Torontonians." Unlike the first motion which entailed a series of requests, the 2014 motion comprised a series of directions (rather than requests) such as "immigration information only be collected when required by Provincial or Federal legislation," including compulsory training, budget planning and annual reporting on progress requirements to name a few aspects. The 2014 motion was also accompanied by an "Access T.O" initiative, providing clear directives to city staff and community members on access as well as details on how to report denials of service. Following the adoption of multiple municipal motions, local organizers noted that little had changed (Solidarity City Network as cited in Keung, 2014, p. 1).

In December 2015, the City of Toronto adopted an additional motion titled "CD8.4 Access to City Services for Undocumented Torontonians: Progress of the Access T.O. Initiative" which directs City divisions to revise their approaches to customer service so that they include Access T.O material. A year following this motion, I had interviewed former Toronto city counsellor Mihevc who was involved in supporting the adoption of a sanctuary motion, in which he described the need as follows:

> Big business has put out this call for free trade, so money moves, all over the world… all in search of the cheapest this, cheapest that… and they

> argue this is about the freedom of money, well guess what batman? You're going to do that with money, people are going to follow the money. They are going to find a way to get to where they need to go, so they can live a basic life, and feed their families and so on. So, if you have a North American Free Trade Agreement . . . jobs are going back up, and back down… So, what you are seeing in the 21st century is the mass migration of peoples, in search of jobs and opportunities, and national borders. I guess they are important? But I guess they are becoming less important (Recorded Interview, in Anderson, 2016, p. 21).

This description by a local city councillor is in line with Bosniak's (2018) claim that all iterations of sanctuary entail some effort to contain the scope of the state's bordering procedures. When asked if the City of Toronto's sanctuary motions were in contradiction with other existing laws, Councillor Mihevc stated, "Sanctuary City is agnostic on federal law… we don't have an opinion on the righteousness, or non-righteousness of federal laws… we acknowledge facts on the ground, we live our life on the street…" (Anderson, 2016, p. 44-45). Taken from this perspective, the City of Toronto relied on logics of jurisdiction in the production of its sanctuary motions, which as a technique of government (Ford, 1999) is actively engaged in the creation of new legal subjectivities in its effort to expand inclusion, membership, and rights to migrants with precarious immigration status. Despite Toronto's efforts in securing multiple adopted sanctuary motions, health care remains largely beyond the scope of these municipal motions, despite health care being one of the most important public services that is inherently tied to the right to life. Responding to the limits of municipal sanctuary motions in 2017, the Ontario NDP's former leader Andrea Horvath publicly committed to supporting Ontario becoming a "Sanctuary Province," a first for a provincial leader in Ontario (Ontario NDP, 2017). Such statements demonstrate the struggle for authority over migrant rights across scalar and jurisdictional levels, with both municipalities and provincial level political leaders engaged in the attempt to recraft interjurisdictional policies that impact migrant's rights, membership, mobility, and belonging.

In addition to social movements in support of DADT and sanctuary policies at the municipal level, Toronto has also been home to significant health advocacy movements and more broadly migrant rights movements for decades. At the local level, over the past few years many groups which are largely comprised of health care providers, community organizations and community members have continued to advocate for health care access for medically uninsured migrants. These organizations include the Women's College Hospital Network for Uninsured and Undocumented Clients, Health for All, OHIP For All as well as Toronto's Health Network for Uninsured Clients among many other. As Healthcare Coordinator 2 describes, back in 2006 there "…was a real need for all of us health professionals to come together and coordinate our efforts and help with the problem-solving network that could help us deal with all the complex and nuance things that are coming in our way" (Toronto, 10/21). Healthcare providers would meet and develop informal and formal partnerships with hospitals and specialists, ultimately leading to a group of 40 health and service communities joining what is now called the Health Network for Uninsured Clients. These groups have been engaged in advocacy efforts using a variety of tactics such as conferences, presentations, demonstrations, open letters, educational teach-ins in health spaces as well as public information campaigns (Doctor 6, Toronto, 04/22).

This section highlighted some of Toronto's local demographics, its early interventions (i.e., early in comparison to other Canadian cities) as well as social movements in support of a Sanctuary City and healthcare access. These factors are important contextual background for investigating what local supports exist today for medically uninsured migrants in Toronto and how its local history, beliefs and populations have influenced the city today as an assemblage of health care barriers. In the following section, a brief history of Ontario's public health care laws leading to present day is investigated to assess what health care entitlements exist for medically uninsured migrants at the time of writing.

4.3 Law in the Books: The Governance of Ontario's Health Care Laws

This section first provides a curated review of key legislative changes that have occurred since the origin of Ontario health care legislation in the 1950s through to present day, exploring the ways in which different actors and interest groups intervened in its development. This review helps to bring to light the fact that there has always been resistance against restrictive changes to Ontario's health care laws, demonstrating that public health care rules and regulations have never been set in stone, frequently changing over time. Second, this section addresses the first research question of the law-in-the-books theme by demonstrating that the primary legal gatekeeping tool is the definition of "residency" in the Ontario Health Insurance Plan (OHIP). As we will see, a narrow interpretation has resulted in denied care and barriers to care. Such interpretation is essential for understanding how healthcare entitlements become smaller across each scalar and jurisdictional level.

A Brief History of Ontario's Provincial Health Care Laws: Expansion, Resistance and Contestation

This section provides a brief overview of major legislative developments and debates from the 1950s to the present that have shaped Ontario's public health care into the program it is today. Ontario currently operates "one of the largest and most complex publicly funded health care systems in the world," which required $67.8 billion in spending during 2020-2021 (Health Canada, 2022). As journalists have recently flagged, with 15 million inhabitants, Ontario spends $2000 less per person relative to the average amount that other provinces provide, meaning it would need to spend another $30 billion more per annum to reach provincial average figures (Nicoll, February 28, 2022). Originating in 1972, OHIP is administered by Ontario's Ministry of Health and governed by the Ontario Health Insurance Act (1990) on a non-profit basis. Significant legislative developments occurred leading up to the enactment of OHIP, through to present day. With each historical

legislative change, there was resistance either from the official opposition, religious institutions, civil society or physicians themselves.

In 1959, Ontario passed Bill 165, the "Hospital Services Commission Act," the first of many bills designed to implement a near universal health care insurance (Lavis & Mattison, 2016). Conservative Premier Leslie Frost is quoted at the time saying, "our objective in Ontario will be to attain as close to universal coverage, total coverage, as possible, premised upon good administration and other factors" (Simner, 2020, p. 3). Before Bill 165, many Ontario residents avoided hospital care due to the tremendous financial costs. Despite being only a voluntary enrollment plan and not compulsory, Bill 165 saw 5.3 million people or just over 90% of Ontario residents become insured beneficiaries of hospital care for the first time (Lieutenant-Governor of Ontario, 1959, as cited in Simner, 2020, p. 12).

Under yet another Conservative majority, Bill 136 "the Ontario Medical Services Insurance Plan" was passed in 1965, introducing fully subsidized health insurance for residents earning less than $500 per year. The Liberal official opposition responded to this bill in strong discontent:

> We are firmly committed to a universality in the Medicare plan for Ontario and we are disturbed, even shocked, at the government's hypocritical consistency in introducing a health services bill into this house which will not reach as many citizens of this province as are covered by our hospital plan. We are opposed to Bill 136 because it is a minimum-effort bill" (as cited in Simner, 2020 p. 13).

Likewise, in stark resistance to government's bill, NDP member Kenneth Bryden proposed to rename Bill 136 too "An Act respecting temporary and partial medical services insurance," (as cited in Simner, 2020, p. 14). Historian Marvin Simner (2020) documents that there was also significant public and religious resistance against this bill, with United Church ministers holding a two-day vigil at Queens Park, along with 75 ministers who gathered outside of the Premier's office, sending 15 members to talk with the premier about their dissatisfaction with the limited reach of bill 136 (p. 15).

The impact of the public's distaste for Bill 136 was ultimately quite significant. Despite receiving royal assent, in a highly unusual turn of events, the proposed Bill 136 did not actually become law.

Six months after the Bill 136 chaos, the Ontario government proposed Bill 6, "An Act to Amend The Ontario Medical Services Insurance Act." This bill would, for the first time, eliminate private insurance companies' regular health care insurance, and instead, the Ontario government would offer one standard contract from the Department of Health to all Ontario residents. Residents not already on welfare who wanted to enroll would pay on an annual basis $60 for an individual, $120 for a couple, or $150 for a family of three or more (Simner, 2020, p. 16). Individuals with an income below a specific cut-off could also apply for a 50% subsidy. At the same time, there was significant unrest among doctors at the time. Around 4500 of 6500 practicing doctors signed a declaration that was delivered to Queens Park during the reading of this bill, indicating that they rejected the bill, and would continue to bill patients directly and refuse to collect payment from the government (Simner, 2020, p. 18). In keeping with the Conservative party's preference at the time, this bill, like the previous ones, would not include compulsory membership, and doctors could personally decide to opt out of the province's plan. Due to the lack of compulsory membership, the Ontario government was unclear if their insurance plan would satisfy the Federal government's new up and coming cost sharing health care plan that was set to commence July 1, 1967 (Simner, 2020).

During 1968-1969, the next Conservative government under Premier John Robarts adopted Bill 121, "the Ontario Medical Services Insurance Amendment Act." Introduced again by the governing Conservative party, Bill 121 would reduce fees that doctors received. Previously the Ontario Medical Association (OMA) would set its own fees, however, the Ontario government found that fees had increased just prior to the OMA discovering that Ontario was introducing universal health care insurance. Bill 121 set out that the government would only cover 90 percent of the OMA's doctor fees, and not 100 percent (Simner, 2020).

To help satisfy the federal government's eligibility criteria for the Canada Medicare Act, Ontario passed Bill 195, "Health Services Insurance Act" (1969) (Lavis & Mattison, 2016). Bill 195 created a Health Services Insurance Council, to investigate if the OMA should independently establish rates on their own or not, and to investigate any complaints. Bill 195 also made coverage mandatory for firms with 15 employees or more, marking the first time any compulsory membership attached to Ontario's public health care laws (Simner, 2020). The policy changes throughout the 1950s and the 1960s to Ontario's public health care laws have been characterized as a "core bargain," in that they ended up maintaining the province's legacy of private delivery models when the payment system switched from a private to a public one (Lavis & Mattison, 2016).

In 1971, Bill 5, the "Ontario Health Insurance Organization Act," was passed, and was implemented in 1972. This bill combined the two health insurance programs, the Ontario Health Insurance Plan and the Ontario Medica Services Plan, becoming what is now know today as the Ontario Health Insurance Plan (OHIP). Today, the frequently amended Health Insurance Act R.S.O. (1990) continues to govern the operations of OHIP. 1971 also marked the Department of Health renamed to the Ministry of Health (Lavis & Mattison, 2016).

To help administer health care at a more local or regional level, in 2006, the Liberal government at the time established Local Health Integration Networks (LHINs) under the Local Health System Integration Act (2006). Between 2007 to 2021, LHINs were responsible for funding, planning, and integrating health care within their regions, including hospitals, community care centres, community health centres, long-term care homes, and mental health services. LHINs were delegated significant policy authority over many important local health planning decisions. As described by a doctor interviewed for this research, LHINs also held authority over provincial funding for clinics and organizations to access funding to provide care for medically uninsured migrants or populations made vulnerable, stating "From the ministry of health to the LHINs, there

was funding for each LHIN for vulnerable persons' health and care and we had gone to subregions at that point" (Doctor 3, Toronto, 01/22). They further described the change in size of LHINs: "…So many of the LHINs were that big and they developed these subregions planning tables to handle and break it down into smaller regions. Which I thought was a good step, bureaucratically heavy but a good step" (Doctor 3, Toronto, 01/22).

Effective April 1, 2021, however, the Ontario government under the Conservative leadership of Doug Ford transferred all of Ontario's 14 LHINs to a newly created centralized agency, Ontario Health (Ontario Ministry of Health, 2021). The elimination of regional LHINs was implemented through the Ontario government's People's Health Care Act and Connecting Care Act. Many health care providers spoke out against Premier Ford's elimination of LHINs. Additionally, the former Deputy Minister of Health indicated that because LHIN's health leadership role was not easily recognized or understood by the public, that they were perhaps an easier target for the Conservative government to eliminate (Bell, Nov 26, 2019). A review of Ontario's health care policies and institutional frameworks over the past few decades demonstrates significant changes from one political leadership to the next, as well as a jurisdictional tango over local or regional leadership in public health. According to interviewed participants, the creation of LHINs was instrumental to receiving specific funding for clinics to be able to work with medically uninsured migrants under the label of health care for "vulnerable" persons health. At the time of writing in 2024 it is unclear how the important role of regional leadership that was provided by LHINs will be replaced, however, the most recent health care policy changes in Ontario have signaled further privatization.

Presently, the Ford government has allowed for the violation of the CHA, whereby the profiteering of private COVID-19 testing has been made acceptable, with some companies charging $400 per test (Nicoll, February 28, 2022). In addition to privatized COVID-19 testing, in an unprecedented move, the Conservatives further extended 18,000 privatized long-term care beds with

30-year contracts assigned to for-profit companies, despite the fact that during COVID-19, the death rates of senior residents were twice as high in for-profit facilities compared to publicly funded long-term care homes (5.7% vs. 2.8% respectively) (Ontario Council of Hospital Unions, 2022; Nicoll, February 28, 2022, p. 1). Ongoing moves toward more private health care "innovations" by the Progressive Conservative government provide an important context for investigating the eligibility rules of OHIP today which signal a shift in the reduction of public health.

OHIP Today: Immigration Status, Ontario-born Infants & COVID-19

This section addresses this project's first research question (i.e., law-in-the-books), by investigating how provinces have interpreted the concept of universality and defined the eligibility criterion of "residency" narrowly in their provincial health regulations. Such interpretation is essential for understanding how healthcare entitlements become smaller across each scalar and jurisdictional level and reinforce racial capitalism.

Residency & the Precarity of Legal Status

Typically, in order to qualify for OHIP, a person must: (1), "be physically in Ontario for 153 days in **any** 12-month period," (2), "be physically in Ontario for at least 153 days of the first 183 days immediately after you began living in the province" and (3), "make Ontario your primary residence" (Ministry of Health, 2022). In addition to temporal requirements, contrary to the CHA that contains no such restrictions, Ontario has added immigration and employment requirements to its definition of insured persons.

More specifically, the Ontario government further requires that you fall into one of the following identities or situations, including being a: "Canadian citizen," "Indigenous person,"

"permanent resident," "applying to permanent residence" and have submitted an application to the IRCC who have confirmed you meet the requirements, have a "valid work permit" and "are working full time" for at least 6 months, "on a valid work permit under the federal Live-in Caregiver Program," are a "convention refugee" or "protected person," have a federal "Temporary Resident Permit" but only in certain cases, or are a "clergy member" who will be ministering full time for at least six months (Ministry of Health, 2022, p. 1). Finally, individuals who are granted "emergency authorization" to enter and remain in Canada for humanitarian reasons are also entitled to OHIP if they meet the first temporal requirements of residency. The Ontario government also indicates that "visitors" are not eligible for OHIP coverage and recommends that they purchase private insurance.

With respect to migrant workers, unlike Alberta, which will be discussed in the next chapter, Ontario provides OHIP coverage to migrants with Seasonal Agricultural Worker Program (SAWP) visas upon arrival to Canada. With all other categories of temporary migrant workers, employers must provide private health coverage for the first three months of residency, and then the employees switch to OHIP coverage after meeting OHIP's residency length requirements. This three-month waiting period could be characterized as an exercise of state power (Auyero, 2012) that is underpinned by ideologies of racial capitalism. Here, the province uses the techniques of public health policies eligibility criteria of waiting periods to legitimize the denial of state funded health care for migrants during their first three months in Ontario. According to interviewed participants, the concern with private health care coverage within the first three months of residency at the expense of the employer rather the standard OHIP coverage like in the case of migrants on SAWP visas is that often migrant workers have not been provided with the full details of their health care plans, or even worse, in some situations where they require access to their private health insurance, employers may be incentivized to discourage workers from accessing it in order to reduce their ongoing premiums. It is unclear why Ontario's migrant workers who are working legally across different

industries in Ontario have different entitlements to provincial health care (e.g., agricultural vs. service industries etc.), especially when there are documented concerns with this model. An interview passage from Lynn sheds light into the experience of too many migrant workers and the risks involved with having to rely on an employer for health care entitlements. She explains,

> But my first encounter with my employer is not really good. He just like because I don't know the community at that time because I'm just new here, it's happened that an employer did not follow what's written in the contract. Just a lot of labor dispute, it's supposed to be 40 hours a week, it gives us only 20 hours. And apart from that is that if the restaurant is slow. They used us to go to their farm, like to cut trees, that is not part in our labor contract. Yeah, and then the other ones that like, our first winter experience is just that we don't have safety winter gear to wear. So, we're shaking outside in the winter at that time. Yeah, those are the things that really, we like, not comfortable at the time but we cannot seek help. And after that, in Toronto during the time you cannot get the, what do you call it, the OHIP? (Lynn, 08/22)

Because Lynn's employer did not fulfill her work contract for 40 hours which she immigrated to Canada for, she was made ineligible for OHIP coverage. To make matters worse, she was stuck in a position where she was exploited for her labour to work outdoors on a farm and without proper protection when she had accepted a job and signed a contract for work in a restaurant. Lynn later explains, that after raising these concerns with her employer, her and the rest of her colleagues were laid off, placing them in an even greater status of precarity, without access to OHIP and without work. The topic of Ontario-born infants is another concern with OHIP rights in Ontario.

Ontario-born Infants & Denied Health Care

All infants born in Canada are considered citizens at birth according to Canada's Citizenship Act (Part 1, Section 3). Regardless of their parents' immigration status, babies born in Ontario are entitled to OHIP provided that their parent live in Ontario. Upon birth, either a registered midwife or hospital staff can provide a newborn's parent with an "Ontario Health Coverage Infant Registration" form. This form asks for the infant's name, address, birthdate, a declaration that the

baby's place of residence is Ontario, and confirmation that their child intends to live in Ontario for at least 153 days of any 12-month period. Both a registered midwife or a hospital can submit this form directly upon the parent's completion from the hospital or birthing centre. Unfortunately, hospitals are not legally mandated to issue an Ontario Health Coverage Infant Registration form to parents of newborns. As one interviewed midwife described:

> …it has to do with babies being denied OHIP because their parents don't have OHIP. Which is not the law but often the hospital system is refusing to issue and has even built it into their administrative systems that if one parent doesn't have OHIP then the baby doesn't get issued an OHIP card which is not the law. They're not following the law, it's not even the spirit of the law, they're not following the letter of the law and we have to fight offense on behalf of Ontarian, Canadian infants to get the access that they deserve (Registered Midwife 2, Toronto, 01/22)

This participant's account of hospitals not consistently issuing Ontario Health Coverage Infant Registration form is also identified by the Ontario government's website, which specifies that if hospital staff have not provided a parent with the necessary form, that parents should visit Service Ontario to apply for OHIP. As highlighted by the Health Network for Uninsured Clients (2020), delaying OHIP coverage to eligible babies may lead to delayed care, substantial costs for families as well as potentially adverse health outcomes for children. Another midwife discussed how previously, if one parent didn't have OHIP, it would be more automatic that the parents would be required to go to Service Ontario, stating that:

> …in the days when if one of your parents didn't have a health card then you also didn't automatically get a health card, you had to go apply in Service Ontario. So that case, everyone at the hospital was kind of scratching their head, they didn't know what to do (Registered Midwife 1, Toronto, 12/21).

One midwife described significant issues for babies who are born in a specific Toronto hospital who may require care in the Neonatal Intensive Care Unit after birth, describing:

> Which technically these are babies born in Canada, they're completely have access to a health card and yet hospitals are not giving them that access. And those things slide really quickly. Like (name of hospital) it's the same thing, they've decided if you're not in the 30 month

> wait for your PR, we've decided that's the only exception, that's the only definition of residency that they accept (Registered Midwife 1, Toronto, 12/21).

From this account, it is clear that hospitals in Toronto have adopted their own practices on the facilitation of health care or OHIP registry for babies born to medically uninsured parents, which based on participant interviews, varies greatly from one hospital to the next. Additionally, documented interviews as cited above illustrate that some of Toronto's hospitals have adopted their own definition of residency, which at times, differs from Ontario's own health care eligibility requirements, ultimately creating a third tier of criteria (i.e., CHA, OHIP, local health care institution) that becomes narrower at each scalar level. Requiring new parents to attend Service Ontario appointments (i.e., no online applications are available for Ontario Health Coverage Infant Registration form at the time of writing) to register their legally eligible babies for OHIP coverage is a major barrier to accessing care. There are limited Service Ontario offices in Toronto, with most requiring lengthy waits and no in-person translation services, whereas Toronto hospitals have access to translation services (language lines) to assist the parents of new-born infants who are not fluent in English. As indicated by one health care professional participant, not all Service Ontario offices will issue health care cards to migrants with work permits, further reducing options depending on their city of residence. According to the participant:

> …we try to book them an appointment at a service Ontario location and there's only one service Ontario location in their city that will serve people who are on a work permit and expiring. Like four out of five service Ontario locations do not process those applications….Only one place in their city they can go to and it's appointment only during Covid, there's no appointments til the end of December, it's November right now…If you look on the service Ontario website, you look at it and print out a location, a lot of them will have a notice at the top that's like you cannot access health card services here if and the only bullet on the list for a lot of them is if you have a work permit with an expiry date (Healthcare Coordinator 3, Toronto, 12/21).

These examples of newborn infants being arbitrarily denied healthcare cards at the hospital when the parents do not meet the definition of residency interpreted and adopted by the hospital (e.g., 30-

month wait for your PR) highlight some of the ways that the production of waiting for migrants with precarious status is relationally assembled not only by legal orders but also by institutional cultural norms. The discrepancy in service provisions across local health care institutions will be addressed in further detail later in this chapter.

Society and migrant justice movements have tended to position infants and children through an innocence framing, such as in the case of Toronto's DADT school sanctuary movement in the early 2000s discussed earlier. This framing is not unlike that of the political campaign for Dreamers – migrant undocumented youth in the United States. While infants and children should indeed be viewed deserving of rights and health care entitlements, this innocence framing has been criticized by positioning their parents and adults as less than deserving groups of the migrants with precarious status. Sirriyeh (2020) documented how in the campaign supporting Dreamers, youth were presented as "innocent, non-threatening, assimilated" and viewed as being able to make valued contribution to society (p. 3). Nonetheless this framing often operates in juxtaposition to their parents and adults, who are viewed as less deserving of rights. This is the case in Ontario, whereby infants born to migrants with precarious status receive health care entitlements, while their parents remain medically uninsured or at heightened risk of becoming medically uninsured based on their employment contract. Having addressed health care entitlements for infants, the following section discusses changes to OHIP pre and post COVID-19.

Pre-& Since-Covid: Eligibility for Health Care

At the time of research, standard OHIP eligibility requirements are commonly referred to by local health care professionals as "pre-Covid," as they have all been on hold as of March 25th, 2020, due to a temporary regulation change (i.e., Ontario's Bulletin 4749: "Temporary Billing Codes"), making

all residents physically present legally entitled to public health care provisions. These Temporary Billing codes were in effect throughout all fieldwork conducted during this research and were discontinued in March 2023.

As of March 25, 2020, the Ontario government, under the leadership of Premier Doug Ford, introduced Bulletin Number 4749 "COVID-19 Expanding Access to OHIP Coverage and Funding Physician and Hospital Services for Uninsured Patients." Bulletin 4749 waived the three-month waiting period, also indicating that it will be "…reinstated at a future date" (Ministry of Health, 2020). In addition to eliminating the three-month waiting period, the government introduced "temporary billing codes" that allowed physicians in clinics and hospitals to bill the Ministry of Health for services provided to uninsured patients. These temporary updated regulations were the result of ongoing advocacy efforts from many health care advocates. As a result of these temporary billing codes, interviewees refer to their work experiences as "pre-covid" and "since-covid," as it has had a tremendous impact on their work with uninsured patients (e.g., "I mean, yeah there's before the pandemic and since the pandemic…" (Registered Midwife 2, Toronto, 01/22).

Prior to Bulletin 4749, patients experiencing COVID symptoms were documented by NGOs and clinics as being turned away from hospitals unless they offered payment upfront. For example, The Canadian Centre for Refugee and Immigrant Health Care posted publicly on March 12, 2020, the following experience:

> On March 6 2020 a recently arrived Permanent Resident to Canada walked up to our Refugee Centre. He was coughing, fever, muscle aches, worsening shortness of breath, growing uncomfortable. Since arriving in Canada 2 months earlier he was attending ESL classes when he became ill. A number of his classmates from Iran were coughing, unwell. We assessed him (full PPE) then contacted TPH. "Send him to hospital if you feel there is a concern? Have him tested We have all newcomers with risk of COVID in voluntary isolation/quarantine, including all those with symptoms from Iran." We contacted our hospital ER, explained all of the above, and they agreed to see the patients. The nurse I spoke to knew he was uninsured. We masked our patient, provided a face shield and they drove to the hospital ER with a letter in hand from the Clinic. Our patient was seventy days into the 90 day wait to be eligible for OHIP when he became ill. He knew he was a medically

> uninsured newcomer without access to care, one of about 200,000 PRs who enter Canada each year. In 4 provinces they face the 3 month wait. Our patient knew the hospital might ask him to pay up front to be tested. Like most newcomers they (his wife) didn't have the money. They came to our refugee cliic (clinic) for uninsured newcomers. I called the family the next day to follow up. The patient never did get seen or treated at the Hospital ER. Not tested either. They arrived to the ER but could not produce the $800 the ER registration demanded up front before they would register our patient, then quoted them "hundreds of dollars more" for doctors and testing. The patient produced our referral letter. They left, went home. Today, his wife fell ill. Their elderly parents wait in the same home. We still have no idea if he has COVID or a different respiratory virus? We can't tell him anything. We have no idea what to tell our health provider volunteers and staff, nothing about their risk. The patient and family are self-quarantined (The Canadian Centre for Refugee and Immigrant Health Care, March 12, 2020, public Facebook post, original quotations).

A few days later, The Canadian Centre for Refugee and Immigrant Health Care shared a similar story of another medically uninsured migrant being turned away from a local hospital, posting:

> Our uninsured patient, with COVID symptoms, who was turned away from the ER in the GTA 5 days ago was turned away again, a second time when he worsened and sought help last night. TWICE now. In 5 days. Because he did not have money, $500 to pay for care in a Canadian Hospital. We have been treating him in isolation by phone. But when he had more difficulty breathing last night, he took himself in, scared, alone, from the middle east, in Canada. He works under the table at a factory in the GTA. With many others new to Canada supporting our sweatshop economy. When he fell ill, he asked his boss to go home. He was fired on the spot. He now can't afford food or rent. He is a student here…. He is the 5th patient denied in the past 2 weeks we are aware of. No advice, no care until they provide $800. Today another turned away. GTA, 500$ ASKED FOR THEN TURNED OUT WHEN COULD NOT PAY. JUST TOLD 5 MINUTES AGO WHILE WRITING THIS. Over and over again we continue to treat patients new to Canada who are living and working in our communities, yet turned away from our hospitals for care when they arrive with COVID symptoms… (The Canadian Centre for Refugee and Immigrant Health Care, March 20, 2020, public Facebook post).

Following experiences like the ones shared by the Canadian Centre for Refugee and Immigrant Health Care and documented pressures from health care professionals ultimately resulted with Ontario announcing its Temporary Billing Codes so that medically uninsured migrants could access health care during COVID-19. Health care is not limited to COVID-19 treatment and the Temporary Billing Codes could be used to pay for all medically necessary health care that would otherwise be covered by OHIP. The temporary OHIP measures also allowed for uninsured patients

to access funded COVID testing, vaccines and to seek health care in hospitals or in physician offices, though as interviews will demonstrate, none of these changes were adopted perfectly or evenly across health care institutions, with many continuing to charge patients directly. Ontario's Temporary Billing Codes were removed on March 31st, 2023. Following the removal of these Temporary Billing Codes, Tolentino, Schmidt, Marshall, Da Silva, Suleman and Singh (2024) surveyed 66 service providers (i.e., physicians, nurses, midwives, nurse practitioners and social workers across different health care institution types) and found that since Ontario ended the funding for health care services for medically uninsured migrants, the following findings were observed: (1), worsened coordination between hospitals and community-based care, (2), increased discriminatory based practices toward uninsured patients, (3) higher service fees, (4), worsened health outcomes as a result of newer barriers to care, (5), heightened negative impacts to emergency care, reproductive care, and non-acute care for severe conditions, and (6), heightened "moral distress" among practitioners as a result of difficulties encountered in effort to provide equitable care (p. 4).

Fees for Uninsured Migrants

Outside of Ontario's Temporary Billing Codes, it is important to consider how fees are determined for medically uninsured patients in Toronto and Ontario. The College of Physicians and Surgeons of Ontario (CPSO), the body that governs medical practice in Ontario, has a specific policy for governing uninsured services, which, according to their definition includes services to individuals not insured by OHIP.

The CPSO's (2017) "Uninsured Services: Billing and Block Fees" policy indicates that a physician must not charge "any amount in excess to what OHIP has paid or will pay" (p. 1). In Ontario, it is considered professional misconduct if physicians charge fees considered excessive and

complaints can be directed by patients to the CPSO (Health Canada, 2020). The CPSO's "Advice to the Profession" (n.d.) companion document advises that if physicians become aware of a patient's financial difficulties, that "… physicians can use their professional judgment to determine if it would be appropriate under the circumstances to reduce, waive, or allow for flexibility with respect to the fee." (p. 1). In advising physicians on how to deal with patients who have unpaid fees, the CPSO (2017) does indicate hiring a collections agency as a possibility. Nonetheless, they reiterate for a second time that "…physicians must always pursue payment in a professional manner and must consider whether it would be appropriate to reduce, waive, or allow for flexibility in the amount owed based on compassionate grounds." (p. 1). Irrespective of the CPSO's policy that restricts profiteering from medically uninsured patients using excessive billing, an analysis of research interviews (i.e., law-in-action) demonstrates that these policies are not always followed, and that medically uninsured patients have little recourse to challenge excessive billing in Toronto. The chart in Appendix E details the funding models associated with each health care institution type in Toronto. As interview findings later demonstrate, funding models have a significant impact on an institutions or health care providers' ability (or in some cases personal choice) to provide services to medically uninsured migrants.

With the exception of CHC's and non-profit or volunteer-based medical clinics, most health care institutions charge medically uninsured migrants on a fee-for-service model. For a variety of reasons, this model is not an efficient way of working with medically uninsured migrants, as one interviewee explains:

> …fee for service is a lousy way to take care of vulnerable marginalized people with high needs and addictions and mental health. So, fee for service doesn't work in the refugee business, even with IFH and it's a lousy way. You spend half an hour, 45 minutes because the traumas, then mental health traumas, trauma, mental health addictions (Doctor 3, Toronto, 01/22).

In this section, the question of law-in-the-books was explored, first through a review on the evolution of Ontario's health policies and the status of health care eligibility for medically uninsured

migrants today. Relevant professional bodies responsible for the governing of medical doctors and standards in billing were identified. An analysis from the 1950s to today shows that there have been significant changes in health care policy, often from one provincial political party's governance to the next, expanding and decreasing local authorities in health governance over time. The creation of LHINs during the provincial Liberal parties' governance was identified as a crucial moment in the opening up health care funding for patients seen as "vulnerable," creating a pathway for service providers in CHC's to offer care to medically uninsured migrants to this day.

This section also began to identify concerning techniques that are employed in the government of migrants, whereby the production of waiting is relationally assembled. This is done through the provision of seemingly arbitrary waiting periods, such as the three-month OHIP waiting period for all migrant workers except for those on SAWP visas, the waiting created for Ontario-born infants to migrant parents when hospitals exercise the discretion to not complete the OHIP registration form, or finally, through the waiting manufactured by hospital-created residency requirements (i.e., 30-month PR waiting period). The following section investigates further the effects of this governmental power, which manifests in the form of delayed care, expensive costs, and at times, risk to life to name only a few examples. Having set the legal context and identified preliminary techniques of power in the government of medically uninsured migrants, the following section draws on interview findings to investigate the law-in-action research questions.

4.4 Law-in-Action: Experiences with Navigating the Local Health Care System

This section draws on interview findings to analyze how residency and health care eligibility is enforced in practice across Toronto's health care institution sites (i.e., spaces) as well as how barriers to health care services are experienced by migrants and specifically in which ways, for example, waiting, delays or denials of care. By conceptualizing this problem as assemblages of health care

barriers, emphasis is placed on the multitude of governing agencies as well as authorities – in this case, namely health care workers and health care institutions, and multi-scalar government bodies, employers, and NGOs. By drawing on Brady and Lippert's (2016) 'ethnographic imaginary' approach to governmentality, narratives (i.e., interview findings) are given equal insight into understanding the problematization, relevant rationalities and technologies in the governing of migrant health (Howard, 2016). This section highlights the intended and unintended effects of governmental power that migrants experience in their efforts to access health care in Toronto, categorized by themes of hospital billing, down payments, and facility fees; different standards of care and premature risk of death; interprovincial billing; medical specialists and profiteering; Covid-19 and temporary billing codes; discrimination, racialization and impacted service delivery; language and translation; and the governance of immigration status. Further, this section positions that racial capitalism continues to underpin these effects of governmental power, where the denial of rights to migrants with precarious status is taken for granted and ultimately a naturalized process that these authorities have positioned as acceptable.

Hospitals

Billing, Down payments & Facility Fees.

Interviewed health care providers shared significant barriers to health care experienced by medically uninsured migrants at local hospitals, with one of the most cited issues being hospital fees, for example:

> I've had clients come in who had tried to seek care at hospitals before and who had been charged and then not seen. And then the hospital refused to refund them, the charges…I have had clients who have decided to go back to their own countries because they were charged so much money when they went to the hospital. Just like a lot of, especially with hospital fees because hospital fees are fairly unregulated and can be really exorbitant (Healthcare Coordinator 3, Toronto, 12/21).

One issue highlighted by many interviewees with regards to hospital billing is the requirement of many hospitals to secure a down payment prior to treatment or admission as previously discussed in section two of this chapter as documented by The Canadian Centre for Refugee and Immigrant Health Care. One interviewee shared a client's experience where even in an emergency visit, medically uninsured migrants are often made to pay a deposit in order to be admitted:

> I've had clients who have walked into ER and have been asked for a down payment. This is emergency, have been asked for a down payment. There was a time where there was a few hospitals in downtown Toronto where they had signage on their front doors and in their registration area that said have a credit card available if you don't have insurance. So that's a huge deterrent, so if you're sick and you see that, automatically at the hospital door as you're walking in, chances are you're gonna turn around and walk away, right (Healthcare Coordinator 2, Toronto, 10/21).

The unclear and varying billing practices across hospitals can also be a deterrent for medically uninsured migrants, which in some cases prevents migrants from accessing care, as one doctor indicated, "…I think actually the best word is probably scared to go to the ER. You know because they're not sure how much they're gonna have to end up paying" (Doctor 1, Toronto, 10/21). One migrant participant, Aayla, also described being charged $600 for emergency room visit, sharing,

> Yeah, cause like there was like an ongoing headache, you know, and it was like do I go, do I not go? Because I know that I don't have a health card so therefore I would have to pay, right. And also, not knowing that they will not deny me the care, rights, regardless. You know, even if i go, right, they will not deny the care but it's also just thinking of all the money that I have to pay, right. So, you're not gonna be denied the care, you know, they will see you, a doctor will see you. But if I don't have the money, you know like, how am I gonna pay this, right? So that's definitely a deterring factor and, you know like, to go or not to go …When I hesitated for a while until, you know, the pain got, you know, worse and I said okay I just have to go. Because, you know like, for me the thing was, you know like, you go to a walk-in doctor, you might be charged maybe $80 for a visit but at the same time they're not gonna do anything more than, you know like, maybe prescribe something, most generally nothing, right. So, like going to emerg would be, you know like, a better option so if you need more things, you kinda get it done (Aayla, 06/22).

Aayla's story further provides support to the fact that medically uninsured migrants often wait and delay seeking care due to financial barriers, potentially worsening their health outcomes. In another

interview, one doctor described cases of their patients reporting feeling discriminated against by hospital staff, explaining the demoralizing impacts of billing practices:

> We hear it from the perspective from somebody that's already probably been through so much trauma and experiencing a difficult situation like a hospital. But you know, right away asked for the money and payment and I think that can be really demoralizing when you're trying to show up for help…I felt yeah, there was some, probably some maybe misguided treatment at the door (Doctor 5, Toronto, 02/22).

Similarly, Aayla shared experiencing feelings of discrimination even when presenting to hospital registry with a third-party billing letter:

> …like I feel discriminated because the first thing is do you have a health card? Oh, no I don't have a health card. But you know, I do have a note here from the doctor saying how to bill it. But she was, you know, a bit hesitant about it. And then she was like okay that's fine if they have it on the paper then that's fine but otherwise, you know, like it wouldn't work. I was like okay but it's written there (Aayla, 06/22).

Medically uninsured migrants who are patients of a Toronto CHC often receive a letter (i.e., third-party billing letter) from the CHC which provides the hospital with billing details to cover certain required service provisions. However, as one doctor explains, not all hospitals are willing to bill the CHC directly, stating,

> …there's one group of hospitals in Toronto that makes the clients pay up front. You have to pay upfront and then the community center will cover you afterwards. A lot of our clients don't have the money to pay up front…we've also had, like certain consultants say "No, you've got to pay," even though they know that we're gonna pay them, they're like "Nope, we need the money up front." And that's quite frustrating, it goes to show that not everybody cares about patients (Doctor 1, Toronto, 10/21).

A large cost associated with hospital visits for medically uninsured migrants is the "facility fee," often referred to by health care providers as "hotel fees," which are distinct from health service or provider costs. As multiple interviewees reported, many Toronto hospitals charge facility fees at significantly higher rates than the cost of facility fees for OHIP insured patients. As one healthcare coordinator explained,

> Facility fees is more like a hotel room fee …basically if you're using the services, just for the lights being on in the hospital and they can be quite expensive if you're spending the night. So, they can range, anywhere, depending on why you're there from $1,000 to $10,000 a night, right. And it depends on the hospital as well. It also depends if they're charging resident fees or visitors fees. Some hospitals, and they often confuse that, they often, that's another problem, is they'll see someone, they don't understand the complexity of being uninsured and what category you all in so they automatically assign that person to a visitor's status which is astronomical amounts that they're charging versus someone who's actually a resident and insured…I mean some of these rates are like three, four times higher. And that's the problem, because they automatically assume something, automatically assume if a person is uninsured that they're out of province fees, right (Healthcare Coordinator 2, Toronto, 10/21).

Ultimately, the requirement of inconsistent down payments prior to treatment and the use of higher 'visitor' facility fees for medically uninsured residents in Toronto hospitals are both techniques of government in this assemblage. Hospital administrations appear to align their interests with that of the provincial government, where operational fees for service are downloaded to medically uninsured migrants. While the Ontario government's goal, apparent in public policy, is to avoid paying for health care insurance for medically uninsured migrants, public hospitals may in turn utilize this as an opportunity to profit from migrants by inconsistently charging them fees as 'visitors' and not as 'residents.' While Toronto's hospital's may have the goal of recovering costs from tightened budgets from their funder (the province), the varying 'problems' of these actors ultimately come together in an agreement that medically uninsured migrants can be charged at the discretion of the health care institution. Nonetheless, research suggests that racial capitalism continues to underpin these effects of governmental power, where the denial of rights to migrants with precarious status is taken for granted and ultimately a naturalized process that these authorities have deemed acceptable. In addition to concerns of hospital billing, interviewed participants have highlighted concerns about reduced standards of care for medically uninsured migrants compared to OHIP insured patients.

Inequitable Standards of Care & Risk of Pre-Mature Death.

Many interviewees discussed concerns about the quality of care provided to medically uninsured migrants relative to OHIP insured patients. One hospital employee briefly described this concern during the following dialogue:

> Participant: …There might not be follow up, there might be a battery of tests that might happen to somebody who are much more selective than someone who is potentially going to have to pay for it.
>
> Interviewer: So, they're more selective in the tests that they go forward with knowing that the person will get a bill and might not be able to pay?
>
> Participant: Yes, yes.
>
> Interviewer: And do you think that's a concern?
>
> Participant: Well sometimes I wonder whether or not we are giving them the best possible care that we could give for them. (Healthcare Coordinator 1, Toronto, 10/21)

It is clear from interviews that an organizations' billing practices, in this case hospitals, appears to trickle down to the individual health care provider level, as this interviewee reported being present for discussions about service provisions and patients' lack of insurance. Multiple health care providers interviewed discussed concerns around different standards of care for medically uninsured migrants compared to insured patients, particularly so in hospitals, and this has become one of the many effects of governmental power in this assemblage. For example, one interviewee explained how a hospital's approach to asking about billing could itself implicitly cause a denial of care:

> …nobody wants an uninsured client because they realize that it might cost the hospital money. It makes providers really anxious giving care because they can't practice the way they normally would. There's a lot more advocacy work involved, there's a lot more, it's a sensitive [issue] that a lot of people don't want to take on. And again, the other is like, often times in hospitals people can be implicitly encouraged to forgo treatment, right. And that's not okay, people can get quoted astronomical amounts, pay for things. And you know, nobody has that kind of money to pay, so they often just, they're not provided with other options which is sad. This is how much it costs, do you want to get, you know, cancer treatment for your breast cancer, oh you don't have the money, sorry don't worry about it. So, it's like, yeah, yeah, yeah, it's really problematic the way the hospital system, it's run like a

> business and treats individuals who are uninsured (Healthcare Coordinator 2, Toronto, 10/21).

One of the most common and most serious examples of denied health care to medically uninsured migrants is the denial of cancer treatment. As one interviewee explained,

> I mean that (cancer care) costs a lot of money so when I go with my clients and they're about to get, you know, I've advocated for them to get the diagnostic testing that they need to identify whether they have cancer or not, for example. And you go on with the client and they say, in fact you do have cancer, stage three, stage four, here's all the things you require but I notice you don't have insurance. Are you able to pay for this out of pocket? Nope, no I'm not. Well, I'm sorry, there's not much we can do for you... that's often the denials of care that happen, and it is a matter of life and death, so they have no interest in finding anything out about the client, you know. How long have you lived here; do you have kids who are Canadian? You know, are you planning to apply for status? Do we have any compassionate funds? Can we refer you to the social worker within the hospital, who can advocate for you? And a lot of the times I hear from hospital's social workers that they're too afraid to advocate for their own clients because the bureaucracy that exists within the hospitals, they're often forced to discharge patients. Get rid of patients who are uninsured and for them to push back they feel like it's risking their own jobs and clinicals directly from providers within hospitals (Healthcare Coordinator 2, Toronto, 10/21).

This interviewee further explained that even in cases where a migrant patient may have accessed cancer treatment, often medically uninsured migrants are not provided with necessary follow-up care that medically insured patients get, stating:

> …follow up care is basic, if for example I did have a client who was assessed and treated for cancer treatment, there's often years of follow up care that needs to happen to continue to check their status. And often they're not offered that. You have to be the one who's calling in as a provider and saying when are you gonna see this client next (Healthcare Coordinator 2, Toronto, 10/21)?

Another medical doctor interviewee shared similar experiences of witnessing medically uninsured migrants pass away subsequent to restricted access or denials of care for cancer treatment:

> I feel like, you know, sometimes through a lot of advocacy people have gotten care, I don't know specifically about radiation. But sometimes not, and people have died (Doctor 6, Toronto, 04/22).

An interview with a migrant participant, Lynn, who lived in Toronto before moving to Edmonton, also shed light into concerns of her colleague passing away, in part, due to lack of health care insurance, sharing:

> Lynn: Yeah, yeah because at that time within [a] couple of months, because we complained to our agency (unknown 3:36) that's where I encounter with our employer who end up, employer knows about it. He terminated us, the five of us. So, it's just like two months at that time… we don't have healthcare at that time. And my friend, who was working with us also at the time, he has a medical condition to be treated and then because we don't have healthcare at that time because we're only a couple months during at the time, and then the hospital charged him everyday like thousand bucks. And then he passed away (Lynn, 08/22)

Due to raising concerns about their exploitation to their employer, Lynn and her colleagues were laid off from their contracts, causing them to be cut off from health care insurance. In the interview, Lynn connects her colleague and friend's death as being correlated with having a period of time where they did not have access to care. Ultimately, different standards of care and the risk of premature death are both horrific effects of governmental power in this assemblage that necessitate our concern and attention. In the following section, I discuss additional effects of governmental power that stem from interprovincial billing processes and profiteering, both which are techniques of government in the regulation of migrant health care access that result in barriers to care.

Interprovincial Billing

Another common barrier to accessing care discussed by participants includes issues with interprovincial billing. When migrants do have health care coverage in another province, but are temporarily residing in Toronto, health care providers reported that many health care institutions would not participate in interprovincial billing. As described by one interviewee, abortion clinics and medical specialists were common sites and professionals where access to interprovincial billing was denied:

> It really depends on the clinic. It depends on what they've set up in terms of their billing. Some places will deal with interprovincial billing, some places won't. All …abortion clinics won't. … I totally talk to clients who are like okay do you use it a walk-in clinic last week, why doesn't it work at the abortion clinic. So, there do seem to be some walk-in clinics that are accepting it, but it is a really hit and miss situation. And yeah, if you need a specialist kind of care and the specialist kind of care you need doesn't take that, then you're kind of out of luck (Healthcare Coordinator 3, Toronto, 12/21).

One of the suspected reasons for denial of inter-provincial billing by abortion clinics and medical specialists is the difference in payment rates across provincial insurance plans. Such difference may lead to providers receiving a lower payment for a service than what they would typically receive from OHIP.

Another interviewee described working alongside a doctor in a Toronto hospital with a patient who had health care insurance from another province, yet the doctor had them translate to the patient "…ask them how much money they have, how much they can afford, and how much they could take out of an ATM," at which point the interviewee reported communicating to the doctor that they did not feel comfortable with translating their requests (Nurse Practitioner 1, Toronto, 09/21). Despite being located at a hospital, which in Ontario, is an institutional site that has official inter-provincial billing agreements, this doctor was requesting funds in cash from a patient and was not utilizing the hospital's official administration to facilitate payment. In this situation, the interviewee speculated that the doctor would be pocketing the cash. The issue of profiteering by medical professionals was discussed by multiple participants and is addressed below.

Medical Specialists & Profiteering

Interviewees reported multiple instances of medical specialists who charge medically uninsured migrants or CHC's through third party billing at rates significantly above the OHIP rate, which is a serious barrier that may impact access to care. As one doctor shared:

> …there's a couple that got so above the administrator, like why are you sending these people to these very expensive places? …One case was a lab that we hadn't used before. It was a place to get cardiology testing, you know heart testing, out in (GTA region). Because the patient lived in that area and they billed us above OHIP rate and that raised a red flag…another one happened when I sent to an ear nose and throat specialist who's not one that we normally used. And again, they billed a higher than OHIP rate (Doctor 2, Toronto, 10/21).

A nurse practitioner working at a difference office shared a similar experience with specialists' billing their CHC at three-five times the OHIP rate:

> I've even had a patient where I've sent them to a specialist and the amount of money they're requesting from our community center it's not even to the patient. Doing it outright in front of everybody that they're requesting it, like a crazy amount of money…I think it's a bit of an injustice for those who are working hard and trying to make a living (Nurse Practitioner 1, Toronto, 09/21).

As a result of medical specialists that bill medically uninsured migrants above OHIP rates or refuse to provide services, CHC staff have reported adopting multiple strategies for supporting their medically uninsured patients when it comes to accessing specialists. For example, one commonly cited issue is navigating referrals to specialists. As one interviewee explains:

> …we will put our medical sector as being like, this person's not nice and at multiple times they've said this person's not nice. I've had multiple you know messages that are from this specialist saying XYZ I think we should, let's not take them off the list, how about we put them lower on the list, we'll put a sticky note next to their name saying don't with your uninsured clients (Doctor 1, Toronto, 10/21).

Most interviewed health care providers reported having a 'special' internal list of service providers or specialists who do not profiteer or charge uninsured migrants above the OHIP rate – typically the result of years of institutional knowledge as well as trial and error. At the same time, uninsured migrants may at times request a referral to their specific geographical region, in which case the referring health care provider may need to refer to a new specialist who is not already on their internal list. Nonetheless, specialists that charge above the OHIP rate in Ontario appear to be doing so in violation of the CPSO's (2017) "Uninsured Services: Billing and Block Fees" policy described in part two of this chapter.

Specialists profiteering at the expense of migrants, charging rates significantly higher than established OHIP rates for insured residents also creates significant barriers to care for medically uninsured migrants. This technique of discretion, works to reproduce ideas of sovereignty in medical offices while actively blurring notions of belonging or lack of belonging in the process. The

technique of health care providers in establishing internal lists of specialists who do not profiteer from migrants in an effort to provide accessible care signals a form of resistance against these discriminatory practices as well as an effort to re-craft jurisdiction at the local level. In their actions, they push back against the redefining of borders in medical offices by profiteering providers and institutions. In the following section, I review the impact of Ontario's Temporary Billing Codes in Ontario during the first three years of COVID-19.

COVID-19 & Temporary Billing Codes

Ontario's temporary billing codes policy, Bulletin 4749: "Temporary Billing Codes," in place March 2020 to March 2023, had provided the most substantial change and improvement to medically (e.g., OHIP) uninsured migrants ability to access to health care in Ontario during this time. At the same time, however, health care providers and migrants have consistently been required to navigate both denials of care and excess billing in violation of the Temporary Billing Codes. During the period in which research interviews were conducted for this dissertation, these temporary billing codes were still in effect. As one doctor describes:

> During COVID, we know that they shouldn't have been charged and we heard cases of some people showing up at very big hospitals still being charged for emergent presentations and so that was also very confusing. So, we kind of often would send them with letters or with sort of the actual papers saying that actually the fees should be covered (Doctor 5, Toronto, 02/22).

Other providers also described how patients were billed by hospitals for care that should have been covered by the Temporary Billing Codes. For example, as one healthcare coordinator indicated, "…we talk to a client every couple of weeks who's charged something by a hospital or sent a bill" (Healthcare Coordinator 3, Toronto, 12/21). The inconsistent application of temporary billing codes by multiple hospitals across Toronto and the overbilling of medically uninsured migrants during this time signals another technique of discretion employed by hospitals and engaged in the governance

of migrant health. Intentional or not, these practices of inappropriate billing again re-craft notions of sovereignty and belonging in the process. At the same time, the Temporary Billing Codes when applied properly have been of huge significance to both medically uninsured migrants and health care providers. As one midwife shared:

> …with this directive from the ministry that everyone just get health care, it has freed up a huge amount of our time and energy. There was so much angst and exhaustion around dealing with the billing office, the hospital. I haven't thought about the billing since years. So, while there have been plenty of things that have been much more challenging in the pandemic, of course like it's exhausting. But that part has just gone away and it's like good riddance, it's such a delight to not have to worry. We have our population in terms of comorbidities we have higher rates, certainly higher rates of anemia. We see a lot more pica, which is a condition where people want to eat clay or ice or dirt. Because of severe anemia, I had never seen that in my practice before… People who have just experienced malnutrition and food insecurity because of migration. So, I'd say we have a very high rate of people who received IV iron, and that's also something that previously would have been a struggle to cover and pay for. And since the pandemic we can just simply refer to our kind of internal medicine doctor, and they'll go and receive the medical care that they need without much worry…Life changing (Registered Midwife 2, Toronto, 01/22).

The Temporary Billing Codes freed up a lot of time that health care workers could spend with patients instead of navigating affordability issues and billing requirements. The advocacy and organizing efforts of health care workers in Toronto responding to denials of care and enforcement of the Temporary Billing Codes during the COVID-19 pandemic are discussed in greater detail in Chapter 6 *Reform & Resistance.*

One interviewee, Diego, discussed his positive experience with accessing health care from a hospital during the time of Temporary Billing Codes, sharing,

> Diego: I was just related for my depressions and for my stress, I started feeling my stomach bloated. And there was a time during covid, they didn't make you pay the hospitalization on any hospital. And I went to the hospital just to check out everything.
> Interviewer: Yeah.
> Diego: I went once, I take that chance once. They never asked me my status or any payment of something. Also, my kid went once, was in a kind of (unknown 14:43) or something, I don't remember exactly the situation but nothing serious. And that's it, I mean nothing thank God nothing to be worried about but it's like you are playing with fire, right. Just do

> the job because even that here it's job is more relaxing [compared to previous job as high-rise window washer], just like a little bit.
> Interviewer: Yeah.
> Diego: You can be damaged by any tool or something you cannot use. You can cut your finger, you can just smash your feet or something so, you're in the hotlines, but thanks god for me never has happened nothing really serious. Just on the floor or something like a runny nose or in this case my stomach was blow up a little bit (Diego, 06/22).

Diego's story helps illustrate both the importance of the Temporary Billing Codes as well as the ongoing fear that uninsured migrants have regarding potential injuries, and concerns regarding how they would work and or pay for their care. Diego further shares,

> I have three days been sick. Since Wednesday, Tuesday but I cannot miss the work because if I don't come to the work they don't pay me, right. So, for me a lost is a day that I cannot pay for my groceries or rent or something. So, I have to come to work and do as much as I can and even one of the things that I don't like is like, my manager or like the people oh no it's allergy, don't worry all the time because with covid this is more risky then, right. So this is disturbing, it's one of the toughest things, come to work even if you feel bad, if you're dizzy, if you're feeling headaches or something…It's really hard for me and for the medicine, this life has been really tough for me and struggling with my headaches and with my running nose and stuff and lie to everybody that I'm fine when I'm not, I'm not fine. I'm feeling terrible, I'll prefer standing in my bed, sleeping away in my bed, but that's the way it is (Diego, 06/22).

Diego's story helps demonstrate how migrants with precarious status in Canada have different rights. As an undocumented employee, Diego is not eligible for any paid sick days and at the same time, has limited options for health care coverage, requiring him to work through his illnesses to support his family. The following section explores discrimination, racialization and impacted service delivery as some of the effects of governmental power in this assemblage that migrants experience in their efforts to access health care.

Discrimination, Racialization & Impacted Service Delivery

During their interviews, health care providers often reflected on the connection between the denial of health care for medically uninsured migrants and the fact that most medically uninsured migrants in Ontario are also predominantly racialized. As explained by Healthcare Coordinator 2,

> I think it's important to type out is who's uninsured, right. Typically, it's racialized immigrants who are coming here, escaping war-torn countries or escaping poverty or escaping whatever. So, we have to identify who it is that is being turned away. That's important and all these hospitals now, trying to digest that they're you know, all about anti racism and anti-racism training and you know, it's insane to me because the uninsured people are the ones they are turning away and that is the racialized people that are being impacted, right. So, a really good example of that would be like, I've had clients who go and medical admins there about to rush to the clients, well those clients don't have a health card to be seen, they have no mortgage here, they haven't paid taxes. You know, why should I have to spend my hard-earned money to somebody else to get uninsured care. I've heard this from doctors…You know, and it's, it's quite disgusting. (Healthcare Coordinator 2, Toronto, 10/21).

Unfortunately, all too often health care providers have reported hearing racist or discriminatory comments by other health care providers or by the administrative staff of health care institutions. This discourse that positions migrant health as a tax burden to citizens is again underpinned by shared ideologies of racial capitalism across different communities in Canada and works to legitimize barriers and denials of care while recrafting who belongs and doesn't belong in the process. For example, as reported by Healthcare Coordinator 4,

> I will talk about one experience that I had with this person at the hospital. He was trying to get admitted at the ER and the person who was on the reception, like the front desk, she was telling him like "because of you, and because of people like you, the system it's like broken." And I was like "oh my goodness" that's when I just jump in and then I said to him "okay put me on speaker." Yeah, because I knew that this guy, he understand English a little bit and he was able to at least say "I need to see a doctor" in English, right. So, I said to him "okay when you are at the hospital, please give me a call and then you're gonna put me on speaker and then I will be happy to help you, like as an interpreter while you get admitted at the hospital and then at the hospital they have interpreter services." And then this person at the front desk, she was very rude (Healthcare Coordinator 4, Toronto, 02/22).

Similarly, Healthcare Coordinate 2 proposed, "I think the connection to denying care, specifically to so many racialized people, is so important to capture, especially in the climate that we live in today. People need to keep their personal judgements and values in check when they're providing professional care" (Healthcare Coordinator 2, Toronto, 10/21). Even in instances where no explicitly racist or discriminatory comments have been made, interviewed health care providers reported having concerns around potential biases in the provision of care. For example, as Doctor 2

reported "I mean I think most people who are uninsured, they are seen. But whether either consciously or unconsciously the care that's delivered is biased, I don't know" (Doctor 2, Toronto, 10/21). These examples speak to both the extent to which racial capitalism trickles down to the service delivery level, whereby health care professionals are questioning the quality of care that racialized and medically uninsured migrants are receiving but also speak to the far reach of internal bordering practices, which make their way beyond territorial border and within health care institutions.

As previously disclosed by Healthcare Coordinator 1, there is a documented concern that at times fewer tests may be completed for medically uninsured migrants seeking care at Toronto hospitals due to their inability to pay: "Well sometimes I wonder whether or not we are giving them the best possible care that we could give for them" (Healthcare Coordinator 1, Toronto, 10/21). Similar concerns regarding the intersection of limited institutional resources and the reduction of services or testing were shared by several interviewed physicians. Doctor 4 reported:

> …incredibly challenging because of the financial constraints. So being able to order tests, diagnostic imaging, referrals to specialists, procedures. We had, through the organization, about (*dollar amount*) allocated to each patient. But that money is used up quite rapidly, also considering the cost of medications if they're going to be covered. So, it was very, very, very challenging to provide that care and I often felt sort of ethically conflicted about am I, because I'm thinking about the cost considerations, because I'm thinking about okay I have this much money to use for an individual patient. Are there tests that I normally would do if there weren't those financial constraints that I wouldn't do in this case because I'm trying to, you know, be most efficient with those resources…I tried really hard to think about, you know, not providing a different standard of care but you're also, you know, the reality is that there were constraints and so sometimes there's thinking that okay what is the, you know, sequence of investigations, maybe rather than doing things all at the same time, being more sequential (Doctor 4, Toronto, 02/22, *specific dollar amount removed to prevent deductive disclosure*).

These realities of minimal service delivery such as reduced testing are effects of governmental power in this assemblage of health care barriers and they cannot be analyzed independent of other biases in care, including the reality that most medically uninsured migrants in Toronto are also racialized. In the following section, the consequences of waiting for health care are discussed.

Waiting.

In addition to ethical considerations that health care providers are required to undertake in the provision of services to medically uninsured migrants, there is also a concern around additional periods of waiting for care distinct from the typical waiting that insured patients are subject to. For example, many health care providers reported that uninsured migrants often have to wait to join a CHC as a new patient in order to undergo further diagnostics so that they have access to funded care. Unlike insured patients, uninsured patients are not able to access private walk-in clinics instantly while waiting to become a new patient at a CHC without having the financial means to do so. As Doctor 4 documents,

> …thinking about potential delays, saying okay we're gonna wait until this person is connected to a community health center before we can do this additional consultation with a specialist. And would that have any adverse impact on their health. So, I found it very, very challenging and certainly people grappling with a wide range of physical and mental health concerns…CHCs are amazing in terms of the care that they're able to provide and any additional funding that they have for uninsured. But they also have capacity constraints and so there were often, you know, it would take time for people to get appointments with CHCs as well (Doctor 4, Toronto, 02/22).

Health care providers have reported that, while waiting to become to a health care organization where health care services are funded, uninsured migrants may incur significant health risks, especially when they are seriously ill and require immediate medical assistance. Furthermore, the migrant's condition may ultimately become far worse as a result of waiting. For example, as one medical doctor suggested,

> …for a number of patients, they've maybe been dealing with health issues for many months, even a year. And hadn't been able to seek care or maybe they've gone to a walk-in clinic one time, you know, faced charges for that and then not been able to connect to care. …there could be quite a delay there… (Doctor 4, Toronto, 02/22).

While Toronto has some emergency walk-in clinics for uninsured migrants as previously indicated, medically uninsured interviewees reported needing to spend entire days to be seen, sharing that "…that my experience is to get an appointment or just, you know, even get the service you have to

wait, you know like, at least, you have to spend a whole day, right. You have to leave in the morning to get an appointment in the evening and you might still not even get seen by a doctor" (Aayla, 06/22). In addition to spending an entire weekday to potentially be seen by a physician, many uninsured migrants are face additional financial hardships because they are more likely to be working at under the-table jobs, which do not provide time off for appointments or 'sick days.' As a result, a visit to an emergency clinic can cost migrants a day's pay or even put their employment at risk, not just because they need to take a day off, but employers may not want to keep workers who are potentially ill and unable to complete work as demanded. Of course, for migrants working under-the-table, benefits such as workers compensation are not an option for addressing work related injuries. In her interview, Emilia (08/22) reported delaying care all together for a workplace injury from her job in a factory and instead opted to treat the injury herself, citing inability to pay for care and take time off work. In addition to waiting longer periods for care and delaying treatment, language and translation is another important barrier that emerged during interviews.

Language & Translation

Toronto hospitals and CHCs have access to funded language translation lines, which are essential to providing health care to migrant patients who are not fluent in English. At the same time, many health care providers reported additional challenges with patients receiving access to translation in hospitals. For example, interviewees reported,

> And they often will send someone who doesn't speak any English to the section of the hospital where they have to fill out all these province forms (forms to charge higher out of province facility fees despite being an Ontario resident) which basically gives them consent to charge that amount of money without providing an interpreter or aid (Healthcare Coordinator 2, Toronto, 10/21)

> …this one particular case where a patient, you know, went to the hospital, she needed to be there for an emergent reason, and she actually said to me she could read the sign, she knew

> enough English to read the sign that said we have interpreters. We just dial this number and tell us what language you speak, she kind of could read that line. And she said that nobody actually used an interpreter with her and she just didn't know what was going on, nobody could explain to her what was going on and she felt completely lost (Doctor 5, Toronto, 02/22).

Based on interviewee responses, migrant patients who are not fluent in English may gain access to translation services, albeit typically during service delivery only, though not consistently. There are also concerns that patients are being asked to sign financial documents without having access to translation services, despite these services being readily available. Another commonly occurring theme that emerged the analysis of interview data concerns the governance of immigration status through access to health care.

Governance of Immigration Status

The immigration status of patients is often governed not only federally, but also locally within medical offices, at times by administrative or front desk staff, and at other times by health care providers themselves in their provision of care. As reported by an interviewee, in the CHC in which they previously worked, a social worker was responsible for determining which services could be covered. According to the health care professional,

> … if you're uninsured, as an NP or even the doctors had to go through the social worker to have the request validated. So, let's say we were prescribing lab work, well is this okay and all. So, she would have to go through every request we were making, and she would accept them or deny them. So, it was a lot tighter in terms of what was acceptable or not…she wasn't deciding what if it was necessary or not from a medical perspective, but more in terms of discussing with the patient, why is it that you're still uninsured. Is it because you're not filing your papers or is there another way that you can get insurance (Nurse Practitioner 1, Toronto, 09/21).

When asked "…if someone didn't want to regularize their immigration status, would that be a reason why the social worker might deny them or not necessarily?" the interviewee responded:

> … So, there's so many ways so I think if someone was open to at least discussing it, most of the time she was okay with that even if they weren't necessarily ready to file their papers. But

> I think if someone would say well, no, I don't care, I don't know if she would deny it but I think it was a little harder to (unclear) they really needed that... Are they really here for good reasons? (Nurse Practitioner 1, Toronto, 09/21)

While most interviewees expressed that health care providers have an ethical obligation to provide preventative and urgent care and stated that all patients should have access to health care regardless of immigration status, some health care providers expressed doubt or uncertainty that such care would be provided. In the CHC described above, a social worker has been given the unofficial role of immigration governance, denying or approving care requests by nurse practitioners and doctors. Again, the technique of discretion can be seen within the confines of medical offices, in this case a local CHC, whereby redefined ideas of belonging or a lack of belonging are crafted. In other CHCs where health care providers participated in interviews for this project, social workers were not involved in approving or denying requests for care. The idea that medically uninsured patients should be "here for good reasons" (Nurse Practitioner 1, Toronto, 09/21) was expressed in another interview, where an interviewee discussed the need for "…incentives for people to migrate legally and in a regular fashion," further elaborating:

> So, should they be eligible for OHIP? Yeah, I mean maybe it would be an OHIP with like, you know, OHIP bronze, not OHIP gold or something like that… then again, it gets very tricky because again when I start to see somebody I see a patient, I don't want to have to think about which prescriptions and limitations when I can treat the individual patient that's in front of me and if they need a CAT scan they need a CAT scan, you know (Doctor 2, Toronto, 10/21).

Interview findings across the board consistently demonstrate that immigration status and the lack of insured services for medically uninsured patients are consistently present in the minds of health care providers when delivering care and determining future steps, such as the need for testing, diagnostics, and specialists. It is also clear that, for uninsured patients access to services is not even across the city of Toronto, nor is it even among similar types of health care institutions, with each organization demonstrating different limits, structures, funding, and ethics.

4.5 Conclusion

This chapter began with a brief introduction to the City of Toronto, its demographics, immigration histories, its origin as a "place of bounty" for many Indigenous peoples, and some of it is more recent social and municipal movements toward its status as a sanctuary city. As the largest city and capital of the province, this context is essential for a better understanding of how Toronto's history, demographics and population have supported the evolution of the public health policies and health care institutions that exist today. Toronto's efforts to adopt numerous sanctuary city motions further signify local efforts to expand services to migrants with precarious status. At the same time, they fall short of substantive change when it comes to health care access, due primarily to limits to its jurisdictional powers.

Secondly, this chapter provided a history of public health care in Ontario, highlighting the ways in which there has always been resistance against change over time. This section also highlighted the disconnect between temporary federal immigration programs and provincial legislation determining how the various categories of migrant workers qualify at different times for health care coverage. For example, migrant workers under the SAWP are entitled to OHIP immediately and where other migrant workers are required to wait a three-month period. Additionally, this section draws awareness to the ways in which some hospitals have interpreted and employed different concepts of 'residency.' Perhaps one of the most appalling examples involved the denial of health care for newborn babies, ultimately requiring parents to delay access to health care their child until they can arrange a card through Service Ontario.

A key focus for this chapter has been the investigation of health care access for migrants with precarious status through an analysis of interview findings and by analysing Toronto as an assemblage of health care barriers. Ultimately, this chapter highlights the exclusionary nature and

ableism at play in the denial of health rights to migrants with precarious status in Toronto, and are reminiscent of Canada's early immigration history, as previously discussed in chapter one (Adjekum & Joseph, 2023). Medically uninsured migrant workers in Toronto, often in between temporalized visas, are by and large racialized and therefore, their denials of health care rights, or experiences of medical repatriation and deportation upon disability, appears reminiscent of Canada's earlier eugenics-based screening requirements required in order to access full rights (Adjekum & Joseph, 2023). In this chapter, interview findings were organized by predominant, reoccurring empirical themes and analyzed through a socio-legal critique on denials, delays and barriers to care. Some of the key techniques of government identified in the regulation of migrant health care included: inconsistent hospital billing practices, such as the requirement of down payments prior to treatment (often with increased fees); heightened facility fees by registering uninsured migrants as 'tourists' instead of as 'residents'; profiteering by specialists at rates above OHIP rates; inconsistent application of temporary billing codes (2020-2023); and the denial of health care cards for legally eligible newborns to name a few. Whether intended or unintended, these techniques in practice effectively work to redraw the lines of sovereignty and borders in medical offices, signaling exclusion and lack of belonging by reconceptualizing different health care standards for medically uninsured migrant. These standards may cost significantly more relative to OHIP, promote inconsistent access and quality of services, require longer periods of waiting and referrals to a more specific list of providers, limit or even prevent adequate testing or assessment, and may even lead to pre-mature death for some migrants who are denied adequate and timely healthcare.

Several health care professionals alluded to the ethical dilemma they face when making decisions about access to care and medical services for uninsured migrants. They struggle with two competing frameworks. First, a policy framework which is utilitarian in nature (and not always clear),

which requires them to follow rigid rules based on funding and eligibility. Second, a framework based in the ethics of patient care, which fundamentally involves putting the clinics needs of the individual patient first. Many view the system itself as unreasonable, in that it requires them, as medical practitioners, to make decisions that may not be based entirely on clinical needs but reflect other domains such as finance.

Many different actors and authorities identified through interview findings (i.e., hospitals, provincial government, profiteering providers etc.) may ultimately have different goals, interests, and problems, yet as they assemble around the issue of migrant health, they are creating a cultural norm that positions both the denial of health care and the increased in fees for care for medically uninsured migrants as acceptable practices in Toronto, Ontario. These practices and norms are supported by an underlying ideology of racial capitalism across Canadian society and institutions – the acceptance of differentiated and racialized labour and rights. As an act of resistance, CHCs develop internal lists to avoid some of these unscrupulous providers, effectively pushing back against these practices in an effort to re-craft jurisdiction at the local level, pushing back against the redrawing of borders in medical offices by profiteering and institutions. These acts of resistance against the denials of health care to medically uninsured migrants and competing rationalities are discussed further in chapter 5 – *reform and resistance*. In the following chapter, health care access for medically uninsured migrants in Edmonton is investigated.

Chapter Five.
Edmonton / amiskwacîwâskahikan |

4.1 Introduction

This chapter investigates health care access for migrants with precarious status in Edmonton, with particular attention to barriers to access and denials of care. This chapter posits that the systemic barriers and denials to health care for migrants with precarious status is supported by the dominant political rationality of racial capitalism. First, a brief review of the City of Edmonton's immigration history, demographics, social movements (i.e., McKenna Law) and municipal motions in support of Edmonton's status as a Sanctuary City are discussed to provide a contextual grounding that encompasses how local beliefs about belonging and health may be recoded at the service provision level or provincial level. Since CRT scholarship further emphasizes the importance of investigating how racial hierarchies have been produced spatially across scalar levels, it is important to consider Edmonton's immigration history and acknowledge that, like Toronto, the city's local borders are not historically fixed. Rather, findings echo those of critical migration scholars and demonstrate that borders operate primarily in the interest of racial capitalism (Walia, 2021).

Second, as public health care is operationalized provincially, this chapter will provide a curated review of key legislative changes following their origin in the 1970s to present. Health care spending, policy and provincial-political branding are reviewed, covering the Conservative "Klein era" to the present. The organization of health care governance across Alberta today through regional zones and Primary Care Networks (PCNs) is introduced. This section begins to address the first research question of the law-in-the-books theme, investigating how Alberta's health laws have interpreted the federal CHA and defined residency for AHCIP eligibility. Similar to Ontario (Toronto), a narrow interpretation by the province has often resulted in denied care. At the local level, in Edmonton, health care providers and government offices often confuse AHCIP eligibility

entitlements, resulting in a narrow interpretation where a parent's entitlement gets mistaken as determinative of their Canadian-born infant's legal entitlement. As well, this chapter shows that healthcare eligibility in Alberta is linked to immigration or employee status. It also highlights the regulation of associated fees charged by physicians. This investigation demonstrates how the intersection of legal orders in Alberta (e.g., federal immigration programs and provincial health policies), the techniques of discretion of employers, and the directed profiteering by the Alberta Medical Association assemble to create detrimental effects of governmental power for medically uninsured migrants in Edmonton. The consequences of these techniques are discussed in the final section.

Third, this chapter examines access to health care for migrants with precarious status through the analysis of Edmonton as an assemblage of health care barriers, including the different types of institutional sites available as well as key findings from interviewed participants (n=12). Themes of space and time are privileged in this analysis, helping to investigate the consequences of waiting and delayed care, as well as how federal and provincial health care laws have been spatialized locally, shifting boundaries of state sovereignty across medical offices in the process. Drawing on the law-in-action theme, this also shows how much more uniformly the criterion of residency and eligibility is enforced across different health care institutions in Edmonton. Since Edmonton has no dedicated services for medically uninsured migrants, the definition of residency did not shift significantly from one agency to the next as in the case of Toronto. Nonetheless, as we will see, AHCIP registration for Alberta-born infants was identified as the primary location of discretion, whereby interpretations of residency are consistently questioned or denied. As in the case of Toronto, this section demonstrates how the technique of systemic denials for health care by employers, health care institutions and government agencies ultimately work to normalize delays, denials and barriers of care by recrafting who belongs and does not belong in the process. Empirical

findings are categorized by reasons for becoming medically uninsured; services available in Edmonton; common issues of fear, delayed care, and financial constraints; billing, standards of care and denials of care; and the local governance of immigration status. Collectively, these findings help to demonstrate characterizes the experiences of delays and denials to care in Edmonton. To conclude, this chapter summarizes key findings and identifies rational capitalism as the emerging political rationality that supports the continued denial of care.

4.2 City of Edmonton

While the next section of this chapter begins with describing Edmonton's early immigration history with European settlers, it is vexed by the risk of reinforcing norms that Canadian cities are settler spaces, and as Tomiak et al., (2019) warn, "it is also to risk reifying settler colonial entitlements to the city" (p. 2). To address this concern, this section begins with a recognition of the land and its traditional peoples, and the following section highlights some of the contemporary realities of Edmonton, such as the large Indigenous populations that continue to live there today. In an effort to disrupt Canadian national mythologies (Razack, 2002) and to support ongoing treaty obligations, this section begins with recognition of the Indigenous territory in which Edmonton is situated. The City of Edmonton, also known by the Cree name amiskwaciwâskahikan, is located on Treaty 6 territory. The land is the traditional territory of many Indigenous peoples, including the Nêhiyaw, Dené, Anishinaabe/Ojibway/Saulteaux, Haudenosaunee, Nakota Isga, Nakota Sioux and Niitsitapi peoples. Edmonton is also recognized as the homeland of the Métis Nation of Alberta Region 4 and has the largest community of Inuit south of the 60th parallel. Treaty 6 was first signed August 23, 1876 between the Nehiyawak, Dene Suliné, Nakota Sioux, and the Crown; however, today it includes 17 First Nations (Edmonton & Area Land Trust, 2020). There remain varying perspectives among Indigenous Nations on the full parameters of Treaty 6, which is not surprising given the

documented evidence that translation was not always made available and at times, there was deceit on the part of the Crown (Borrows, 2002). Speaking on Treaty 6, elder Alma Kytwayhat shares "We were told that these treaties were to last forever. The government and the government officials, the Commissioner, told us that, as long as the grass grows, and the sun rises from the east and sets in the west, and the river flows, these treaties will last" (Cardinal & Hildebrandt, 2000, cover). It is clear from the stories of elders that Treaty 6's spirit and obligations continue to persist today.

Brief History & Demographics

As previously discussed in chapter one, it is necessary to investigate how this how Edmonton's history, migration and borders have developed historically leading toward the present-day economic arrangement whereby fewer human rights and protections are exercised for migrants with precarious status. Further, it is important to acknowledge that Alberta and Edmonton's borders are not historically fixed but have shifted over time. It is also necessary to eschew notions of the city as a settler achievement, which Tomiak et al., (2019) caution could lead to viewing contemporary cities as "… exempted from the long history of settler-Indigenous spatial relations that is invariably at their root; they are discursively rendered as places that exist outside of the messy negotiation of colonial contestation" (p. 3). The most significant migration to Alberta was actually that of domestic migration during the years of 1890 to 1911, with land granted to European settlers who would gain ownership after three years of settlement and farming of the land. During 1901 to 1905 alone, 40,000 "homesteads" were given away (Hiller, 2009, p. 13), undoubtedly that of Indigenous land. At the same time, from 1885 to 1908 the federal government was sending scrip commissions for what is now known as Alberta and northern Alberta, designed to unsettle the Métis nation and extinguish their land title, so that the government could offer land to settlers as homesteads. This important fact is often excluded from written migration histories about Alberta yet was a key federal policy in

effort to "Claim the West." Following this era, Alberta's population remained relatively stagnant until the 1970s when it began to steadily increase (Hiller, 2009).

Beginning in the 1970s, Alberta's population began to shift from being comprised mostly of Indigenous populations and European settlers, to gaining more racialized migrants from East Asia, who had arrived first to Vancouver and other parts of British Columbia and began to move out toward neighboring provinces. By 2001, 15 percent of Edmonton's population consisted of racialized persons (Hiller, 2009, p. 46). For a long time, Edmonton was considered the "gateway" for bringing capitalism and US security to the North. Throughout the 1940s, thousands of American military troops and citizens moved to Edmonton to help develop the highways (e.g., Alaska Highway) and airfields (e.g., Northwest Staging Route), contributing to the city's economic development and population's expansion (Hiller, 2009, p. 51). During the early 1990s, Edmonton became home to a community known as 'Packingtown', where meatpacking grew into a major industrial employer in the region, until the 1980s when operations changed distribution centres, with the meatpacking industry expanding across Alberta (Alberta Labour History Institute, 2021). Meatpacking in Alberta continues to be an industry where workers report high probability of injury and dangerous work conditions, and where refugees make up only 2.5 percent of Alberta's population yet account for 18 percent of meatpacking workers (Bragg, 2021, p. 2).

With Alberta becoming a settler colonial Canadian province for the first time in 1905, many historians and sociologists have argued that this "later" Confederation history has continued to play a role in the province's consciousness as one that is distinct from other provinces (Hiller, 2009). For example, this shift is marked by the province's slogan which changed in the 1990s to "The West Wants In" to that of "The Alberta Advantage." This Klein-era (Alberta Premier from 1992-2006) verbiage was re-popularized again in 2019 by former United Conservative (UCP) premier Jason Kenney among other UCP candidates, despite the fact that this era is largely viewed as a period of

austerity that "…harmed the notion of Alberta as a place of equal opportunity and prospects" (Durou, Maroto, & Brown, 2023, p. 119).

Shifting population demographics in Edmonton and Alberta today signify a larger increase in the diversity of residents and immigration to Edmonton compared to just 15 years prior, while simultaneously point to ongoing systems of marginalization and oppression. In 2021, Edmonton has one of the largest numbers of Indigenous residents in Alberta, with 58,165 individuals identifying as Indigenous, an increase of 15.7 precent over the past five years (City of Edmonton, 2023b). While recognized as racialized groups, Indigenous peoples are not counted as visible minorities in Canada. In 2016, Edmonton's immigrant population represented 23.8 percent of total residents, up considerably from 14.6 percent in 2001 (Statistics Canada, 2016b). In 2016, 28.1 percent of Edmonton residents identified as "visible minorities," with the top four groups identifying as South Asian (7.0 percent), Chinese (4.6 percent), Black (4.5 percent), and Filipino (4.7 percent) (Statistics Canada, 2016b). In 2021, this figure is now up to 40.3 percent of Edmonton residents identifying as visible minorities (City of Edmonton, 2023, p. 1). In undertaking an intersectional analysis of Alberta's census data (2016), Durou et al., (2023) challenge for whom does 'Alberta's Advantage' exist, while pointing to staggering statistics on low income and unemployment. For example, in Alberta, a married racialized woman was found to be 4.4 times more likely than a white married man to earn a "very low income," with gender, Indigeneity and marital status identified as the strongest markers for low income, very low income, and unemployment (p. 126). Sizeable wage gaps also exist for Black Albertan workers compared to non-visible minority Albertan workers (white), with a 25 percent higher gap compared to the Canadian wide data (p. 118). These preliminary intersectional demographics point to a concern of existing marginalization in Edmonton characterized by race and gender and are therefore a useful starting point before unpacking the status of health care services for uninsured migrants today as local beliefs may be recoded at the service delivery level. In the next

section, this chapter reviews key social movements for migrant rights in Alberta and Edmonton in order to help contextualize the status of health care access in Edmonton today.

Social Movements & Municipal Motions

Two key recent social movements and municipal motions described in this section include the community dubbed 'Mckenna Law' as well as a municipal motion in support of accessing service without fear. Local histories can be helpful for identifying new possibilities for reform at the local level through investigating past successes or failures for learned lessons. Up until January 2016, the province of Alberta denied Canadian-born children health care entitlements if their parents were considered non-eligible for the Alberta Healthcare Insurance Plan (AHCIP) themselves (i.e., medically uninsured migrants). The McKenna Law campaign, spearheaded by Lynn, who at the time was a non-status Filipina migrant worker in Alberta, along with Migrante Alberta, publicly fought to gain health care coverage for her two-year-old Canadian-born daughter. Lynn lost her health care eligibility in 2015 when she reported her employer for abuse and assault, which resulted in her losing her job and, in turn, losing health care coverage for herself and her Canadian-born daughter (Luciano, 2022, June 21; de la Cruz, 2017, June 12). After a successful campaign, Health Minister Sarah Hoffman announced a new policy in January 2016 that would provide AHCIP coverage to Canadian-born children. However, following the announcement of this policy change, parents continued to face barriers and denial of health care cards for their children. NDP Member of Legislative Assembly (MLA) Rod Loyola for Edmonton-Ellerslie reported working with Migrante Alberta to assist 20 families to apply for AHCIP for their children, stating,

> I personally connected with about 20 such families and children who were sick and needed prompt access to health services. Due to their parents' non-status, there was much confusion from the parents and those within the health care system and the appropriate coverage for the children under the AHCIP (de la Crus, 2017, June 12, p. 1).

At the time, the Alberta government had established a hotline to enable medically uninsured parents to call and obtain assistance if they faced difficulties applying for AHCIP cards for their Canadian-born children (The hotline is no longer in service). However, parents continued to express issues including a breakdown of communication with staff responsible for administering AHCIP cards and processing applications. At the time of interviews, two interviewed participants also expressed difficulties with obtaining a health care card for their Canadian-born child and were even informed that their child was not Canadian due to their immigration status. As one interviewed nurse described,

> … [what] we've had difficulty navigating is the charges for babies. We used to actually think that once babies who were born […] that they automatically had health coverage but that seems to be not the case or at least some of the time not the case because there are families that have received bills for the babies' hospital stay for like the pediatrician… (Nurse 1, Edmonton, 10/22).

Despite inconsistent applications of Alberta's new rules for Albertan-born babies, Lynn's advocacy efforts in partnership with Migrante Alberta have been life changing for many, paving the way for all future Canadian-born children of non-status or medically uninsured migrants to have legal entitlements to health care in Alberta. Local migrant justice movements were also key in the City of Edmonton's move to develop an Access to Municipal Services Without Fear motion in 2018. In addition to Migrante Alberta, other significant groups and NGOs concerned with health care for medically uninsured migrants included the New Canadians Health Centre and the Edmonton Refugee Health Coalition. This list is not expansive but identifies the key groups that were raised by participants at the time of research.

Access to Municipal Services Without Fear

The City of Edmonton introduced Access to Municipal Services Without Fear motion (C606) in 2018, stating that all municipal services and programs will be accessible without fear and regardless of immigration status or documentation (City of Edmonton, 2018). The City of Edmonton's motion

does not make any requests to other jurisdictions to review their policies or accessibility. The term 'health' does not appear in Edmonton's motion. At the same time, a city stakeholder consultation document by the Community and Public Services Committee suggested that "There are areas outside of the City of Edmonton's jurisdiction, including education, health and justice, where advocacy efforts would help to ultimately improve the well-being of undocumented individuals" (City of Edmonton, 2018, p. 2) – signaling a jurisdictional tangle regarding the desire of the city to promote change at other scalar levels. In the same report, the City of Edmonton acknowledges that some agencies provide "very limited primary and non-emergent health care services to undocumented individuals" (City of Edmonton, 2018, p. 4). Like many Canadian sanctuary cities or cities with Access Without Fear motions, Edmonton's 2018 motion has been referred to by local organizations as "a symbolic gesture." As city councillor McKeen put it:

> We didn't give amnesty; we don't have that authority. We said, you are stuck in a fearful situation in Edmonton. As far as services Edmonton provides, we will work with our front-line workers to make sure there is no heavy-handedness as far as asking for identification. (Fida, 2018, September 17, p. 1.)

Following the city's 2018 municipal motion, efforts continued to improve health care access in Edmonton. At the time, Edmonton was the only major city in Canada to have no medical clinics offering specialized care to migrants or refugees (City of Edmonton, 2018). This changed in 2021 with the opening of the New Canadian Health Centre, a clinic providing health care for government sponsored refugees only, with long-term plans to expand services to other migrants.

In this section, Edmonton's shifting demographics over time were highlighted as well as some more recent local social movements activism in support of a Sanctuary City and healthcare for Canadian-born children. This important local background helps to lay some of the context for investigating how local health care providers, migrant-led networks, civil society groups, NGOs and migrants navigate restrictive health care policies in a city with not a single clinic or service with designated funding for providing primary care to medically uninsured migrants. In the following

section, a brief history of Alberta' public health care laws leading to present day is presented to assess what health care entitlements exist for medically uninsured migrants at the time of writing.

4.3 Law in the Books: The Governance of Alberta's Health Care Laws

This section beings with a brief review of Alberta's provincially funded health care origins to current legislation, highlighting key eras, from the United Farmers of Alberta in the 1930s to the Klein era. As with the case of Ontario, this chapter demonstrates the changing nature of the regulations of Alberta's health care, and the contestation and elimination of more localized jurisdiction over time. Secondly, this section addresses the first research question of the law-in-the-books theme, investigating how Alberta's health laws have interpreted the CHA and defined residency for AHCIP eligibility, in addition to the ways in which this narrow interpretation often results in denied primary care in the absence of up-front financial payment.

Brief History of Alberta's Provincial Health Care Laws

The Alberta Health Care Insurance Act has governed public health care in Alberta since 1969. Today, public health care in Alberta is operated by the Department of Health (Alberta Health), as well as the Regional Health Authority (Alberta Health Services [AHS]). Alberta Health administers AHCIP, while AHS oversees the operation of insured hospital services across the province. Some medical historians argue that Canada's public health care system originated not in Saskatchewan as typically referenced, but in Alberta, due to the Alberta Health Insurance Act of 1935, which proposed an employee-employer-province funded health insurance plan for preventative and urgent care (Lampard, 2008; Canadian Museum of History, 2010c). Nonetheless, the plan that passed in 1935 by the United Farmers of Alberta government was not fully operational before the parties' defeat by the Social Credit Party, preventing its implementation from coming to fruition. Alberta's

provincial health care policy changes have not been as well researched and documented compared to other provinces, such as Ontario.

During the 1970s and the 1980s, Alberta was one of Canada's largest spenders on health care per-capita (Fletcher, 2009, p. 1). Shortly after the 1970 to 1980s oil crisis, Ralph Klein of the Progressive Conservative (PC) party, and a former mayor of Calgary, was elected premier in 1992 and was responsible for what is now commonly referred to as the "Klein-era cuts," bringing Alberta's health expenditures from the highest to the second lowest in Canada in 1996 (Fletcher, 2009, p. 1). Reay and Hinings (2005) note that 1994 was the year that Alberta's public sector began to signal shifts in its institutional belief system through its use of new language, moving from a "medical professionalism" logic to one of "business-like health care" (p. 357). They argue that prior to 1994, physicians were key players in Alberta health services and actively involved in the governance of its organizations, stating "Physicians were the only gatekeepers of the system" (p. 356).

The new "Made in Alberta" approach to health care introduced in 1994 by the PC's saw the elimination of 200 hospital boards, public health boards, and nursing agencies as a cost cutting measures: they were replaced by 17 regional health authorities who would hold authority over all health providers in their geographic location (i.e., except for physicians) (Reay & Hinings, 2005, p. 358). Harry Hiller's (2009) documentation of Alberta's immigration history notes that the Klein Revolution was "exceedingly painful" and "debilitating" when it came to health care cuts (p. 48). In the case of the creation of Alberta's Regional Health Authorities, nurses advocated that this provincial shift in health care models would be a digression, stating concerns over the introduction of fees, while physicians fought against their loss of authority over health governance (Reay & Hinings, 2005).

In 2008, under the PC government's leadership, Alberta eliminated all existing Regional Health Authorities overnight, replacing them instead with one centralized health authority, Alberta Health Services (Longwoods Publishing Corporation, 2018), losing any remaining local input into regional health care needs. Over time, the AHS developed five regional zones to administer public health care. Two of the five zones are based in larger cities (i.e., Edmonton and Calgary), and their surrounding communities.

In 2015, again under the PC government's leadership, Alberta appeared to reverse its previous decision on having only one health authority with five local zones and was set to re-introduced ten "operational districts" to help provide governance over public health, particularly in rural areas. The premier at the time, Jim Prentice, was quoted as saying "…people have the right to have input into local decision-making in something as important as their healthcare institution" (CBC News, 2015, March 18, p. 1). Little information was released on the status of these "operational districts" and their status today is unclear, as Alberta is still organized by five regional zones. Nonetheless, at the time of writing in 2024, Alberta has 39 Primary Care Networks (PCNs) across the province (see: Appendix G), which assist in providing tailored programs for local needs, with more than half the province's population now associated with a local PCN. As one interviewed physician in Edmonton described, "Most of them will offer some psychology services and they kind of choose what programs they do based on their patient population and, you know, what the physician's kind of collectively decide would be most helpful" (Doctor 2, Edmonton, 04/22). As a localized network, many health care providers discussed accessing language lines (i.e., translation services) through their local PCN.

Ultimately, it is important to note that as in the case of Ontario, there has always been local resistance against legal changes when it comes to health care in Alberta. For example, during the years of 2015-2019, Alberta saw a brief New Democratic Party (NDP) leadership. During their time

in power, the NDP government passed Bill 6 Enhanced Protection for Farm and Ranch Workers Act on December 10, 2015, which extended basic occupational health and safety rules to farm and ranch workers, made it mandatory for agricultural businesses with paid employees to offer workers compensation coverage, and provided access to unionization and collective bargaining (Barnetson, 2019, March 21; Bellefontaine, 2015, December 10). The NDP government saw strong resistance against these newly introduced protections, with thousands of people protesting across the entire province, allegations of cyberbullying against politicians, and a tabled petition by the Alberta Wildrose Party (i.e., conservative political party) with 30,000 signatures (Bellefontaine, 2015, December 10). Farm owners petitioned against this bill claiming that it would lead to the end of family farms in the province (Barnetson, 2019, March 21). Nonetheless, the data from the Alberta Worker's Compensation Board clearly demonstrates that the province's move from an employer-voluntary system to a mandatory requirement showed a doubling of injury claims from 2015 to 2017 alone, further highlighting the higher level of injuries and under reported injuries among Alberta's farm workers (Barnetson, 2019, March 21, p. 1), many of whom are migrant workers (i.e., TFW and SAWP workers are expected to fill 61 percent of the peak domestic labour gap by 2030 in Alberta) (Canadian Agricultural Human Resource Council, 2024, p. 1). While the NDP indicated receiving calls of support, including that from the Farmworkers Union of Alberta, this example demonstrates the ongoing contestation in both directions of support for and support against the expansion of health care rights for migrants in Alberta. Having identified key changes to health policy in Alberta over time, the following section reviews the eligibility for AHCIP to determine eligibility requirements for migrant workers.

AHCIP Today: Immigration Status, Alberta-born infants & COVID-19

AHCIP requires that, in order to remain eligible for health services, persons must be living in Alberta for 183 days out of every 12-month period. Like Ontario, in addition to temporal requirements, and contrary to the CHA, Alberta has added immigration and employment requirements to its definition of insured persons. Alberta provides AHCIP coverage to migrants with "a valid Work, Study, or Temporary Resident Permit and, in some cases, a "Visitor Record" (AMA, 2020, p. 1). AHCIP specifies that persons with expired immigration documents or failed refugee claimants will be denied health care services, explicitly attaching AHCIP eligibility requirements to Canadian immigration statuses (Government of Alberta, 2020).

For migrant workers, AHCIP is only provided for workers who enter Canada with a minimum active six-month work permit, yet at the same time, they must intend to be working for twelve months and maintain an active work permit in order to maintain coverage. Alberta issues temporary health care cards for temporary workers and issues an expiry date that matches the "valid until" date from their Canada entry document. In order for migrants to extend their health care card coverage, they must show AHCIP a copy of their new work permit (Government of Alberta, 2022).

With respect to migrant workers with visas shorter than twelve-months, such as the Seasonal Agricultural Worker Program (SAWP) and Temporary Foreign Worker (TFW) program, Alberta requires that employers offer private insurance coverage. This presents a major concern for migrants coming to Canada with visas under SAWP, as they are tied to SAWP-employers only (Government of Canada, 2022). As a result, if they lose their employment or quit due to abuse or exploitation, their health care coverage immediately ends, and they do not have access to the province's AHCIP in-between employment positions. Individuals must also apply for a new SAWP visa when switching employers, as the Government of Canada (2022) states, "You can only work for one employer at a time, and you can't work for a different employer until you receive your new work permit(s)" (p. 1). Nonetheless, switching employers within the SAWP may create a costly barrier ($155 for new visa)

and result in a gap in coverage while waiting for a new job offer and visa. These examples demonstrate the many significant ways in which the intersection of legal orders in Alberta (e.g., federal immigration programs and provincial health policies) and the actions of individual employer's impact waiting for migrants when it comes to access to health care.

In a positive light, as already discussed in the introduction of this chapter, in 2016, the Government of Alberta finally mandated AHCIP coverage for children born in Canada to parents who are non-status or former migrant workers living in Canada (Canadian Council for Refugees, 2018). The change has also since been reported by the province to the federal government and is recorded in the Canada Health Act Annual Report 2019-2020, which states, "Children of non-entitled residents (e.g., residents on a Visitor Record, with expired permits, or refugee claimants) who are born in Canada and meet residency requirements are eligible for AHCIP coverage" (p. 1). Interviews with migrants in Alberta have demonstrated that unfortunately this rule is not consistently applied, often requiring multiple efforts, appeals and months of waiting.

Lastly, when migrants go from being medically uninsured to medically insured, it is often reported by interviewees that Alberta Health may pay for previous outstanding bills accrued within the province. At the same time, the inconsistency of this process remains a mystery to most participants, for example, as described by one participant,

> …with Alberta Health they will often go back retrospectively and pay for the hospital delivery charges and stuff. But we don't know the timeframe, nobody knows that timeframe, about when, what does that mean? So, if a client gets their coverage within two months will they go back and pay for the delivery or is it six months, nobody seems to know that. I'm not sure that there is a specific number but we've tried to get it but can't (Nurse 1, Edmonton, 10/22).

In addition to provincial eligibility requirements, fees for medically uninsured migrants are a significant barrier to accessing care in Edmonton as discussed in the following section.

Fees for Uninsured Migrants

In Alberta, uninured migrants are required to pay for all of their health care services. While there are a few non-profit organizations in some areas of Alberta offering subsidized health services, the waiting lists can be as long as eight months (Salami et al., 2020). In Edmonton, there is no agency dedicated to providing health care services for uninsured migrants. Only as recently as 2021 did Edmonton open its first ever health care centre for government sponsored refugees (New Canadians Health Centre), one of Canada's only major cities that did not already have such a clinic at the time.

As previously mentioned, the Alberta Medical Association (AMA) refers to uninsured migrants in Canada as "out of country patients." Of serious concern, the AMA's guidelines on billings states that physicians should charge out of country patients two to five times the Schedule of Medical Benefits (SOMB) fee, which is the fee set and covered by the AHCIP. The AMA also directs physicians that they may require either partial or full fees prior to their service or appointment. The AMA (2020) recognizes migrants in-between work visas as "out-of-country" patients, stating, "If a patient is in-between visas, they can be charged as an out-of-country patient, and they may be charged 2-5 times the SOMB fee" (p. 1). This is in stark contrast with Ontario, where the College of Physicians and Surgeons of Ontario (2017) advises members not to charge above the provincial rate, directing them not to bill "b. any amount in excess to what OHIP has paid or will pay," and where members are encouraged to "reduce, waive, or allow for flexibility with respect to the fee." (p. 1). While profiteering from migrant workers also occurs in Toronto, the recommendation to do so by a regulatory authority is unfortunate. As techniques of government in the regulation of migrant health, the AMA's recommendation to bill at rates two to five times the AHCIP rate actively reproduces ideas of sovereignty in medical offices, contributing to lack of belonging in the process. Only in cases where a migrant receives a back-dated visa, does the AMA allow for a refund and directs physicians to bill AHS. Interestingly, Alberta offers a one-time 90-day

extension of AHCIP coverage for migrants who have applied for an updated status and are waiting for response from the IRCC (AMA, 2020). It is important to highlight that this one-time extension does not exist in Ontario at the time of writing.

The AMA (2020) crosses their jurisdictional boundary with respect to health care in their "Billing for out-of-country patients" guideline, providing interpretations of immigration law, despite holding no relevance to the role of a medical provider:

> It is important to note, individuals who are waiting for their spousal sponsorship or confirmation regarding their application for Permanent Resident Status to arrive, **do NOT have legal status to be or remain in Canada** unless they have a Work, Study or Temporary Resident Permit or a Visitor Record. Unfortunately, many believe that they do have legal status during this waiting period (p. 1, bolding added).

It is unclear why the AMA is advising Alberta physicians on the legality of physical presence for migrants waiting on Permanent Resident Status or spousal sponsorship as it does not relate to the work of physicians, yet it simultaneously contributes to the government of migrant health and the government of migration status at the level of health care offices.

COVID Measures

In April 2020, AHCIP released Bulleting Gen 126 entitled "COVID-19 Billing Process for non-residents of Canada." At the time of writing in 2023, this Bulletin appears to remain in operation, providing physicians with billing codes to receive fee-for-service payment, in order to provide health care to medically uninsured migrants specifically for the testing and treating COVID-19 only. The directive requires physicians to provide the patient's name and residence for the purpose of reporting to AHCIP. The requirement to provide a name and address may also be a deterrent to accessing these services for individuals at risk of deportation. Unlike Ontario, Alberta's temporary billing codes for COVID-19 do not extend beyond the treatment and testing of COVID-19 for

medically uninsured migrants. It is possible that there was less political pressure from health care providers in Alberta compared to in the case of Ontario. While both provinces had conservative governments at the time, one possible explanation for this different approach could be the result of more organized and consistent pressure in Ontario, or that the premier of Ontario was more suspectable to the pressure to expand health services to medically uninsured migrants during this time.

In this section, the question of law-in-the-books was explored. The chapter provided a review on the evolution of Alberta's health policies, the status of health care eligibility for medically uninsured migrants today and identified relevant professional bodies responsible for the governing of medical doctors and standards in billing prescribed by the AMA. Alberta's public health history demonstrates an ongoing effort to centralize, and then later, decentralize the governance of health care back and forth over time, also signifying the potential for future changes to this effect. The potential for Alberta to expand beyond five zones in the future may present an opportunity for more localized networks to mobilize around funding to provide care to uninsured migrant workers. For example, in the case of Ontario, medical practitioners had utilized LHIN's to initially secure special funding from the province in order to treat uninsured patients. Having set the legal context, in the following section, I draw on interview findings to investigate relevant law-in-action research questions and begin to unpack the effects of governmental power for medically uninsured migrants in their efforts to access health care.

4.4 Law-in-Action: Experiences with Navigating the Local Health Care System

This section draws on interview findings to analyze how residency and health care eligibility are enforced in practice across Edmonton's health care institution sites (i.e., spaces) as well as how barriers to health care services are experienced by migrants, and in which specific ways (e.g.,

financial concerns, delayed care, employer misinformation etc.). Unlike in the case of Community Health Centre's in Toronto, no health care institutions receive funding to provide health care to medically uninsured migrants in Edmonton, and until recently in 2022, Edmonton was one of Canada's only major cities without a health clinic dedicated to providing services to refugees. For this reason, interviews and findings cast a broader net compared to Toronto, in an effort to capture narratives from a variety of actors engaged in work with migrant workers and medically uninsured migrants across organizations. By employing an analytics of assemblage approach, emphasis is placed on the multitude of governing agencies and authorities, and in the case of Edmonton, this emphasis particularly focuses on employers and NGOs as well as civil society groups and health care workers. By drawing on Brady and Lippert's (2016) 'ethnographic imaginary' approach to governmentality, narratives (e.g., interview findings) provide considerable insight into understanding the problematization, relevant rationalities and technologies in the governing of migrant health (Howard, 2016). This section highlights findings regarding reasons for becoming medically uninsured; services available in Edmonton; common issues of fear, delayed care, and financial constraints; billing, standards of care and denials of care; and the local governance of immigration status.

Medically Uninsured Migrants in Edmonton

Health care professional participants in Edmonton were asked to describe the most common situations in which the migrants whom they serve end up in situations where they become medically uninsured. Identifying these situations is particularly important in an effort to dispel stereotyped beliefs about non-status migrants in Canada and to share more stories and personal narratives. For one doctor who regularly works with medically uninsured migrants, the most common situations they experience involve young workers, who come to Canada under a foreign worker program but end up losing their employment. These workers "are of young age they very well maybe have right

as a refugee and they're fleeing for one reason or another," however for them, "… returning to their home country is not really a possibility" (Doctor 3, Edmonton, 04/22). As reported by local health care professionals, one of the most common reasons migrant workers are laid off by their employers is due to pregnancy (Doctor 3, Edmonton, 04/22), despite this practice being largely against Canadian employment laws. Termination of employment in turn results in a loss of health care insurance.

Multiple health care professionals also cited receiving multiple referrals from women's shelters or NGOs that work in human trafficking. For example, women who migrate to Canada for marriage and end up experiencing emotional and/or physical abuse and in turn find themselves medically uninsured (Doctor 3, Edmonton, 04/22). Sponsorship breakdown due to domestic violence was also a significant concern in the Edmonton region for women losing their health care coverage. As one interviewed nurse shared,

> Clients are here, their spouse is supposed to sponsor them and they're withholding that from them or they have fled that abuse and then, like they're starting at square one or square zero even have nothing (Nurse 1, Edmonton, 10/22).

It is important to note that the above scenario is also covered under the federal visa, Temporary Residence Permits (TRPs) for victims of family violence (Government of Canada, 2024b). Nonetheless, while a TRP can extend legal residency for those living in Edmonton, migrants with TRPs in Alberta are not automatically eligible for AHCIP and must secure full time employment and satisfy AHCIP criteria for entitlement.

Finally, another cause for loss of health care coverage in Edmonton, involves international students who lose their coverage required through their academic institutions subsequent to withdrawing from a program, for example, due to pregnancy. The issues and barriers to accessing prenatal and obstetric care throughout pregnancies for medically uninsured people is a constant reoccurring concern in the Edmonton area and is discussed in more depth further in this chapter.

Some of the health concerns most commonly reported by those working with medically uninsured migrants in Edmonton include:

> dental care, mental health, you know, the stress they face. And vision, no, they also are looking for those regular checkups, particularly women, migrant women…from time to time we have…cancer, renal and liver failure (Civil Society Group 1, Edmonton, 01/22)

For many participants, health care issues are further made more complicated due to social determinants of health. For example, as one nurse described "…it relates to the financial component. So, you know, poor nutrition, lots... with anemia and they can't afford their iron supplements and then multivitamins" (Nurse 1, Edmonton, 10/22).

Since Edmonton has no official health care institutions with funding to provide services to medically uninsured migrants at the time of writing, the following section outlines the services that were available for migrants and in some cases medically uninsured migrants.

Services Available in Edmonton

Reproductive & Sexual Health Clinic.

Edmonton has a reproductive and sexual health clinic that at the time of interviewing (April, 2022) was providing services to medically uninsured migrants. At the same time, a new funding model was just introduced on April 1st, 2022, because of Alberta Health Services eliminating clinical stipends across the board, making it increasingly more difficult to provide care for people who are uninsured. As one doctor from the clinic shared, "…we just all agreed that it would be kind of up to the provider at their discretion. And so, I believe that's the current thought at the moment" (Doctor 2, Edmonton, 04/22). At the time of interviewing, this clinic was one of the only health care centres openly providing health care to medically uninsured migrants without operating through an informal

referral-based system. As this clinic strictly provides reproductive and sexual health services, medically uninsured migrants must seek primary care through other local and unofficial means.

Community Referrals to 2-3 Local Physicians.

There are only two to three physicians in Edmonton accepting patients from community and NGO referrals at different times for primary care issues. These referrals require individuals who are medically uninsured to actively seek out support from a local non-profit organization or civil society group. Through word of mouth, the individual may be referred to one of these physicians for care. None of these providers do any advertising and prefer to remain anonymous in order to protect patients who may be undocumented and fear risk of deportation from their clinics. No provider or clinic receives any funding (i.e., provincial or federal) to provide primary care to medically uninsured migrants, making it very difficult for medically uninsured migrants to navigate care locally. It also means that these providers are not paid for any of their services during these appointments. It is possible that more physicians in Edmonton provide pro-bono primary care to uninsured migrants, though they are not formally known to local civil society groups or NGOs service migrants in the city.

One physician whom I interviewed has secured free lab testing for most lab tests such as blood tests and free or discounted tests such as ultrasounds, from a local imaging company, for their referred patients who are medically uninsured. According to the physician, "I think they [these companies] view it as a valuable kind of community service" (Doctor 3, Edmonton, 04/22). Interestingly, this service of free or discounted lab work and imaging by private companies was not identified in any Toronto-based interviews or services.

Two different approaches to referrals have been observed by these physicians, likely influenced by capacity of patient lists at these clinics. For example, one physician describes accepting most referrals, stating that:

> …I might at some point so I was just more telling myself that I'll just kind of keep going and essentially accepting any and all referrals from social agencies. I find that overall, it's not a huge burden capacity because eventually these individuals do get coverage. Cause, you know, maybe they're applying for permanent residency so they eventually do get it. And then when they do get it, they may find their own physician, that might be more convenient or closer. Or some of them have stayed with me, some of them got coverage and then they still see me (Doctor 3, Edmonton, 04/22).

Another health care provider offers medical services to uninsured migrants through certain referrals, though it is reported these services are more restricted due to capacity limitations. For example, one civil society group member described the procedure for referrals to this office, explaining that,

> … why we do the referrals and intake is that we do the interview and the forms and they said, you know the doctors instruct them on how to get into the clinic. Not to go to the front desk, right…it's a regular clinic that they have other doctors. But within that clinic, only two doctors provide, you know, pro bono services. You know, according to the doctors the other doctors know about it. It's just, like they don't let them go through the front desk. So, there's a mechanism that we deal with the doctors themselves. When exactly are the migrant workers gonna go, you know, they would get an appointment directly to the doctors as opposed to the front desk (Civil Society Group 1, Edmonton, 01/22).

While it is of significant importance to the local community that these doctors are offering pro bono services to medically uninsured patients, this particular description is reminiscent of public symbols that served as reminders during the Jim Crowism era in Canada from the 1850 to 1950s. Walker (2012) describes how in the Canadian-context, Jim Crowism was not exclusively customary nor exclusively legalized. Here, the spatialization and effects of Alberta's health laws become highly visible, impacting the mobility of medically uninsured migrants in their efforts to access care across different offices. The arrangement with these referrals to access the medical office in a physically different way than other patients carry with it a psychological effect, for example, "they think there's no dignity to it because, they feel like going to the back door they feel like they're stealing something. You know, there's a sense of, you know, self-pity, you know" (Civil Society Group 1, Edmonton, 01/22). In Canada, medically uninsured migrants are often treated as "separate but equal." The state has legally argued that there is no systemic discrimination against medically

uninsured migrants, they simply need to pay for services, yet health care providers overwhelmingly report (as is the case with participants in this research), that medically uninsured migrants may experience lower standards of care as well as premature death as a result of denials of care.

New Canadian Health Centre.

Edmonton previously had a volunteer-run clinic around 2012-2013, organized by a local physician in the basement of a church that first opening during the Harper-era cuts to refugee health. Anderson and Soennecken (2018) detail how in 2012, the Conservative government announced it would remove rejected refugee claimants and asylum seekers (on a specific designated country of origin list) from all benefits, such as the IFHP, with the exception of emergency coverage. Later in 2014, in Canadian Doctors for Refugee Health Care v. Canada (AG) FC 651, a federal court judge found the Harper-era cuts to IFHP to be unconstitutional (Anderson & Soennecken, 2018). Eventually, IFHP was fully restored in 2016 under the successive Liberal government. Organizers involved in Edmonton's volunteer clinic found that after opening, there were many more migrants who were medically uninsured and without health care all together, which substantially expanded their patient intake to include those without any health care coverage. As one participant described "… I think if it was one afternoon per week, on Friday afternoon, or something like that. And I remember that it was one of the doctors and then sometimes it would be more than one doctor… But they had to close because basically it was not sustainable" (Coordinator 1, Edmonton, 03/22). This clinic unfortunately closed due to a lack of official funding sources that were ultimately necessary for continued operations.

In 2016, local social service agencies, advocates, academics, and health care professionals began planning for a new clinic, which would become the New Canadian Health Centre. As shared by one clinic organizer,

> … we started really advocating for Edmonton because Edmonton was the only major city in Canada without a dedicated health center for refugees and newcomers. We talked to a bunch of people, we advocated, we went to everywhere and we continue, and we formed what we call the refugee health coalition (Coordinator 1, Edmonton, 03/22).

Edmonton opened its first ever funded health care centre for refugees in 2021, called the New Canada Health Centre. At the time of writing, the organization only has capacity to provide services to government sponsored refugees but plans to "keep going towards being able to see undocumented [migrants]" (Coordinator 1, Edmonton, 03/22). This clinic is in the same building as other settlement services and is designed to be a one stop shop for multiple health needs. For example, one participant shares:

> We didn't want it to be just a clinic because that's not what our clients need. We wanted it to be like a multidisciplinary place where we have the family doctors but we also have the specialists but we also have the mental health support, we also have the health navigation piece. We have the best people welcoming and making people feel accepted, safe and also that we're taking care of their medical needs. Taking into account the social determinants of health as well…(Coordinator 1, Edmonton, 03/22).

The following section of this chapter outlines the various issues and reoccurring themes that were shared by research participants with respect to access and barriers to care for medically uninsured residents.

Common Issues: Fear, Delayed Care, Financial Constraints

One of the most significant issues for uninsured migrants in Edmonton is the need to delay seeking care due to financial constraints. Paired with frequent requirements for payment up front, these migrants also experience the fear of deportation. As one doctor describes,

> …someone who may have been unwell for some time and they really delayed it because they're worried it would incur a charge or another thing we see typically in particularly in Edmonton, Alberta, there's been some, like negative sort of discussions and sort of on a provincial level and you know folks with precarious immigration status and I think people fear being reported or being deported when accessing healthcare and so there's a lot of hesitancy accessing healthcare services (Doctor 1, Edmonton, 02/22).

Speaking with a member of a local migrant rights group, they described how medically uninsured migrants in Edmonton often rely on unofficial community health resources, explaining that,

> …migrant workers don't have the funds to pay for those kinds of physicians so then they seek out mostly health information or advice from less than reputable sources…obviously it's not the standard of care that the Canadian healthcare system would want for Canadian citizens. So, yeah, I guess that's what I'm familiar with is people relying on community leaders for their medical advice rather than seeking out physicians because of the lack of trust (Civil Society Group 2, Edmonton, 02/22).

These findings also became evident during interviews with migrant workers who described relying on traditional remedies to treat their health issues instead of visiting a doctor. For example, Valentina explained that in the summer, she could rely on traditional medicine practices from her home country, "…here in Canada when it's winter I can't…It's not possible. So that is a hard part about our health. Pretty soon midwifes will not attend us anymore. So will be again a problem for us" (Valentina, 07/22).

The inconsistent fees across health care providers in Edmonton with the AMA encouraging fees of two to five times the provincial rate, also present challenges for medically uninsured migrants who frequently experience unclear, and elevated billing rates. These inconsistencies also cause issues for advocates and provides who provide referrals. For example, one nurse participant described this challenge as,

> … it's really hard for us to know what to tell clients about what things will cost because it varies through care providers, it varies based on, you know like, sometimes physicians will want money up front, sometimes physicians will take a payment plan. Sometimes we can advocate with the physician to do free prenatal care, it doesn't happen very often but we have had success with that (Nurse 1, Edmonton, 10/22).

Many uninsured migrant women also forgo prenatal care almost entirely, for example, "they don't get that (prenatal care), they just, like I said, they look up on what vitamins to take, you know…regular prenatal, it's not in their radar because of the cost" (Civil Society Group 1, Edmonton, 01/22). Pregnancies and labour are particularly expensive in Edmonton. Most of the

interviewed participants shared stories about women going without prenatal care altogether. For example, one nurse described that,

> …we are working with these moms who don't have the resources to pay for prenatal care. So, lots of times they can't pay for it, then it's you know, you have to go to the hospital when you're in labor with your concerns. So obviously that's a challenge for our moms because we worry about them not having prenatal care (Nurse 1, Edmonton, 10/22).

The fees for the delivery of babies are particularly high, with many women leaving the hospital shortly after birth only to be followed by collection agencies for payment later on. One civil society group member shared their experience, reporting that,

> I recently drove three moms to the hospital to give birth and then just get them out. So, it's in and out. They don't really, they ask for health cards but they cannot really refuse, you know, healthcare for anybody right. So, but they charge, they charge up to $7,000 for regular childbirth. And after, you know, after they get home, they start getting, these moms start getting bills from the hospital to approximately three to six months. And then the collection agency, a private collecting agency starts harassing them. So, I mean yeah, they're scared… (Civil Society Group 1, Edmonton, 01/22).

Lynn, who moved from Toronto to Edmonton, also shares her experiences with the delivery of her child in an Edmonton hospital and being asked to leave almost immediately afterwards:

> When I gave birth to my daughter that was (year, prior to Mckenna Law). By the time waiting my new work permit to my new employer because I would be changed employer because of the harassment that they'd given to me. When I gave birth to my daughter that was (year). I don't have healthcare because my work permit hadn't arrived. So, the hospital charged me on everything. No (unknown 7:58), I saw thing that when I gave labor to my daughter. When they found out that I didn't have healthcare, okay we will let you deliver but you need to pay after and then just like after I gave birth, couple of hours they told me that we need to start our signing up. You need to pack because you can't stay longer because your bill getting up, you know what I mean. So that's the worst that I experienced at the time, don't they assist me delivering my baby. But after I get delivered, just like a couple of hours only, they ask me pack because my bill will get higher because I don't have healthcare. I'm not sure if they are concerned with me, to not get my bill get high. I don't know but the feeling is just like okay, I really don't know at the time but I'm really just upset because my daughter was a Canadian by born but she cannot get access also. By the time they billed my daughter also…That time when they bill on me it's like $5,000. And I don't have money to pay and then they put in the collections agency for like you are being harassed every day. You have a call and then they give you a letter and then when you saw the letter also my daughter, she's just a baby…I just gave birth to her at that time, then she owes already. She has already a debt to pay, you know (Lynn, 08/22).

Despite Lynn's daughter being born a Canadian citizen, she was born into the world with a debt to the Alberta government for her health care needs. This example is reminiscent of the ongoing historical effects of indentured labour, slavery, debt bondages and the effects of colonial racism. For example, migrant workers on SAWP visas are required to be from a list of select countries, largely Caribbean states and Mexico. Yet it is broadly recognized that the transatlantic trade enslaved Africans to the Caribbean Islands, roughly 40 precent of all enslaved African people, thereby sustaining the Atlantic economy through African enslavement (Sherman-Peter, 2022, March 24). Yet in the 21st century, the Canadian economy, based on the state's own assertion (IRCC, 2018, I), depends on temporalized labour from these same regions. As a result, descendants of slavery end up labouring (and waiting on) again, in industries marked by risks of exploitation and contemporary forms of slavery (OHCHR, 2023, September 6). Children born to medically uninsured migrant workers in Alberta prior to the McKenna Law, like in the case of Lynn's daughter, are in turn born into a modern-day debt bondage. Beyond migrant workers eligible for SAWP visas, many other migrant workers on TFW permits come from Global South countries, drawing parallels between the international political economies of both north and southern states that are interwoven. For example, the Philippines, which was colonized by Spain, now relies on international migration as one of its key economic engines (Opiniano & Ang, 2024, January 3), whereby many TFWs in Canada in turn send remittances back home. Colonial dispossession thus continues to impact both migrant workers who are descendants of states impacted by colonialism, as well as Indigenous peoples in Canada, which in turn creates similar shared materialities for both groups.

Another participant, Valentina, shared a similar experience with attempting to access a health care services from an obstetrician for the delivery and prenatal care of her child:

> Valentina: ...when we went to doctor ___ he was rude with us.
> Interviewer: Oh, no.
> Valentina: So, he said like you can't pay me so I would not attend you.

Interviewer: Okay.
Valentina: You should like prove about you have money for pay the hospital.
Interviewer: Okay.
Valentina: You can't pay the hospital; you should not be here.
Interviewer: Wow. And how much did he ask for? How much money did he want to see?
Valentina: (speaking Spanish)
Filipe: (speaking Spanish)
Valentina: He said you should pay the room; you should pay the doctor, and you should pay the service. In total, was like $8,000.
…
Valentina: Yes. The first question of the doctor was if we have status and if we have money.
Interviewer: Okay.
Valentina: So, we were so disappointed about the doctor.
Interviewer: Yeah.
Valentina: Because we answer about maybe we don't have money now, but we will work for paying. I mean, my intention was not like get everything free, of course. We will pay, we wanna pay but we don't have at the moment money for paying everything (Valentina, 07/22).

Ultimately, Valentina was able to access the support of a local midwife that was arranged through a social worker and had a home birth for her child. However, Valentina noted being worried about the dangers of not being able to deliver her child in a hospital or clinic had anything gone wrong, as she did not have the financial means to pay the hospital room fees. It is also important to note that multiple research participants indicated that midwife services are not regularly available for medically uninsured migrants in Edmonton. After Valentina's child was born, she was routinely denied a health care card (AHCIP) for her Canadian-born child from Alberta's Ministry of Health. After exchanging the Citizenship Act and Alberta's health care regulations after our interview demonstrating her child's entitlement to health care, Valentina reported that she was finally able to secure a health care card after multiple previous unsuccessful attempts where she was regularly told by local government offices that her child did not qualify.

It is important to emphasize that children born to medically uninsured migrants in Canada are Canadian citizens, yet many are routinely denied funded health care after birth in Edmonton despite Alberta's adoption of its new policy – the community labeled 'Mckenna Law.' As shared by a nurse participant, this has recently become a recurring issue, explaining that:

> You just come home [from having a baby in Alberta], you get a sticker that has your baby's healthcare number on it and then within a couple weeks you get the actual healthcare card…Just within the last year or so all of a sudden, we're having babies that are getting the bills from the hospital that we didn't encounter before. They were given healthcare cards before. And so that is actually one of our things that we're trying to figure out. We honestly don't know and that's one of the hardest things, we don't know what to tell parents (Nurse 1, Edmonton, 10/22).

The ongoing denial of health care cards for Canadian-born children to migrant workers in Edmonton is a clear disconnect between law-in-the-books versus law-in-action, emphasizing the significant need for scholars to investigate these incongruencies. Here, the province's health department is employing techniques of jurisdiction and discretion to obfuscate the eligibility for health care entitlements of Canadian-born children of migrant parents. Such techniques recreate boundaries of sovereignty signalling a lack of belonging in the process (Pratt & Templeman, 2018). As documented by multiple participants through first-hand accounts and through health care providers, it is clear that these denials are systemic and not a one-off scenario.

The next section further addresses billing of health care for medically uninsured migrants, with a focus on how billing practices result in varying standards of care and denials of care, which can lead to serious health consequences for these migrants.

Billing, Standards of Care & Denials of Care

It is important to highlight that some physicians in Edmonton, both in hospitals and primary care clinics, routinely forgo payment when working with migrants who are medically uninsured. One physician who was interviewed shared that when working in the hospital, they often forgo charging patients who they know are medically uninsured, stating that:

> …in the hospital, the cost of bill that you receive at the end of the day of that experience the physician charge only represents a small portion of that. So, there's also charges that we have no control over. So, the hospital will have charges, diagnostics, laboratory equipment. So, there is the physicians, it's more often like I will choose not to charge, if someone doesn't

> have healthcare status I will just write on my, I have a billing clerk that does my billing, I write no charge. So, I don't get paid for that charge, it doesn't bother me much. I mean like it's, you know, one encounter in my day. But the person will still get a bill, right (Doctor 1, Edmonton, 02/22).

It is difficult to identify accurate statistics on how many physicians opt to forgo payment for uninsured patients, though interview findings demonstrate that this is not the norm. As demonstrated, even with providers opting not to charge, hospital fees and diagnostics may up a large portion of the bill. The financial barriers created by a system that leaves some people medically uninsured creates more complicated issues that alter the standard of care provided. One doctor provided insight into their legal consciousness of this reality, explaining that:

> The moment I'm being asked is it absolutely needed, it's not a place we're used to being, maybe in places like the states where they're often having this sort of okay but this is very expensive and maybe not. So, I think we're not great at being put in that position as physicians. It's uncomfortable, right, because you might miss things, the care might be incomplete. But then you also are weighing up with do I want to potentially, you know, severely bankrupt this family or, you know, make them sell their home or car because, you know, I would normally do a CT scan in this circumstance. So, I don't know for like as physicians we're very good at sort of playing that dynamic very well. But I think it can either come across as like, you know, not so much not offering as maybe sort of prioritizing certain interventions versus others and yeah, it's difficult right. Because it's not a standard care you're used to delivering in any way (Doctor 1, Edmonton, 02/22).

These findings were also documented in Toronto interviews, demonstrating that health care providers across Canadian cities are often placed in the difficult position of changing the standard of care they would normally provide to a medically insured resident. Of particular concern, multiple participants shared stories of medically uninsured migrants being denied treatment for terminal illnesses due to lack of upfront payment. As described by one doctor "…so the one patient I'm thinking of who had that emergency, she had very severe symptoms and then they treated her symptoms, but they did not treat the cancer" (Doctor 3, Edmonton, 04/22). Participants demonstrated a discomfort with discussing stories where they have seen patients not receive adequate care, using indirect language to describe situations of cancer and pre-mature death. For example, one participant shared "…a little bit of them would have terminal diseases and then they

couldn't, they didn't have any way of actually, yeah. There was not a lot of hope for them…" (Coordinator 1, Edmonton, 03/22). Another doctor shared an impactful story of one of their patients delaying care due to the high costs which lead to worsened conditions and inability to access the care they needed:

> …somebody who had their mom was staying with them from out of country and the intention was I think mom was planning to stay. But they did not have status in Canada to stay at that point. So, mom had been sick for some time, she'd been losing weight, she'd been very frail, and then started to have some bleeding in her stool. And the family really delayed because they were quite worried how much it would cost and understandably, right. I mean we're talking, you know, the work up for tension, it ended up being for gastric cancer. Very expensive to overcome. There was not a lot of access, not a lot of routes and I think especially Edmonton and Alberta in general we really struggle to put together the access points for those who don't have healthcare coverage…So obviously by the time the family had brought her in she was very sick, you know, we were having discussions about, you know, blood transfusions. The family was super worried about having her admitted to the hospital because of the cost it would incur. And I was super worried if she left hospital, she would die… It's like a very uncomfortable place to be sitting with a family and trying to, you know, make a sort of budget on healthcare (Doctor 1, Edmonton, 02/22).

Another doctor shared a similar story, explaining how the cost of treatment for cancer results in denied care, stating that:

> We know they have a certain diagnosis, like a cancer diagnosis, but the treatment for it might be radiation or chemotherapy, those are also very expensive. And that has happened. We've experienced that as well where they need chemotherapy, but I spoke with the medical oncologist and they said "you know, this would cost easily 10 or 20 thousand dollars a month and we can't give it to them for free" …I recall one case where she was just not able to get their cancer treatment that she needed. We just had to treat her, unfortunately, as a palliative patient. So, we just kept her comfortable and then eventually she passed away.
>
> Interviewer: There was a chance that she might have lived but not 100%, there was a chance, but she had to forego it due to financial reasons?
>
> Participant: Yeah, and then it's also, it's very uncomfortable for us as Canadians to talk about these things, right (Doctor 3, Edmonton, 04/22).

These stories point to irrefutable evidence that medically uninsured migrants in Canada are experiencing systemic discrimination in the provision of health care services, and at times, are associated with cases of premature or preventable death. One participant named this experience

more directly, stating that, "…my clients have said they felt like they were discriminated against. That, you know, people didn't want to give them the same amount of care. A lot of them, you know, have fear about going to the hospitals about like 'I'm scared'" (Nurse 1, Edmonton, 10/22).

These examples further highlight the way in which waiting is relationally assembled, and the roles that various actors and institutions play in the production of delayed care, and the extreme cost of health or life that is connected. For example, the stories shared demonstrate how waiting and its impact on health care and right to life was directly linked with government staff who denied legally eligible children the right to health care cards, how family members delayed bringing in their loved ones to seek treatment due to the lack of funds, or how the processing delays of immigration permits, such as labour impact assessments by employers all lead to varying barriers to care for medically uninsured migrants. In the following section, the recurring topic of language and translation in Edmonton clinics is discussed, in relation to health care for medically uninsured migrants.

Language & Translation

As in the case of Toronto access to translation services was a major barrier to health care services in Edmonton for medically uninsured migrants. As one physician described,

> … one of the biggest barriers to trying to transition patients to the community and also when we're doing referrals to specialists and things like that. You know, community physicians don't have access to those language supports and so it definitely is a barrier to kind of helping people access care in the community (Doctor 2, Edmonton, 04/22).

Other participants shared a concern with issues regarding informal translation services, stating "And we are very very strong about the way that you use the interpretation services. It shouldn't be your kid, it shouldn't be a community member, it should be somebody who is trained" (Coordinator 1, Edmonton, 03/22). At the same time, in many institutions where "language lines" are available,

there is a concern that staff are forgoing using them. For example, as one interviewee explained "…any single Alberta health center inside, it has to provide interpretation for clinics. And many people do not know about it. And they don't even reach out for the language line, just because which number to call or which phone to use." (Coordinator 1, Edmonton, 03/22). As a documented issue in each city engaged in this research, more consistent and professional translation services would go a long way in improving health care services and reducing barriers to adequate care. Based on the analysis of interview data, a final and frequently occurring theme presented in the next section is governance of immigration status by local actors.

Governance of Immigration Status

The governance of the immigration status of migrants in Edmonton was noted particularly by employers and by local NGOs. An investigation into the governance of workplace injuries emphasized the disconnect yet again between law-in-the-books versus law-in-action. For example, one doctor explained a common situation witnessed through their work practice, stating:

> …if they [migrant workers] were to report this as a workplace injury that they would essentially be sent back home so you see those kinds of dynamics play out as well, where technically by the law that's not appropriate but the way that might happen, you know, between someone and their boss (Doctor 1, Edmonton, 02/22).

The technique of discretion can be seen within the confines of employer relations, whereby workplace injuries or illnesses for some categories of migrant workers become tied to the legal right to remain in Canada with health care access. NGO participants echoed this concern, explaining similar incidents. For example,

> So, they're coming here and there's some horrible stories of folks getting injured on a farm and getting deported…While injured, while needing care, cause it saves money for WSB or for Alberta. (unknown 14:28) there's all sorts of things that make me angry about that but really a lot of our temporary workers in Alberta are working in agriculture and a lot of it is precarious in what kind of access to rights let alone healthcare they have (NGO 1, Edmonton, 01/22).

In Edmonton, it was reported that many factories that have migrant worker employed, have a stationed nurse working on site, which employees must go through first when injured. One NGO participant speculated some concerns with this arrangement, explaining,

> So, there's the Alberta Immigrant Nominee program and part of their collective agreement is that those employers will put them on a path to citizenship through that program as being an employee there. So that was kind of a huge win for ensuring people have some sort of fair status. But also, at those plants what the employers do is they have nurses who work on site, that work for the employer. And so, if an incident happens you have to go through the nurse first before elsewhere and so that can impact the care you get, including part of that goal is to decrease WCB [Workers Compensation Board] claims, right, for the employer. Which, you know, it concerns us that who knows what happens in that room…what people are getting and what advice they're getting or what referrals they're getting. So, there's definitely some vulnerability there (NGO 1, Edmonton, 01/22).

Local NGOs form another level through which migration status becomes governed. This finding is consistent with research on church sanctuary movements in Canada, in which he identified that churches would often mimic the official immigration screening mechanisms of Canada's refugee determination system (Rehaag, 2009; Lippert, 2005). This research identified a detailed pamphlet created by the United Church of Canada to help other congregations to review requests for sanctuary protection as well as to interpret the 1951 Convention and documented a pastor discussing the need to differentiate between economic refugees from those who could prove physical danger (Rehaag, 2009; Lippert, 2005). In the case of Edmonton for example, some physicians who see uninsured patients have them screened first through a local NGO to determine their level of need, not unlike the cases of church sanctuary practices that required the creation of a screening mechanism. One physician explained,

> When we receive referrals, we typically don't get tourists, I mean they might be on a visitor or tourist visa but one of the screening criteria is generally that they may not have the capacity to pay for medical services. ...So, the social agencies that refer these people to us also kind of would ensure that they're not just like, you know, wealthy tourists who are just looking for free Canadian healthcare and so on (Doctor 3, Edmonton, 04/22).

In the case of Edmonton, another participant involved in the referral system as the first point of contact described the situation as follows,

> …there's many many undocumented immigrants that come to us and we refer to the couple of doctors and we also try to make sure that, you know, we also try to limit (unknown 32:02) what cases are, I guess more important than others, so that they also don't burn out, right. Those are the only doctors that we have. So, you would give them a shot and just ask, you know, if they would see them. If not, they would just advise you, you know, either take something, you know not necessarily prescription medicine, just you know, regular pharmacy, you know, off the shelf medicine (Civil Society Group 1, Edmonton, 01/22)

Ultimately, migration status and urgency of health care conditions get triaged through local NGOs and groups, with different physicians and clinics having varying criteria for accepting referrals. It is apparent that at this level, governance of status and a hierarchy of medical need takes place in order to preserve the limited resources available as very few physicians provide services free of charge in Edmonton and there are no official free clinics available. Unlike the case of Toronto, there were no reports of requirements to regularize status by any physicians and services investigated in order to access care. There were also fewer reports of uncertainty on the ethics of care compared to Toronto interviews, with all interviewees agreeing that there is an ethical obligation to provide preventative and urgent health care to medically uninsured migrants. Nonetheless, interviewees also indicated experiences where efforts to govern their status occurred in the health care sector. For example, one participant, Valentina, was told to leave the country by a health care organization, sharing,

> I was looking everywhere… Like the websites, with midwives, I made a lot of calls, I sent a lot of emails. And I don't know, it's a lot of answers for me was no you can't, I'm sorry, a lot of people told me about you should go back to [Country of origin removed for confidentiality], we can't attend you (Valentina, 07/22).

In summary, interview findings in Edmonton, as in the case of Toronto, consistently demonstrate that immigration status and the lack of insured services for medically uninsured patients are frequently present in the minds of health care providers when providing care and determining future steps, such as the need for testing, diagnostics, and specialists. It is also concerning that Edmonton

has no dedicated services or clinics for medically uninsured migrants compared to other large Canadian cities such as Calgary, Toronto, Vancouver and Montreal. Given the substantive number of migrant workers in the Edmonton area, and thus the greater likelihood larger numbers of medically uninsured migrants in between visas, there is a significant barrier exists to access to care in this region.

4.5 Conclusion

This chapter began with a brief introduction to the City of Edmonton, its demographics, immigration histories, ongoing Treaty commitments and some of the local social movements in support of migrant justice. As Alberta's capital city, and the province's second largest city, this context is necessary to better understand how Edmonton's history, demographics and population have supported the evolution of the public health policies and health care institutions over time. As in the case of Toronto, local efforts at Edmonton's municipal government level to expand city services to migrants with precarious status signify local interest in improving services yet fall short of any substantial change when it comes to health care due to limits of jurisdictional powers and a total lack of any funded health care services for medically uninsured migrants in the city.

Second, this chapter provided a brief history of public health care in Alberta from the United Farmers of Alberta in the 1930s to the present, highlighting significant changes, particularly administrative structural moves between centralization and decentralization as well as the ways in which political influence has shaped funding over time. This section also investigated the disconnect between federal immigration programs and Alberta's provincial health care entitlements, such as a SAWP program where participants are only eligible for private-employer funded health care, which may leave some migrant workers without health care in the event that they need to leave their job

due to exploitation. Additionally, this section raises the concern around the inconsistent application of Alberta's new policy for issuing health care cards for "Children of non-entitled residents."

This chapter also highlighted further disconnects between federal immigration programs and provincial health care rules when it comes to migrant worker's health care entitlements in Alberta. With visas shorter than 12 months, such as TFW and SAWP, the employer must provide health care insurance, unlike Toronto, where workers with SAWP visas get immediate entitlement to provincial health care. These rules lead to inconsistent health care entitlements depending on the length of visa for migrant workers within Alberta but also across Canadian provinces and territories. This section emphasizes the many ways in which the intersection of these legal orders in Alberta and the individual actions of employers' impact and relationally assemble waiting for migrants when it comes to access to health care. For example, interviewed participants identified a concern with certain employers withholding information regarding private health care insurance in order to reduce claims from migrant workers, further causing delays for migrant workers in their effort to access health care.

The final section investigated health care access for migrants with precarious status through an analysis of interview findings and by analysing Edmonton as an assemblage of health care barriers. Interview findings were organized by reoccurring empirical themes and analyzed through a socio-legal critique on barriers and belonging. Some of the key techniques of government identified in the regulation of migrant health include inconsistent billing, profiteering by physicians as recommended by the AMA at rates two to five times the established AHCIP rates, and the denial and or delay of health care cards to Albertan-born infants to migrant worker parents to name a few. In the regulation of migrant health, these techniques of government actively work to reproduce ideas of sovereignty in medical offices as well as belonging in the process.

As with the case of Toronto, many different actors and authorities identified through interview findings, including employers, provincial health administration, and profiteering providers among others, may ultimately have different goals, interests, and problems, yet as they assemble around the issue of migrant health, a cultural norm has formed that position's both the denial of health care and the increase in charging for care for medically uninsured migrants as acceptable practices in Edmonton, Alberta. These practices and norms are supported by an underlying ideology of racial capitalism across Canadian society and institutions, that is the acceptance of differentiated and racialized labour and rights. As an act of resistance, civil society groups and NGOs have developed small internal lists to identify providers who offer free or more affordable services, effectively pushing back against these practices in an effort to re-craft jurisdiction at the local level, pushing back against the redrawing of borders in medical offices. These acts of resistance against the denials of health care to medically uninsured migrants and competing rationalities are discussed further in the following chapter – *Reform and resistance.*

Chapter Six.
Reform & Resistance |

6.1 Introduction

This chapter returns to the third and final research questions of this doctoral research, addressing, 'how can the experiences of health care providers, medically uninsured migrants, and civil society groups better support legal reform' and 'what legal and extra-legal strategies are societal actors utilizing across territorial borders in their efforts to improve access to health care and legitimize the human rights of medically uninsured migrants'? To address these questions, interview findings are analyzed to highlight the experiences of migrant participants (n=6), health care professionals and civil society members (n=24). As discussed in chapter two, the analysis of interview transcripts is guided by both the socio-legal critique on denials, delays and barriers to care and draws on Nicholls and Sorrell-Medina's (2023) work that examined three central elements of undocumented migrant activism: framing, political opportunities, and organizations. As we will see, these three elements were also highlighted across participant interviews in this doctoral research and therefore help organize participants experiences as they speak to reform and resistance against restrictive health care policies. This chapter further builds on three elements proposed by Nicholls and Sorrell-Medina (2023) and adds the importance of mutual aid networks and individual actors as central elements that support reform and resistance efforts in the Toronto and Edmonton context.

In part one, this chapter proposes that the "spillover" effects of key negative court cases in effort to recognize health rights for migrants with precarious status in Canada should not be overlooked. For example, Marc Galanter's (1983) seminal work observes that litigation can have powerful effects by encouraging parties to invest in certain types of claims, serve as a symbol for certain groups, spread awareness of an issue as well as resist the status quo (p. 125-126). This chapter considers legal mobilization and investigates the past successes and failures with attempts to

utilize the law as a technique for change (i.e., Toussaint v. Canada), Canada's non-compliance with customary international law (*pacta sunt servanda)* and issues with the 'grounds approach' to human rights in Canada (i.e., Corbiere v. Canada). Legal mobilization is defined by Michael McCann (2016) as an approach that "fully acknowledges that litigation alone rarely advances significant social change, but at the same time it recognizes that legal rights advocacy can in some circumstances provide a useful resource for social movement building and strategic political action" (p. 226). This section highlights the legal mobilization efforts by Nell Toussaint with her historic human rights case at the UN Human Rights Committee, whose efforts spanned over 10 years of litigation efforts both domestically and internationally (2009-2024). While Toussaint's case can be seen to represent overlapping aspects of all three themes referred to by Nicholls and Sorrell-Medina (2023), this analysis focuses on analyzing Toussaint's case from the perspective of political opportunities and the importance of individual actors. Toussaint passed away January 9, 2023, from heart failure and falling into a coma while awaiting a decision for her claim at the Court of Appeal for Ontario (Toussaint v. Canada (Attorney General), 2023 ONCA 117). In her most recent claim, Toussaint (i.e., now her estate) seeks several forms of relief, including damages in the amount of $1.2 million following the UN's ruling that Canada must provide Toussaint with a remedy, including compensation for violating her right to life when they denied her access to health care. It is important to note that the topic of racialization or racism are largely absent in the judgements throughout this litigation, likely a biproduct of the grounds approach to anti-discrimination law, which is discussed further below.

In part two, this chapter documents the framing most commonly employed by research participants. From a governmentality approach, the organizing concepts of framing, political opportunities and organizational support as observed by Nicholls and Sorrell-Medina (2023) in undocumented migrant activism literature can also be seen as competing rationalities and competing

knowledges in these assemblages of health care barriers as they present as an "intellectual machinery for government" (Rose & Miller, 2008, p. 57-62). Frames identified in research interviews include: (1), firsthand story and rights-based framing, (2), economic framing or cost benefit analysis as well as (3), consciousness raising of global asymmetries of power. It is important to underscore that since migrant participants make up a smaller proportion of research participants (n=6), these findings by nature of number break down are more representative of the perspective of health care providers, civil society group members and NGOs (n=24). Taken together, this dissertation argues that these framings or rationalities are employed by advocates and migrant justice organizers to resists the effects and ideology of racial capitalism as a taken for granted regime in the government of health.

With political opportunities, Nicholls and Sorrell-Medina (2023) emphasize the mobilization strategies by activists to engage in the work of "multilevel jurisdictional patchwork" (Provine et al., 2016), whereby migrant justice activists often engage in multilevel mobilization strategies in order to secure gains in more accommodating jurisdictions first, to then later expand opportunities in more challenging jurisdictions. As we will see, my interview findings demonstrate that this is true not only with respect to geographical jurisdictions (i.e., targeting cities, provinces, and federal agencies at different points in time), but also with respect to different health issues and topics. Namely, many participants shared the importance of the strategy of "winnable battles," starting with a more politically acceptable win, such as health care for government sponsored refugees or for uninsured pregnant women, and then expanding mobilization efforts to other areas and issues after securing initial wins. Participants proposed multilevel political mobilization strategies across scalar of government, but also across health issues by seeking reform at all levels of government.

Finally, part two demonstrates that organizations are central to providing resources to support campaigns over time. Organizations were also central to supporting political campaigns and getting important issues heard more broadly by the public, such as in the case of winning McKenna

Law in Alberta for Canadian-born babies. I expand on the theme of the importance of organizational support and add the importance of individual actors and mutual aid networks.

In the following section, legal mobilization efforts in support of health care for uninsured migrants is investigated by documenting efforts to utilize the law as a technique for change.

Part One.

6.2 Legal Mobilization in Canada and Internationally

This section investigates how the law has been employed as a technique for change in efforts to broader health care entitlements for migrants with precarious status in Canada. Legal mobilization efforts by Nell Toussaint internationally at the UN Human Rights Committee is the foundational legal case discussing the rights of medically uninsured migrants in Canada. Toussaint's case is seen as foundational to this issue due to a decade of litigation efforts as well as her success in international court – a first international legal win for a medically uninsured migrant living in Canada. Toussaint's case is categorized in this chapter through Nicholls and Sorrell-Medina's (2023) political opportunities lens, in that when litigation efforts were proven unsuccessful in domestic courts, Toussaint pursued her case internationally at the UN Human Rights Committee, likely due to it being perceived as a more accommodating jurisdiction to her concerns, thus engaging in a multilevel mobilization strategy across legal jurisdictions. To help contextualize the results of this case, Canada's non-compliance with customary international law (i.e., *pacta sunt servanda*) and the issue with the 'grounds approach' to human rights in Canada is investigated. Ultimately, part one argues for the importance to have justice movements supporting health care rights for medically uninsured migrants addressed through the law as well as through extra-legal activities, such as through local networks and mutual aid initiatives. In line with socio-legal approaches to the law, Flood and Chen (2010) have posited that failed legal court cases in the Canadian health care context may in turn rally political support and work to initiate policy change, which will be explored further below.

Domestic Legal Mobilization Efforts

To first begin domestically, efforts to engage equality rights under the Canadian Charter of Rights and Freedoms (the *Charter*) to obtain health care for migrants with precarious status have been unsuccessful for far. Courts have ultimately ruled that immigration status is not 'immutable', eschewing any systemic barriers that may prevent access to full immigration status in the process (Chen, 2017), and by extension access to health care. Socio-legal scholars contend that anti-discrimination law in Canada is itself "…part of the originary violence of settlement and the materialization of the state itself" (Hodes, 2020, p. 63). Following *Corbiere v. Canada* (1999), anti-discrimination law in Canada assumes individuals have essentialized characteristics and identities which must fit into pre-established grounds (i.e., boxes) that are universal, fixed, and unchangeable. Following *Corbiere v. Canada* (1999), anti-discrimination law in Canada employs a formalist approach to investigating which types of discrimination deserve constitutional protection, which has led legal scholars to advocate for a new model or test at the Supreme Court that includes a focus on the social relations or asymmetries of power (Eisen, 2013; Hodes, 2020). As a result, discrimination based on immigration status or poverty has often been deemed 'immutable', in turn, implying a level of choice when migrants have been systematically denied health care coverage. While not a health care ruling, it wasn't until 2013 that the Human Rights Tribunal of Ontario adjudicated in favor of a migrant farm worker in the Monrose Decision. In Adrian Rose v. Double Diamond Acres Limited (2013) HRTO [1273], Monrose (who previously came to Canada on a SAWP), was subjected to anti-Black racist slurs from his employer, and then laid off and repatriated to St. Lucia when he spoke up about his abuse while working at a greenhouse. Monrose was awarded $23,500 in damages for having suffered racial abuse.

It is not surprising then that legal efforts in Canada to mobilize change for medically uninsured migrants have yet to be successful. For example, agricultural workers in Canada have also

made unsuccessful efforts to gain health care entitlements rights protections through the law. At the Ontario Divisional level in *Ontario Health Insurance Plan v. Clarke et al.* (2014), two migrant workers in Canada under the SAWP program were injured in an automotive accident in their employer's vehicle on their way to work. They were subsequently denied access to OHIP once they transitioned from the end of their SAWP visa to a visitor visa. While they successfully appealed the decision at the Ontario Health Services and Appeal Board and temporarily regained access to OHIP, the general manager of OHIP appealed the decision in court, which ultimately restored OHIP's original decision to deny coverage. Ultimately the court ruled that employers are responsible for providing health care coverage if their employees remain in Canada following their contract and not the province. While there has yet to be success in Canadian courts to remedy the denial of health care coverage to medically uninsured migrants, it is nonetheless essential to examine how international law has been mobilized as a technique for change. This chapter turns to *Toussaint v. Canada* to highlight one successful case for medically uninsured migrants based on Canada's status as a signatory to the International Covenant on Civil and Political Rights.

Nell Toussaint's Legal Efforts 2009-2024

The following timeline of Nell Toussaint's immigration and health struggles in Canada is assembled using the statement of facts submitted by Toussaint herself to the UN Human Rights Committee (2018). Toussaint came to Canada from Granada in 1999 under a visitor visa. She began working in 1999 and continued to do so through 2008. In 2005, she used most of her savings and hired a dishonest immigration consultant, which prevented her from making further efforts to regularize her status at that time due to financial constraints. In 2006, Toussaint's health began to deteriorate, in 2008 she lost the ability to work due to disability and in 2009 her health status became life-threatening. In 2009, Toussaint was diagnosed with a pulmonary embolism and had significant

health complications relating to "poorly controlled" diabetes (p. 2). In 2008, Toussaint secured a pro-bono immigration consultant who initiated an application for permanent resident status under humanitarian and compassionate grounds.

In 2009, Toussaint applied for the Interim Federal Health Program, the federal health insurance program predominantly for refugees and claimants but was denied coverage. Legal counsel posited that international instruments can be determinative of immigration law per *de Guzman v. Canada (2005) FCA 436*, and that article 12 of the International Covenant on Economic, Social and Cultural Rights (ESCR) outlines state's obligations to recognize all people's rights to "…highest attainable standard of physical and mental health" (May 6, 2009, letter to director of IFHP). Counsel also indicated that IRPA also allocates discretion to the Minister to waive certain criteria for its programs. Toussaint ultimately sought judicial review following a negative decision in federal court.

Toussaint v. Attorney General of Canada

Toussaint's experiences described in *Toussaint v. AG (Canada)* 2010 FC 810 mirror what has been shared by health care professionals throughout this doctoral project, namely that necessary, lifesaving tests are routinely denied to medically uninsured migrants who are unable to provide payment upfront, placing them at risk of pre-mature death. When Toussaint visited the Toronto hospital in November 2008, Justice Zinn recounts,

> The test required for determining the cause was not performed, apparently in large part because she would not be able to pay for complications that might arise, including special medication that might be needed. Instead, Ms. Toussaint was discharged with a prescription for high blood pressure medication (Reasons for Judgement and Judgement, Justice Zinn, 2010).

Later, in February 2009, when Toussaint's doctor suspected she had a deep venous thrombosis, Justice Zinn accounts, "Ms. Toussaint was asked to return the following day for an ultrasound. When she returned, she was denied the ultrasound on the basis that she could not afford to pay. She

left the hospital and shortly thereafter developed chest pain" (Reasons for Judgement and Judgement, Justice Zinn, 2010). In her affidavit, Toussaint shares her own experience, stating:

> I never know whether I will be able to get treatment or tests I need in a timely fashion. I cannot predict when doctors or service providers will agree to provide services without pay and when they will not. This makes me feel that I lack control over my health. I am extremely grateful for the services that I have been provided by doctors and service providers, despite the fact that I am unable to pay for them. On the other hand, I find it humiliating and degrading to have to negotiate with doctors and other healthcare service providers to receive healthcare, out of charity. It makes me feel that I am not considered of the same worth or value as other patients…

Toussaint argued that denial of health care under the IFHP infringed her rights protected by sections 7 (i.e., right to life liberty and security) and 15 (i.e., protection against discrimination) of the Charter. Ultimately Justice Zinn dismissed these claims and ruled that because Toussaint did not fit into any of the immigration categories who are entitled to IFHP, that he did,

> … not accept the applicant's submission that her exclusion from health care is not consistent with principles of fundamental justice because it is arbitrary. I see nothing arbitrary in denying financial coverage for health care to persons who have chosen to enter and remain in Canada illegally. To grant such coverage to those persons would make Canada a health-care safe-haven for all who require health care and health care services (Reasons for Judgement and Judgement, Justice Zinn, 2010).

Toussaint ultimately appealed the decision in a Federal Court of Appeal in *Toussaint v. Canada (AG) 2011 FCA 213*. The court of appeal held Justice Zinn's (2010) decision and dismissed the appeal, arguing that the Toussaint "…by her own conduct, endangered her life and health. She entered Canada as a visitor and remained therein for many years illegally." Both the federal court and court of appeal dismissed any systemic barriers Toussaint experienced in her efforts to regularize her status, such as the scrupulous immigration consultant who took her savings, impacting her ability to regularize her status. Additionally, both courts dismissed her claim despite agreeing that Toussaint's life and her health were placed at significant risk through the denial of coverage to IFHP.

It is useful to return to earlier discussions in chapter five, which draws connections to the experiences of medically uninsured migrant workers in Canada as one of the enduring effects of Transatlantic slavery. Toussaint, being a woman from Grenada, a country where the majority of Black-Grenadian's are descendants of enslaved Africans by British colonizers, ended up turning to Canada for work opportunities. While laboring in Canada, *waiting on* Canadians (i.e., care giving, domestic work, and factory work), and *waiting for* regularization pathways, she was denied access to medically necessary health care on the basis of her inability to pay. While this analysis is decontextualized by the courts as "endangering her [own] life and health," a broader analysis highlights the systemic realities in which descendants of slavery end up laboring in Canada and on Canadians.

Having exhausted domestic options, in December 2013, Toussaint filled a petition to the UN Human Rights Committee alleging violations to her right to life under article 6 of the ICCPR as well as the right to non-discrimination under article 26. In this example, the usefulness of engaging with a multilevel mobilization strategy across legal jurisdictions is exemplified.

UN Human Rights Committee Decision, Communication No. 2348/2014

In 2013, Toussaint became a permanent resident in Canada based on spousal sponsorship. In turn, she became eligible for health care under OHIP at that time. Having exhausted all domestic remedies possible through the courts, Toussaint turned to the UN Human Rights Committee (henceforth the Committee) and sought two remedies, including 1), "to ensure that illegal immigrants have access to IFHP coverage for health care necessary for the protection of their rights to life and security of person" and 2), "to provide her with compensation for the severe psychological distress, inhuman treatment and exposure to a risk to life and to long-term negative health consequences as a result of the violation of her rights" (Toussaint quoted in CCPR/C/123/D/2348/2014).

In July 2018, the Committee asserted that "State parties have the obligation to provide access to existing health-care services that are reasonably available and accessible when lack of access to the health care would expose a person to a reasonably foreseeable risk that can result in loss of life." Ultimately, they concluded that Toussaint's right to life had been violated under article 6 of the ICCPR due to the serious implications to Toussaint's health between 2009 and 2013 when she was denied access to the IFHP. Additionally, they conclude that admission to IHFP based on legal status and based on who had yet been fully admitted to Canada was not based "on a reasonable and objective criterion and therefore constituted discrimination under article 26." The Committee found that Canada was obliged under the Covenant to provide Toussaint with an effective remedy, specifically, in the form of adequate compensation. The Committee further indicated that Canada is obliged to review its legislation in order to ensure that irregular migrants have access to essential health care going forward. Under article 2 of the ICCPR, all state signatories, including Canada, agree to the competence of the Committee to determine when violations have taken place, and in turn, agree to provide an effective and enforceable remedy in cases where the Committee has determined that a violation has occurred.

Statement of Claim & International Customary Law

Toussaint turned to the Ontario Superior Court of Justice in effort to enforce Canada's compliance with the Committee's decision and ultimately international customary law, seeking her remedy through a Statement of Claim. Canada has continued to challenge her litigation efforts, including most recently a Motion to Strike, which was stayed by Justice Perrell in 2022, characterizing Canada's attempt as "…a dog whistle argument that reeks of the prejudicial stereotype that immigrants come to Canada to milk the welfare system" (Toussaint v. Canada (Attorney General) 2022 ONSC 4747, s.134). Justice Perrell's characterization of Canada's argument laid out in their

Motion to strike is a stark contrast to earlier court judgements by Justice Zinn in 2010, highlighting both the technique of discretion and jurisdiction at work, as the subjectivities of migrants are actively reproduced within the legal system (Pratt & Templeman, 2018; Dorsett & McVeigh, 2012; Valverde, 2015). Nell Toussaint unfortunately passed away in January 2023 while awaiting her claim. Nell Toussaint's appointed estate, Ann Toussaint, continues to represent Toussaint's Statement of Claim and a decision is pending at the time of writing. Toussaint's case is not only of importance for the future of claims and rights protections for other medically uninsured migrants but also raises concerns for Canada's non-compliance with customary international law.

When Canada acceded to the *Vienna Convention on the Laws of Treaties* in 1970*,* it agreed to the principle of *pacta sunt servanda*, that states must comply with their obligations under the international treaties they are parties too. In turn, this informs part of *jus cogens*, a peremptory norm that certain norms, including some human rights protections become recognized through multiple international legal instruments. Part of the issue with Canada's ratification of the ICCPR is that it has not updated any of its laws to require mandatory domestic enforcement of any Committee rulings. Additionally, the views of the Committee are not considered legally binding under international law. Toussaint's estate has yet to see any remedy they are entitled to through the ICCPR ruling, raising the question, is the law and courts the best place to push for reform and resistance?

It is also important to emphasize that Toussaint's case was supported by the Social Rights Advocacy Centre, a non-profit NGO that supports social rights in Canada, and her Statement of Claim in Ontario Superior Court was supported with expert opinions from Amnesty International and the International Network for Economic, Social, and Cultural Rights (ESCR-Net), emphasizing the importance of transnational social movements across borders in their ability to support advocacy efforts to improve migrant health care access and entitlements. Additionally, it is imperative to underscore that the results of litigation cases or changes in law alone are not the only ways to

measure success. As Ethel Tungohan (2023) emphasizes in her work on care activism within migrant advocacy movements, that to base the success of a movement strictly on policy changes is to ignore other important metrics, such as movement activity, growth, and uptake (p. 229). Likewise, in the case of Brown v. Canada (i.e., a highly publicized Federal Court challenge against indefinite and arbitrary migrant detention in Canada), Kristen Lloyd (2020) found in conversation with Karin Baqi, counsel for the End Immigration Detention Network (EIDN), that despite not winning the case, the courtroom provided a tool in which EIDN could raise awareness about the issue, express the vision for their political vision, and empower those involved through the sharing of their stories. In the case of Brown v. Canada, further political effects were also observed, such as the Immigration and Refugee Board citing the Brown case and stating that they would be undertaking an audit of detention reviews for long-term migrant detainees (Lloyd, 2020). Ultimately, it is clear that the broader effects of litigation challenges cannot be overlooked, even in the face of negative decisions.

In the following section, this chapter explores the central elements of migrant activism that have been put forward by participants in effort to help support reform against restrictive health care policies in Canadian cities, looking to opportunities beyond the courts.

Part Two.

6.3 Participant-Directed Recommendations: Framing, Political Opportunities & Support

This section analyzes how the themes of framing, political opportunities and the role of organizations, individuals and mutual aid networks were observed in interview data. Additionally, this section also highlights key recommendations and first-hand experiences from participants. By creating new frames to discuss the issue of health care barriers for medically uninsured migrants in Edmonton and Toronto, participants are actively involved in disrupting the taken for granted rationalities of the racial capitalist regime that underpins immigration and health care in Canada.

Framing

Centering First-Hand Stories & Rights-Based Framing

The most commonly cited recommendations for mobilizing toward accessible health care and the legal expansion of entitlements for health care was the importance of sharing migrant experiences and stories with the Canadian health care system. Medically uninsured migrants are best positioned to provide insight into their first-hand experiences, the Canadian health care system, how health care and immigration laws are operationalized on the ground at the local level, as well as to lend inspiration and guidance on how to better advocate for change. For this reason, the experiences of migrant participants (n=6) in this dissertation were shared throughout its entirety.

In his interview, Diego discusses the importance of undocumented migrant workers having their voices heard, stating, "Like and hear us. Because nobody now can hear us till we have our paper or something, and that's kind of unfair because we offer all of us, all of our job, our fears and our dreams and everybody's here for a reason" (Diego, 06/22). Diego describes in further detail this call, sharing,

> It's hard for us to be invisible for everybody, because we're afraid to get back to our home country. We come here, to support…We'd never come here stole, or to take advantage of nobody. But also, we need to support our families and our self for health. Not being afraid to be not treated because people don't know the language. We need to be safe and feel safe… we always give our best for everything and we expecting the government give us the same attention and give us a chance to stay here a little bit and give us a chance to speak (Diego, 06/22).

Passages shared by Diego help emphasize the importance of migrants with precarious status, especially those who are non-status to have their stories and voices be heard, as well as the frustration with feeing "invisible" to everybody and the fear associated with speaking out about injustices. This example also points to the real-life complexity of migrants with precarious status often not wanting to be identified by legal authorities due to risk of deportation, yet simultaneously, and reasonably, wanting to have their experiences heard by other members of society in Canada.

The majority of health care providers also discussed the importance of sharing patient stories. One interviewed nurse shared,

> The helpful perspective would be education and the story telling, right. It's very easy for people to have that judgment of oh well they're just here and they just want the free ride. Until you hear the story about why they're here and what their story is, they came to be here for a reason, it's not necessarily their choice and I think that often would help (Nurse 1, Edmonton, 10/22).

One interviewed physician also shared how important migrant stories are in a training context to encouraging other medical professionals to provide appropriate care to uninsured migrants, stating:

> I work with medical students and residents and through them they can see me doing my work and they get to see these individuals and get to know them and their story. In the hopes that maybe they all become physicians eventually and so then they may also (work with) some of these people too in the future (Doctor 3, Edmonton, 04/22).

Another doctor shared, "I think it would require a lot of advocacy and a lot of, you know, patient stories or something like that" (Doctor 2, Edmonton, 04/22). In the Edmonton context, health care professionals made it clear that there are very limited concerns about 'birth tourism', and shared some examples of the types of patient stories they often see, including,

> …when we have a client who comes here on a visitor visa or is supposed to be sponsored by her spouse that there's interpersonal violence and the spouse is refusing to sign and submit paperwork. And now we have this mom who is stuck here without healthcare and didn't intentionally make a decision to come here and stay here…we have, you know, people who come here on a visitor visa to escape some sort of something back home, right…maybe they're coming here intentionally but they're trying to get away from something or to better themselves, it's not just, we very seldom, in fact I think once with my program have we had somebody who just wanted to have their baby in Canada. Because of that whole (unknown 25:08) so they can be a citizen. So, I do feel that so many of these people have come from such adversity and then they want better and then we create this unsafe place for them. (Nurse 1, Edmonton, 10/22)

Health care providers and physicians are in a particularly unique position to share (anonymously) the experiences of medically uninsured patients in efforts to dispel myths about so called health tourism in that they are regularly exposed to the material effects of having limited access to necessary services from specialists to imaging that their patients encounter.

In addition to sharing patient stories and privileging the experiences of migrants, this framing was often intertwined with the important of rights-based framing. Part of the rights-based framing was based on physical presence and justice. For example, one participant shared, "So definitely I think that if we're advocating for universal healthcare, that it's universal healthcare for everyone who's here" (Healthcare Coordinator 2, Toronto, 10/21). Another participant similarly shared, "I think the more that the message can be strong and unified, it's like people died and we're a wealthy society that needs to honor, like basic justice for people" (Doctor 6, Toronto, 04/22). Looking back to migrant participant stories, passages shared from Lynn speak to framing health care entitlements from a position of human rights.

Lynn's experience with the undocumented migrant workers she knows in her community are also in line with what has been shared by most interview participants, that undocumented migrants or migrants with precarious status arrive in Canada legally, often with a work visa, and do to unforeseen circumstances such as scrupulous employers, find themselves with lapsed visas or with precarious status. When asked directly for her recommendations, Lynn shared,

> … healthcare must be inclusive to everyone, because healthcare is a necessity. I mean it's a human right, everybody must have access to healthcare. Doesn't matter what is the status, the gender or race. Especially during this pandemic there's a lot of depression, stress and everything deteriorating the health. Especially on the (unknown 27:43) the migrant workers and undocumented workers. Like those undocumented, I just want to point out that those undocumented, they came here legally. I mean they paid everything, they process the papers legally, they went in Canada. It just so happened that there's a lot of unforeseen misfortune that they have encountered despite that they're undocumented. But they forgot that they came here legally, they pay taxes and everything. I mean they are not a burden to any Canadian. Even after now even though they're undocumented we are still paying taxes to the house that we're renting, to the clothes that we're buying, to the food that we're buying, right. How come we are neglected to the healthcare system? Yeah, no one should be left behind because if everybody needs healthcare, everybody gets access to healthcare. Yeah… (Lynn, 08/22)

Lynn previously shared that due to the discrimination she received at her workplace, she ended up on an Open Work Permit for Vulnerable Workers so that she could identify her next steps for employment and regularizing her status in Canada. Yet at the same time, she was made ineligible for

health care in Alberta under this specific visa, another way in which migrant workers are often indirectly penalized when they report employers for exploitation.

In another example in conversation with Aayla, she emphasized the need to make health care services more accessible, citing long waits and the burden of financial pressures. More specifically, she shared,

> make it more accessible so people are aware of it and, you know like, if people are in the country and they feel sick that they don't feel the extra burden added for them off the you know, basic and also just stress and that. I walk into a doctor's office; how much am I gonna be charged? Or you know, walk into the hospital, how much am I gonna be charged? So making these, you know, available by funding, you know, providing more funding so that they can take on more clients because you'll find a lot of these, as I kinda stated earlier, that my experience is to get an appointment or just, you know, even get the service you have to wait, you know like, at least, you have to spend a whole day, right. You have to leave in the morning to get an appointment in the evening and you might still not even get seen by a doctor. So, I think more funding in these centers would be, you know, one of those ways that we could tackle that, right (Aayla, 06/22).

Both Lynn and Aayla's passages also begin to speak to the economic framing of health care access, and the financial barriers experienced. There has long been a struggle over whether to rely on rights-based framing or economic framing, as economic framing (i.e., cost-benefit analysis) can be seen to delegitimize the rights of migrants. For example, if health care rights should be granted on the premise of human rights entitlements, justice and physical presence to one's community, then cost-benefit analysis can be seen as irrelevant or as contributing to the delegitimizing of these rights. For example, on participant shared,

> … healthcare should be seen from the lens of a human right. Not economic, although there's an economic aspect to it. It's a basic right, no? So, you know, these policy makers should principally look at the human rights-based approach to healthcare (Civil Society Group 1, Edmonton, 01/22).

Avoiding economic framing on the one hand may help disrupt and interrogate the naturalization and racialization of differentiated labour that has long been normalized across Canada. On the other hand, economic framing was shared by multiple interview participants, including health care

professionals and those involved in migrant justice movements, as such, these findings are reported below.

Economic Framing

One of the most common cited examples of economic framing referenced in Edmonton and Toronto is the assumption that by not addressing health care issues as they emerge (i.e., medically uninsured migrants avoiding walk-in clinics for developing health care issues due to lack of financial means), that the cost to the province later on when issues become more serious will be significantly higher (i.e., through unpaid hospital emergency room bills that cost more than a visit to a walk-in clinic appointment). For example, in Ontario, one health care coordinator shared,

> I think with lots of migrant workers, they need access to OHIP and they need access to OHIP consistently. As long as you're in this country there should be no breakdown, there shouldn't be. I mean preventative, and this is the thing that I think hospitals need to get a better grasp of. When you have uninsured patients showing up in your ERs and in such late stages of their disease or illness, it's actually costing our hospital sector more money. (Healthcare Coordinator 2, Toronto, 10/21)

In Toronto, another doctor shared a similar argument, stating,

> But if you sort of look at it from a cost benefit perspective, having a patient show up in the emergency room because they need their diabetes medication. That's, I'm sure, much more costly than actually providing a system where we can provide preventative care, you know, provide regular care… presenting different scenarios and pathways and attaching them to actually doing economic cost benefit analysis and showing those reports to them, right. Whether it's looking at models from other countries, even versus showing sort of models from here. I think that's actually another strategy that would probably work really well (Doctor 5, Toronto, 02/22).

Another doctor in Edmonton shared an alternative economic framing, specifically the assumption that the number of medically uninsured migrants across Canada is financially insignificant when considering the total expenditures spent on funding public health care, stating,

> … this is such a small drop in the bucket of healthcare costs and I feel like it should be easily accommodated and so for that reason I think that we should just provide this [healthcare for all]. Now I can also understand this is a fear a lot of physicians and physician administrators have is that word gets out and then you get this huge influx of foreign you know, people

> looking for free healthcare. I think the reality is that something like that probably won't happen. So yeah, so I would be advocating to have a provincial or a federal system to provide care for all people (Doctor 3, Edmonton, 04/22).

This doctor highlighted a commonly referenced rhetoric often employed by conservative leaning politicians and Canadians (e.g., and judges, as discussed later in part two), that if Canada were to provide funded health care to all migrants landing within its territorial borders, that more migrant workers would travel to Canada to take advantage of its health care systems. This hypothesis has been frequently challenged by scholars and institutions who contend that this is unlikely to be the case. For example, the UN Human Rights Committee in their decision of merits in Nell Toussaint's case posited that excluding migrants from the Interim Federal Health Program (i.e., a federally funded health program for refugees) "…coverage on the basis of her immigration status is not an objective, proportionate or reasonable means of deterring illegal immigration" (Nell Toussaint v. Canada, CCPR/C/123/D/2348/2014, p. 15).

Other participants shared that by acquiring more accurate calculations and statistics on the cost associated with providing funded health care to medically uninsured migrants across Canadian communities, that these figures could be employed to counter narrative about "drain on the system." For example, one doctor observes,

> …just kind of figuring out like how much is this really a drain on the system. You know, you can easily juxtapose how much money could be spent on these undocumented individuals versus trying to pinpoint how much executives make or how much physicians make, just help put these numbers into context. Cause my understanding is that it's not very much at all (Doctor 3, Edmonton, 04/22).

Another health care provider shared a patient story pertaining to economic framing, on how migrant health issues can be treated early on and more affordably in a health care system that provides funded care, and how they can easily end up more complex and significantly more expensive to treat, sharing,

> …something that can go on treated because we were able to find about that upon arrival, a few years later this client's gonna be in a very bad situation requiring a lot of care. That's going to cost the health system way more money than when it was a simple blood test. And then referred to a specific program to be able to treat that. So, I have seen cases where, you know, our clients end up in the intensive community because they had an untreated (unknown 49:30) for example, which is a simple blood test coming from certain endemic countries and on top of that the client had hepatitis B… Like that's something that doesn't happen here so then the client is in the intensive care unit like (unknown 49:57) and hepatitis, that's deadly, the combination, right. So, things that would have been able to treat, refer to the hepatitis support program, the client would have been able to control their hepatitis B. And for the (unknown 50:13) there is a medication, Ivamedic, you take it, it's gone. You know, and it's gonna save on that but also, it's gonna save the system so much money. So, if they would do the calculation, it would be great, but I know it's difficult to change a system (Coordinator 1, Edmonton, 03/22).

These examples further emphasize the reality that there are diverse opinions and perspectives among both the medical community as well as those engaged in migrant health advocacy movements. There is no unified consensus on the single best approach to targeting this issue, as well as much debate on the options that have been identified (i.e., whether to use an economic framing or not). Having addressed many examples of economic framing utilized by interviewed participants (specifically health care providers), the following section investigates the framing of health care access through the lens of migration as a crisis of displacement and immobility.

Consciousness Raising of Global Asymmetries of Power

As first discussed in chapter one, this dissertation argues that the systemic barriers and denials to health care for migrants with precarious status is underpinned by the dominant political rationality of racial capitalism. It is not surprising then that interviewed participants also speak to this concern as they present competing rationalities on health care access for medically uninsured migrants. In discussing their recommendations for supporting change, one doctor speaks to directly to capitalist exploitation of migrants, sharing,

> …reemphasize the multi, like the solidarity-based collaboration and organizing that's happened for many years and how important that's been in forming networks and building a

> clear understanding that needs to be reiterated all the time that everybody who is living here needs to have access to healthcare. No matter what their immigration status and that we need to be looking at, you know, both the micro level advocacy as like one to one and we need to make sure that, you know, each individual has a good experience and is able to access care. But also looking at those, like meso and macro solutions which includes, you know, status for all which includes pathways to status for, you know, or status on arrival for people who are migrant workers and who's labor is creating the food that we live off. And a really deep understanding of our own complicity within Canada. I have cause in the conditions that lead to people migrating, not all of them right, but for a lot of people the reasons they're migrating need to be understood within a noble context of capitalist exploitation and so I think the broad organizing that we've seen in Toronto, across Ontario (Doctor 6, Toronto, 04/22).

This perspective has also been articulated by Walia's (2021) work that also advocates for the competing rationality that positions precarious migration in Canada as a crisis of displacement and immobility. This requires not only looking at migration and health policies in Canada, but also at global asymmetries of power. Such an approach emphasizes the importance of a transnational aspect to political organizing around human rights, such as in the case of Toussaint v. Canada. Additionally, it necessitates an analysis of racial capitalism on a global scale. For example, another interviewed participant speaks directly to this issue in the case of migrant workers from the Philippines migration to Canada, sharing,

> It's because of the socioeconomic condition of the country that pushed them out, you know, and of course on the other side how Canada also displaced people in those countries. So, for example in the Philippines and Latin America there is an incentive in mining industries that Canada is a big player. They then displace people, many of them are Indigenous, you know, from rural areas to urban centers. And with that we know work in those industries can support the labor from the rural, they end up working abroad…Canada through its temporary foreign worker program, for example, has been importing many migrants, right, that are temporary. Even though in the recent news about Canada they're saying there is a need to have, to address the issue of labor shortage in the province of Alberta, for example, the other day the food and beverage industry have called in for an emergency temporary foreign worker program to address the shortage. Meanwhile on the other side the Canada immigration have a 1.8 million backlog in immigration applications…So over 500,000 anecdotally, undocumented migrants. So, it does not make sense, you know, they are limiting access for undocumented migrants to be regularized… So, I think our healthcare for all program it's not fully tied to, you know, lobbying the provincial government and the federal government…But also tying them to the immigration policies of Canada. You know, if you give the migrants status the undocumented migrants status, they can pay into the coffers that could provide them healthcare [i.e., through employment tax] (Civil Society Group 1, Edmonton, 01/22).

When it comes to framing the discussion around health care barriers for medially uninsured migrants in Canada, participants speak to the importance of analyzing Canada's role in the forced displacement of migrant workers in confluence with Canada's reliance on temporary worker migration streams. This example from Civil Society Group 1 (Edmonton, 01/22) further speaks to the shared materialities that Indigenous peoples experience across borders, in Canada and abroad, such as in the case of the Philippines, and the enduring impacts of colonization on the dispossession of land and peoples.

Many participants discussed concerns with Canada's temporary worker programs that place migrants at greater risk of precarity, for example as one participant quoted,

> … the behavioral of immigration and really creating this revolving door of use, abuse and exploiting, you know. And essentially in three words are immigration worker policies in Canada, you know, they've used them and abused them and they disposed them like a rag. That has to stop, if there's really a gap in the labor market then it's really important to look at the sustainability of the labor market, right. By providing access to a permanent residency to migrants who come here. They don't jump the border, right, these migrants did not jump the border, they came, they were invited to work here because we lost workers, and then of course for one reason or another they lost their status (Civil Society Group 1, Edmonton, 01/22).

As previously discussed in chapter one, Nobe-Ghelani and Lumor (2022) propose critical reflexivity at the sectoral level as a source of decolonization. For example, by centring the settler colonial violence and colonial dynamics that create migration in the first place. As demonstrated throughout this chapter, civil society group members, health care providers, and non-profit organizations have started taking this approach in the way in which they analyze and make sense of these complex issues that ultimately lead to migrants immigrating to Canada under its' temporalized visa programs, and in turn, become at risk of precarious status and loss of health care entitlements. Here, racial capitalism becomes an increasingly clear rationality upheld by the state in the administration of temporary migration programs. This concern was emphasized in discussions around 'medical repatriation' as one participant described,

> It's (medical repatriation) just like a really sanitized way of saying something extremely terrible which is that people get deported once they get unwell. So, we have the system of exploiting people for their labor year after year after year after year for them predominantly, I mean a lot in B.C. a lot in Ontario, and then when people become unwell, not supporting (Doctor 6, Toronto, 04/22).

The practice of medical repatriation in Canada is one of the ways in which the state demonstrates how they use race as an organization tool to police "surplus populations" (Kundnani, 2020, p. 1), whereby differentiated labour is made explicit.

While it is clear that the state relies on racial capitalism to support the current immigration and health regime, interviewed participants have countered this narrative with rationalities that question global asymmetries of power that create migration in the first place, (i.e., as in the example of Canadian mining companies in the Philippines) and through calls for migration as a form of decolonization. Participants echoed Achiume's (2019) work on migration as decolonization as a source of "corrective justice" for the "legacies of colonialism" (p. 1517). For example, one participant presented an argument for migration as a form of reparations to slavery and colonialism, stating,

> When I look at people in Jamaica, and I'm using Jamaica as an example. So, you're on this island because of some colonial like whatever, this is the luck of the draw, where you ended up because you ended up on that island, you're not allowed to go anywhere else. Like to me I almost would argue if you have Indigenous ancestry obviously, but if you have slave ancestry also, that you should have a passport to the Americas. And same with Central America and Mexico, right. There's a whole Indigenous piece to that. And we now because colonialism makes it, so we all have separate countries, we don't think of it in that collective way. But the stealing of land and resources, we're not one of the richest countries in the world by accident (Registered Midwife 1, Toronto, 12/21).

In this example, the interviewee draws connections between the shared materialities of descendent of slavery in the Caribbean, and arguments for reparations through immigration access as discussed earlier in chapter one (Achiume, 2019). Although they cannot be collapsed into the same experiences or history, Indigenous peoples in Canada continue to experience many shared materialities and inequities that requires further attention. As further elaborated in chapter one, Tuck and Yang

(2012) emphasize the importance of recognition of Indigenous peoples and their struggles for sovereignty when the concept of decolonization is being employed in other contexts. While interviews with participants were focused on health barriers for medically uninsured migrants, participants often drew parallels between the experiences of migrants and Indigenous peoples, for example,

> And then I think the issues also around First Nation, Innuit and Métis people and the lack of understanding for the barriers for people in cities like Toronto and Montreal. There's health access issues that are separate but actually we have such large Indigenous populations in cities like Toronto and the issues are similar actually that those communities are facing in Northern communities that they're facing in urban communities. They have the same lack of access and the same lack of funding and so I think being able to hold new Canadian and Indigenous here and what those needs are and how everyone can access the health system. Those policy conversations need to really be interwoven and I don't know that we're achieving that a lot of time right now (Registered Midwife 2, Toronto, 01/22).

As discussed by the midwife participant above and by many participants, particularly in the context of Community Health Centres across Toronto, health care providers are witnessing similar challenges to accessing health care for both migrants and Indigenous peoples. As previously identified in chapter one, this dissertation investigates how public funded health care in Canada has been linked to racial exclusion since its origin. Interview findings demonstrate that unfortunately, legacies of this exclusionary system continue to manifest today at the local level in service delivery and in denials of care. These findings further emphasize the importance of upholding the living treaties that expand this territory, through the sharing of its resources and mutual respect for all (Bhatia, 2013).

This section analyzed three different ways in which participants framed the issue of health care barriers for migrants with precarious status (i.e., Centering first-hand stories & rights-based, economic, and migration as crisis of displacement and immobility). In turn, these framings serve as a form of competing knowledge and competing rationality in the assemblages of health care barriers. Competing rationalities help counter the state's efforts to naturalize differentiated and racialized

labour, whereby in turn, the denial of health care has become publicly acceptable or at very least an issue not morally significant enough to the Canadian public to fix. Through the sharing of first-hand experiences, cost analyses of emergent care in absence of preventative care, and through a consciousness raising of global asymmetries of power that contribute to forced migration in the first place, interviewed participants are working to shift the narrative and disrupt this taken for granted racial capitalist regime that restricts access to health care for all. In the following section, this chapter investigates the roles of political opportunities and movement support in the movement toward migrant justice and health care for all.

Political Opportunities, Organizations, Individual Actors & Mutual Aid Networks

As previously described, with political opportunities, Nicholls and Sorrell-Medina (2023) depict that commonly, activists will engage in multilevel mobilization strategies in order to secure gains in more accommodating jurisdictions first, to then later expand opportunities in more challenging jurisdictions. This was observed in interview findings, not only at the scalar level, but also with specific health care issues. Participants describe the role of securing crucial organizational support through different campaigns and projects. In both Toronto and Edmonton, organizational power, in the form of health care or social service institutions, NGOs, local politicians' offices, and/or through mutual aid networks were instrumental in supporting political campaigns.

Winnable Battles

While many participants continue to advocate for health care for all, it was not uncommon for participants to discuss the importance of employing the strategy of "winnable battles." Specifically, they recommended starting with a more politically acceptable win, such as health care for government sponsored refugees or for uninsured pregnant women, and then expanding

mobilization efforts to other areas and issues after securing initial wins. For example, one Toronto-based participant proposed,

> I think that covering pregnant people is a really good foot in the door for this issue and I know, you know, I've had other friends who advocate the same area and they're like "okay but what about kidney failure?" and I'm like "I don't know, that's way harder to argue." I think if you open the door to pregnant people and you realize okay, we're not going bankrupt by doing this. That then perhaps we should open the door for other things. But I definitely think some chronic conditions must have care in the community so people don't keep ending up in hospitals. So, diabetes is a really good example of that, where what happens is people are getting care and end up needing amputations end up needing transplants, like end up being in kidney failure. We don't want chronic conditions and same with high blood pressure to end up with people being unwell. And it's hard to say this to the government but I do, I think there's a big reparations piece to this, in my mind (Registered Midwife 1, Toronto, 12/21).

It is not surprising that this example emerged in Toronto, given Ontario's health care laws that fund midwifery care for any resident in the province (OHIP insured or not). As pragmatic as this approach may be, it is not without its critiques as previously introduced in chapter four. This approach relies on positioning some members of the population as "innocent," such as in the case of children, infants, and pregnant people, or framing certain medical issues as more deserving of care than others, such as diabetes. As a consequence, other migrants, such as adult men, women, and non-pregnant people may be left out of advocacy efforts for expanding access to care or seen as less deserving of care. Nonetheless, despite its critiques, this approach has shown to be historically successful in some specific scenarios, such as in the case of midwifery care in Ontario. The strategy of winnable battles was also highly prevalent in the Alberta context. For example, one NGO participant in Edmonton shared,

> …we need to try to do as much as possible because things change, suddenly as well. And one thing that is happening right now can change with the next government, or what one government considers important the other one doesn't. And if we can make changes at all levels at least we can guarantee that we are changing something. And at least we are addressing part of the issue, it is not the whole issue (Coordinator 1, Edmonton, 03/22).

One the one hand, participants advocated for starting small and focusing on 'winnable battles', while on another hand there was an approach to target all jurisdictions at the same time in hopes of

securing some change. Another example of strategizing for more specific change first before later expanding more broadly includes Edmonton's New Canadian Health Centre.

Edmonton's Refugee Health Coalition and the New Canadian Health Centre

Multiple members of Edmonton's Refugee Health Coalition described in interviews how their one and only clinic serving refugees closed around 2016-2017 due to funding issues, leading to the creation of a Refugee Health Coalition, which is comprised of academics, settlement agencies, doctors and specialists. One member describes the early stages of this group, sharing,

> …we started really advocating for Edmonton because Edmonton was the only major city in Canada without a dedicated health center for refugees and newcomers. We talked to a bunch of people, we advocated, we went to everywhere and we continue, continue, and we formed what we call the refugee health coalition…When we started doing the main objective of the coalition was to be able to form kind of a dedicated refugee and health center for newcomers. We didn't want it to be just a clinic because that's not what our clients need. We wanted it to be like a multidisciplinary place where we have the family doctors but we also have the specialists but we also have the mental health support, we also have the health navigation piece. We have the best people welcoming and making people feel accepted, safe and also that we're taking care of their medical needs. Taking into account the social determinants of health as well because there is a very comprehensive A model (Coordinator 1, Edmonton, 03/22)

The New Canadian Health Centre (The Centre) opened doors in 2021, a few months prior to commencing interviews in for this doctoral research. At the time of interviews, the Centre only provided health care services for government sponsored refugees in order to get the center funded and operating, with the goal of eventually expanding to medically uninsured migrants as well as other categories of refugees. In order to secure this new clinic for refugees and newcomers, participants discussed the importance of partnering up with existing social service agencies, for example,

> ..our big settlements agencies catholic social services, they deal with most of our government sponsored refugees, so they were very involved in this push, along with a couple of physicians who had previously worked at the older clinic. And then some new up and

> coming physicians who were really interested in taking this on as their kind of home (Doctor 1, Edmonton, 02/22).

In addition to accessing organizational support, participants discussed the importance of political timing with respect to changes in the provincial government. For example, one member engaged with this project describes,

> … two and a half, three years discussions with Alberta Health Services and Alberta Health, and government. A lot of fundraising, yeah, and then slowly, slowly, now and we've got a clinic but it took a lot of work and I think there's, particularly in Alberta, there has been this sometimes a challenge with finding the political appetite on the provincial level to take on projects unrelated to refugees and newcomers. Which is unfortunate but it's always been this sort of, bit more difficult. I think probably where we had a bit more traction was for a brief period of time we had a more left leaning government provincially. We had an NDP government for a short window and I think this is where we caught a lot more traction and the project kinda got some footing, started moving forward and then currently right now I think we're still doing okay but I think the ability to sort of expand or build upon, around just probably not super realistic right now in the current setting (Doctor 1, Edmonton, 02/22).

Health care providers and Refugee Health Coalition members were very much engaged in 'multilevel jurisdictional patchwork' (Provine et al., 2016) and keenly aware of political limitations. For example, with respect to expanding services to medically uninsured migrants, one participant shared,

> …think if you sort of right off the get go start expanding it into areas the government thinks are maybe not priorities as opposed the risk might be that your lose some funding or you lose that buy in…there's a practical sense of what can we do right now but also this political sense of like how do we take this on in a way that we still very much have what we need the government to buy in right now for funding…(Doctor 1, Edmonton, 02/22).

The creation and opening of the Centre demonstrates how in the case of Edmonton, a "winnable battles" approach was likely considered as the only possible and attainable service that could be secured under the conservative provincial government at the time, and that advocating for medically uninsured migrants during this era may have resulted in no gains to the Edmonton migrant community at all. Local actors were likely successful in campaigning on the recent increase of government sponsored refugees to the Edmonton community at the time in order to secure funding for this centre, leveraging political opportunities where available to improve local access to care.

Having discussed an Edmonton-based example, the following section describes the importance of organizational support in Toronto-based activism during the early stages of COVID-19.

Toronto's Rapid Response Team

Toronto-based organizations played an important role in supporting Toronto's advocacy movements to support medically uninsured migrants throughout the pandemic in a number of ways. First, a local network of activists was strategic in recruiting community health centres (CHC) to sign a declaration confirming their support for providing care to medically uninsured. One participant shared,

> …we got a bunch of different community centers who offered the vaccine to sign a declaration that they were going to support uninsured people with the recommendations we had made. So, we knew and then we developed a list of safe sites people can go to and we can share that with our clients (Healthcare Coordinator 2, Toronto, 10/21)

Local CHC's played a key role in providing health care and vaccines to medically uninsured migrants. Additionally, once Ontario had adopted the Temporary Billing Codes to allow all residents physically present in the province to have funded access to health care, activists (many health care providers) quickly identified that hospitals were continuing to charge medically uninsured migrants instead of following the province's directive. In response, a local network of activists that was housed at the time by a local NGO, created a Rapid Response Team comprised by policy analysts, researchers and heath care providers. One member describes this team below,

> …we did a lot of systems advocacy to work to improve access to healthcare for migrants without any insurance. And we did that through writing letters to their hospital CEOs, to their finance departments, and saying here's the directive, please find it attached, are you in fact honoring these directives sent out by the ministry? Once that communication went out, many of the CEOs, CFOs would respond by saying absolutely we are, we're aware of that, sorry about this summation must have not happened the way it was meant to happen. We'll send it out again, right. For a while there, this happened all at the beginning of the pandemic and we must have reached out to at least 15-17 hospitals. And then they all responded positively, some issued refunds to clients who they had already charged them, many of them gave us their contact information should future issues occur. And just having that

> acknowledgment of leadership that yes, the hospital is aware and is following it, was a massive advocacy tool for us to utilize that if any other clients were turned away, right… (Healthcare Coordinator 2, Toronto, 10/21).

This example demonstrates both the instrumental value of organizations in providing material supports to activist or professional networks through the sharing of physical meeting spaces and through providing administrative support. Additionally, organizations have been beneficial to migrant justice movements politically by adding their reputation and name to movements and strategic letters. Many Toronto-based health care institutions also allowed their employees (i.e., midwives, physicians etc.) to attend meetings and participate in network activities as part of their regular duties, ultimately supporting the broader movement to provide health care to medically uninsured migrants in Toronto. Having discussed the importance of organizational support in Edmonton and Toronto, the following section analyzes the importance of individual actors and mutual aid networks.

Individual Actors & Mutual Aid Networks

Interviews with participants, particularly in the Edmonton context, emphasized the power that one individual actor can have in the resistance against restrictive health care policies. This was observed in the actions of independent physicians, nurses and politicians, who strategically utilized their privilege in their professional positions to bring about change at different levels. For example, an interviewed nurse described how she actively calls the providers where they are referring their clients to and requests that charges be lowered, stating,

> …as a nurse we will phone clinics and start advocating for them basically. Mostly because it's ESL and lots of times because, we always say the receptionists are like the gatekeepers of that clinic and clients can't get beyond the receptionist but we can…So we'll often do that, so we have had success getting physicians to lower their charge, we have had success once in a blue moon getting an obstetrician to not charge (Nurse 1, Edmonton, 10/22).

Another interviewed doctor describes how they have established an agreement with a local medical imaging company that has offered to provide medical imaging for their medically uninsured referrals for free of charge. Such an arrangement, whereby a local for-profit company provides services for free, was not observed in the case of Toronto. This example helps demonstrate the power that an individual actor can have when using their privilege as a professional health care provider in advocating for change.

Local provincial Members of the Legislative Assembly (MLA's) in Edmonton have also been reported to bring about positive change for some medically uninsured patients on a case-by-case basis when approached by local activists and networks. One physician describes,

> We know they have a certain diagnosis, like a cancer diagnosis, but the treatment for it might be radiation or chemotherapy, those are also very expensive. And that has happened. We've experienced that as well where they need chemotherapy, but I spoke with the medical oncologist and they said, "you know, this would cost easily 10 or 20 thousand dollars a month and we can't give it to them for free." So yeah, so I mean unfortunately that is, an so you know, I mean that's the reality and as much as I tried and we had tried to, you know, and sometimes reaching to an MLA…sometimes they can advocate on their behalf as well. And sometimes we've been successful and other times not successful so times when we are not successful, I recall one case where she was just not able to get their cancer treatment that she needed. We just had to treat her, unfortunately, as a palliative patient. So, we just kept her comfortable and then eventually she passed away. (Doctor 3, Edmonton, 04/22)

This example helps illuminate the life and death consequences of the current health care system, as well as the gravity of responsibility that MLA's hold when exercising their discretion to become involved in requesting health care be provided. In addition to individual actors, mutual aid networks are also significant in the supporting of political campaigns.

Community supports and mutual aid networks are instrumental to providing support to migrants with precarious status across Canadian communities. For example, Lynn shares,

> When I'm thinking about the support of the community I'm so blessed because there's a lot that's supporting us to stay here. They even give us help financially, our friendship and everything to consult, to work us. Especially now, my daughter is in the school, the school was very supportive of her needs. I'm just blessed, despite the fighting, I've been strong, we've become strong… So, they are the motivation that I need to be strong and get going.

> Yeah, and to let the government, hey look at us, here as you know, we are also human (Lynn, 08/22).

Mutual support in the form of financial aid, social relations and political mobilization were central to Lynn's shared story. Working with Migrante, another local organization, and with the support of local politicians, Lynn undertook a political campaign to raise awareness about her experience in Canada and to advocate for why she should be granted the legal right to stay, sharing,

> I need to stay here because my daughter has ADHD and OBD that she must stay here because, or the assumptions that she needs to stay in Canada… she needed to get that access because she really needs care. And I cannot provide that back home for her so that's why Migrante helped to come to some petition and the same campaign for that that's why we did campaign for my daughter, to stay here. So, I'm just so blessed that the community and the organization and supporters for the campaign. So that's why the government hear our campaign so he allow us to stay here for a year while waiting on the humanitarian again because I submitted again another humanitarian. So right now, I think it's a positive path because the office of the MP like in office helped me about this time. I think right now we are in a good track because I just had received that I can do my VISA now…The MPP helped me about this case so that's why we get the approval to stay one year. And then the minister, IRCC minister heard our petition so they let us stay for a year. So that I still have time to process my application and gather some documents that IRCC must needed (Lynn, 08/22).

Lynn's story further shines insight into the immigration struggles many migrant workers experience in their efforts to regularize their status, often applying multiple times and through multiple different immigration streams, after years of living and working in Canada and establishing a community. Additionally, Lynn's story highlights how influential and strategic it can be to gain the support of a local Member of Parliament in future advocacy efforts for both discretionary health care from the IFHP or for immigration matters. To conclude, Lynn shares,

> I think the one that I can give advice like keep trying, be patient, your faith must be stronger and connect with our community. Because I learned a lot like when you're distancing yourself in the community it will not make you grow and it not make you stronger. So, you need to, because we all need help, especially us, right. So, seek help from the community, the community will help you (Lynn, 08/22).

6.4 Discussion

Toussaint's foundational litigation history in Canada as well as internationally in support of health care for medically uninsured migrants demonstrates the limits of the law as a tool for reform. Despite ongoing litigation efforts since 2010 in effort to bring about change, no provincial, territorial, or federal legal or policy change has permanently introduced rights to health care for medically uninsured migrants. Yet at the same time, socio-legal scholars contend that litigation efforts have important spillover effects. More recently, in their assessment of litigation in support of refugees during the Harper-era (2006-2015), Anderson & Soennecken (2018) observe that both litigation and "rights talk" were influential to the advocacy work of refugee organizations, public awareness campaigns, coalition building and lobbying efforts in support of policy change. On the other hand, Galanter (1983) also contends that litigation can lead to the opposite demobilizing effect, such as the loss of legitimacy to certain claims, the discouragement of litigation, as well as loss of resource capacity (p. 126). Nonetheless, in the context of health care entitlements of uninsured migrants today, legal mobilization and political campaigns outside of the courts led by migrants and health care workers and supported by mutual aid networks and local politicians have demonstrated multiple wins worth underlining.

During this same time period of Toussaint's litigation efforts (i.e., 2010-present), Alberta gained the 'Mckenna Law' for infants born to medically uninsured parents, Ontario secured temporary billing codes during the 2020-2023 period for medically uninsured migrants, a physician in Edmonton secured free imaging services for their clients and interview findings document that some migrant workers secured temporary and discretionary health care coverage from the province or federally through the IFHP. These wins emphasize the importance of mobilization within as well as beyond the court system in Canada, as well as the importance of organizations, mutual aid networks and individual actors and the power they can mobilize in support of change.

Toussaint's litigation history also shines light on absence of race in court judgements, despite the fact that her denial of health care entitlements for the medically uninsured cannot be separated from the racial capitalist regime that underpins differentiated labour and right entitlements in Canada as argued in chapter one. Additionally, as previously discussed earlier in this chapter and in chapter four, it is important to highlight the ways in which many migrant workers come to Canada from countries impacted by colonization or the Transatlantic slave trade, and in turn, end up laboring on and *waiting on* Canadians (i.e., care work, domestic work, customer service, hospitalist, manufacturing)., while simultaneously *waiting for* health care entitlements. This is likely a biproduct of Canada's 'grounds approach' to anti-discrimination law (Eisen, 2013; Hodes, 2020), whereby claimants are required to have their identities and their experienced discrimination fit into a specific and often a singular and immutable box. Nonetheless, it could be positioned that past decade of litigation history for migrant workers and refugees, including for example the restoration of IFHP after Harper-era cuts (*Canadian Doctors for Refugee Health Care v. Canada (AG) 2014 fc 651*), in confluence with the global post-George Floyd movements for racial justice, that these efforts have worked to inspire new litigation efforts where by discrimination based on immigration and race are beginning to be made more explicit in the courts.

More recently in 2023, migrant workers in Canada who have tied-to-employer visas under the SAWP or TFWP's agricultural worker's stream are seeking 500 million in damages in a new class action lawsuit (*Kevin Palmer and Andrel Peters v. The Attorney General of Canada*). The plaintiffs declare that their Charter rights were breached under section 7, the right to life, liberty and security of the person as well as section 15, which guarantees equal rights under the law without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability. Migrant workers are legally required to pay into Employment Insurance (EI) premiums, yet are they are simultaneously denied access to these benefits in the event that they become sick. Use of

contractual termination clauses also allows for migrant workers to be repatriated in the event that they fall it. Unlike past litigation claims for health care entitlements for medically uninsured migrant workers, the plaintiffs in this case explicitly characterize Canada's migration programs as "overtly racist policy objectives" (p. 6). Specifically, they reference the segregation of racialized farm workers through forced residency at their employer's work site. They allege, that since 1966, the tied employment SAWP visa restricts the freedom and applies more "coercive conditions" of Black and Indo Caribbean farm workers, and later Mexican farm workers, on the basis of race and nationality (p. 6).

Kevin Palmer and Andrel Peters v. The Attorney General of Canada suggests a new direction in litigation tactics aimed at reforming migration and health care policy objectives, whereby experiences of racism are made explicit and logics of racial capitalism are becoming increasingly unveiled. At the same time, the class action lawsuit, *Kevin Palmer and Andrel Peters v. The Attorney General of Canada* are not alone in drawing explicit connections between racism, immigration, and discrimination in Canada. Just a few months prior to their claim, the UN Special Rapporteur on contemporary forms of slavery, Tomoya Obokata, also sounded the alarm on employer-specific work permits, stating "…certain Temporary Foreign Worker Programmes, make migrant workers vulnerable to contemporary forms of slavery, as they cannot report abuses without fear of deportation" (UN Office of the High Commissioner, 2023, September 6, p. 1). In his final report, Obokata (2023) shares:

> The root causes of contemporary forms of slavery such as poverty, inequality and discrimination, which have been amplified by the legacy of colonialism and racism, must be tackled more seriously if Canada is to establish and maintain a truly inclusive society. Closer coordination and unified approaches across all jurisdictions of Canada are also needed in a number of areas affecting the wellbeing of victims or those at risk of contemporary forms of slavery (p. 10).

Obokata specifies a series of intergovernmental jurisdictional issues required to change in order to improve the human rights of migrants in Canada, such as the modification of employer-tied work

permits, the limited reach of provincial and territorial employment laws to those with TFW visas and the need for long-term or permanent residency for migrant workers without discrimination (Obokata, 2023, p. 11).

When it comes to the movement to expand public health care entitlements to medically uninsured migrants in Canada, it is necessary to explore reform and resistance efforts both from within state-law as well as beyond the law. While it is commonly understood that socio-legal studies often privilege research into how the law can be utilized toward resistance and social transformation, such as in the case as Toussaint v. Canada at the ICCPR, at the same time, Mariful Alam and Irinia Ceric (2023) emphasize how alternatives to law, such as community-based initiatives centered on principles of mutual aid and solidarity often remain under investigated. Part of the challenge as observed by Alam and Ceric (2023) is the critique of scale, asking, "(How) Can hyper local and/or culturally marginal projects challenge the hegemony of state law and market forces?" (p. 210).

Efforts to organize volunteer run medical clinics and mutual aid networks documented both in Toronto and Edmonton (i.e., such as unofficial referrals to physicians from a migrant rights group in Edmonton or volunteer-run walk-in clinics in Toronto and the GTA) are prime examples of hyper local efforts that are engaged, in part, in challenging the hegemony of state law that has limited the rights of migrants and their health care entitlements by resisting these norms and by providing care. At the same time, they highlight the paradoxical work of migrant justice activists, as they often "…organize their revolution both within and also outside of the confinements of law and state power" (Alam & Ceric, 2023, p. 208-209). This can be seen in efforts to secure municipal sanctuary motions in Edmonton and Toronto, as well as campaigns targeting policy reform such as in the case of the 'McKenna Law' in Alberta to provide health care to Canadian-born children. This dissertation investigates reform from within the legal system and beyond, yet coded interview findings frequently placed more emphasis on targeting reform from within the law and state power. This is likely due to

the real material effects of state power, whereby the absence of law in favor of migrant health care provisions has led to pre-mature death for too many.

6.5 Conclusion

This chapter began by investigating how the experiences of health care providers, medically uninsured migrants, and civil society groups can better support legal reform as well as what legal and extra-legal strategies are societal actors utilizing across territorial borders in their efforts to improve access to health care and legitimize the human rights of medically uninsured migrants. Research findings shed light in part on a larger phenomenon of the idea of so called earned citizenship, whereby migrant workers are systemically made ineligible for public health care services based on their immigration status until they have "demonstrated their ongoing societal contributions at multiple intervals over a probationary period of multiple years…" which is further characterized by the "…conditioning legalization on the performance of economic, cultural, and civic metrics" (Ahmad, 2017, p. 257). Looking at the scalar level, it becomes apparent that provinces and territories in their governance of public health care services and again more locally in health care institutions, all collectively contribute to this system, acting as borders to membership and belonging. Courts further uphold this system, as documented in Justice Zinn's (2010) reasons for judgement on Nell Toussaint's case, positing that to "To grant such coverage to those persons would make Canada a health-care safe-haven for all who require health care and health care services" (p. 1).

Documented legal efforts for reform against restrictive health care policies demonstrate the need to support resistance through the law as well as through community-based initiatives. Reform and resistance research questions were presented by theme rather than locality (i.e., Edmonton vs. Toronto). While scale, locality and local histories are all important contributing factors as discussed in chapter one, they are only part of the larger assemblages investigated in this research. As described in chapter two, participant's narratives and experiences are privileged in the analysis,

serving as the chapter's focus by prioritizing key findings, such as political framings and strategies. Interview findings for reform and resistance from research participant coded narratives were consistent across Toronto and Edmonton, with participants sharing similar experiences, recommendations, and political framings in both localities. For this reason, data from both cities were combined in this chapter to highlight key findings. At the same time, one primary distinction in research interviews were observed when it came to strategizing for change.

While both provinces at the time of research are led by conservative political parties, participants in Edmonton presented more of a pragmatic approach and concern for "winnable battles." For example, participants were often more careful when discussing the role of politics, while simultaneously noting the provincial government's responsibility in denying health care coverage to medically uninsured migrants. Participants had a clear idea of what was or wasn't achievable with the current provincial government and strategized around topics that felt more realistic within the confines of a conservative leadership, such as securing a health care organization for government sponsored refugees but not pushing too quickly for funding for uninsured patients. In Toronto, likely in part because Ontario already has some permanent provincial funding for medically uninsured migrants through CMCs, this carefulness for political demands from health care providers and NGOs was not observed to the same extent. By way of its former premier Jason Kenney (2019-2022), Alberta has also experienced more recent anti-immigration political discourse. For example, Jason Kenney was commonly known to perpetuate discourse of bogus refugee claimants during his time as cabinet minister for former prime minister Stephen Harper. Nonetheless, migrant justice organizers across both cities less commonly demonstrated this carefulness toward political discussions and continued to politically mobilize for rights for health care services for uninsured migrant workers across government levels.

In part one, this chapter questioned whether the law and courts are the best place to push for reform and resistance by exploring the courts limitations, the lack of domestic enforceability of international customary laws, and the problematic nature and essentialism of anti-discrimination law itself. At the same time, the state's law, both federally and provincially, and in part, local health service delivery institutions, control the gates to public health care access in Canada. As such, they remain foundational elements in the assemblages of health care barriers necessitating attention for reform.

Part two explored reform and resistance efforts beyond the courts and posits' that participants in both cities developed political rationalities and employed discourses of (1), first hand story and rights-based framing, (2), economic framing or cost benefit analysis as well as (3), consciousness raising of global asymmetries of power in effort to resists the effects and ideology of racial capitalism as a taken for granted regime in the government of health. Participants proposed multilevel political mobilization strategies across scalar of government, but also across health issues. This chapter further built on the three elements proposed by Nicholls and Sorrell-Medina (2023) and adds the importance of mutual aid networks and individual actors along with organizational support, as central elements that support reform and resistance efforts in the Toronto and Edmonton context. Documented examples, such as a doctor in Edmonton who secured free medical imaging for medically uninsured migrants is a prime example that demonstrates the power a single actor can hold.

Chapter Seven.
Conclusion |

7.1 Introduction & Contributions to the Field

Guided by a socio-legal critique on denials, delays and barriers to care, this doctoral research analyzed barriers to health care for migrants with precarious status in Toronto and Edmonton, from sparsely located volunteer run clinics to repetitive denials of health care cards to Canadian-born infants. This doctoral dissertation contributes to the scholarship on health care access for migrants with precarious status in three distinct ways.

First, this research documents the denials, delays, and barriers to health care that medically uninsured migrants experience at the local level in two cities in Eastern and Western Canada (Toronto and Edmonton) — an underdeveloped research area in the Canadian context. Second, unlike previous research that is largely state-centric, this research bears witness to the injustices experienced by providing concrete examples and first-hand experiences of barriers and denials of health care from the perspective of medically uninsured migrants and health care practitioners alike. This unique insight is instrumental in identifying relevant sources of governance, authorities, and techniques in the regulation of migrant health across scalar levels. These techniques of documenting and bearing witness are instrument in identifying relevant sources of governance, authorities (from NGO workers, employers, health care providers, hospital policies, boards, regulatory bodies, provincial policies and temporalized federal immigration laws to name a few), and techniques of regulation of migrant health across scalar levels to undercover the way in which they interact to constitute assemblages of health care barriers.

Third, this dissertation argues that racial capitalism is the dominant political rationality that underpins the denial of health care rights to medically uninsured migrants in Canada. This framing helps us to better understand how the barriers and the denial of health care entitlements for

migrants with precarious status are legitimized and maintained. What is more, this pervasive ideology of racial capitalism makes these realities into something that is taken for granted and normalized. The improvement of health care entitlements for migrants with precarious status across Canada is ultimately dependent on the overcoming of this ideology. Overall, these findings may be useful for directing future advocacy efforts engaged in the mobilization for change, such as the expansion of rights to migrants with precarious status. As discussed in this dissertation, they also point to the need for a multi-level political strategy, one which is directed beyond the confines of litigation and the courts.

This chapter begins with a summary of the dissertation's main findings and key contributions from each chapter. Second, this chapter addresses research limitations encountered in conducing field work for this research. Third, a reflection on similarities and difference between Toronto and Edmonton is provided. Finally, this chapter concludes with implications and recommendations for future research.

7.2 Summary of Findings

In chapter two, this dissertation laid out the history of the problem at hand to better understand how barriers to health care are manifested today for migrants with precarious status. Medicare in Canada has been linked to racial exclusion since its origin. Indigenous peoples were excluded from government funded insurance plans, treaties were broken, local advocacy movements prevented the inclusion of Indigenous peoples and hospitals utilized annexes (Lux, 2018). Similarly, a history of immigration acts in Canada over time also demonstrated racial exclusion and ableism (Adjekum & Joseph, 2023), both through explicit and veiled approaches to immigration policy that negatively impacted different groups of racialized people over time in their efforts to migrate peacefully. Following the investigation of these overlapping histories, chapter one set out the federal context in which public health care and temporary migration are governed in Canada. An analysis of the

Canada Health Act identified the broad definition of residency at the federal level that became more restrictive over time at each lower jurisdictional level to limit access and entitlements for groups of migrants and visitors. Chapters four and five demonstrated how this definition becomes narrower at the provincial level, and in some cases, even narrower yet again at the local institutional level, such as in the case of identified Toronto hospitals in chapter four. The Minister of Immigration used discretion legally available to them to expand entitlements to the Interim Federal Health Program for medically uninsured migrants, as only one possible tool that may be exercised federally.

Chapter two also investigated Canada's temporary immigration programs in confluence with its public health laws. Canada's Temporary Foreign Worker programs and its Seasonal Agricultural Worker Program were identified as establishing a temporalized migration regime that systemically increases the likelihood that a participant in these programs may end up medically uninsured. Further, Canada's reliance on employer-tied visas establishes a legalized system where exploitation and abuse flourishes, as recently described as a "breeding ground for contemporary slavery" by the UN (OHCHR, September 6, 2023, p. 1). In addition to immigration programs, and public health histories and their present-day formulations, chapter one also introduced the theoretical framework drawn on for this research, which uses distinct conceptual keys that are woven together at different points throughout the dissertation to help code, analyze and reflect on research findings. Specifically, this approach draws on (1) racial capitalism, borders and temporalized migration, (2) critical legal geographies, (3) governmentality and the law, (4), jurisdiction and discretion, and (5) migration and Indigenous relations.

Woven together, these conceptual keys helped to highlight different yet important considerations necessary for a holistic approach to empirically investigate how barriers to health care are produced to create uneven access to health care across space. First, the conceptual key of racial capitalism, borders and temporalized migration helped to illuminate how under racial capitalism race

works to naturalize different types of labour as well as the rights and benefits associated with them. More specifically, this conceptual key supported my argument that racial capitalism is the political rationality that underpins the government of migrant health as well as helped to identify the discourses that work to normalize barriers and denials to care. Second, drawing on critical legal geographies allowed for a privileging of space and time. A focus on space helps to illustrate how precarious status impacts mobility and access to certain places (i.e., medical offices etc.) and how boundaries of state sovereignty and national borders were reproduced in medical offices. For example, in the case of Edmonton, a civil society group interviewee working with medically uninsured migrants reported that they often felt uncomfortable when accessing local pro-bono care, with special instructions for checking in, which included avoiding the front desk (Civil Society Group 1, Edmonton, 01/22). With the privileging of time, waiting was seen as a technique of government in the governance of migrant health as well as a highlighted the ways in which migrants with precarious status are constantly subjected to both "waiting for" and "waiting on" (see chapter one).

Third, the conceptual key of governmentality helped to decentre the law in my investigations of health care in Toronto and Edmonton, as well as examine health care barriers that have formed at the intersection of both legal and extra-legal practices and discourses (Rose & Valverde, 1998). Additionally, this conceptual key brought attention to competing rationalities and knowledges engaged in disrupting the discourses that normalized barriers to care (as identified and defined in chapter five). Fourth, drawing on jurisdiction and discretion, attention was brought to the many different ways in which residency is defined differently across health care institutions and jurisdictions. Focusing on discretion filters down to the street-level bureaucratic and institutional levels. Lastly, the final conceptual key, migration, citizenship, and Indigenous relations brought attention to not only the acknowledgement of the land in which this research took place, but to the

lived realities on the land for Indigenous peoples and health inequities. This approach brought attention to Indigenous peoples' exclusion from health care entitlements in Canada, drawing on Canada's broken legal commitment to a medicine chest in Treaty No. 6 in 1876 as well as early Medicare developments, both through exclusions by advocacy groups and public policy exclusions.

In chapter two, I described the research methodology employed in this doctoral dissertation, spanning city selection, the application of governmentality as a method (Brady & Lippert, 2016) as well as qualitative analysis (i.e., data collection, recruitment, interviewing, coding and analysis). This chapter provided an overview of interview considerations for three distinct groups, migrant participants, health care providers, and civil society groups/ NGOs) (n=30), highlighting their shared narratives throughout this dissertation as an equal source of insight into the issue. This chapter further described research limitations, ethical considerations, the risk of deductive disclosure in small communities, as well as the role of gatekeepers and trust. In conducting this research, I found that researchers conducting investigations into health care access for medically uninsured migrants in Canadian cities, even larger cities such as Edmonton, must plan ahead to mitigate against deductive disclosure given the small interconnectedness of the community and the care providers operating in this space. Gatekeepers and trust were also a significant consideration for conducting research in this field, signalling a further need for migration scholars to work toward building better trust with communities of migrants with precarious status across Canada.

Following a discussion of research methodologies, the substantive chapters four and five on Toronto and Edmonton were organized by a traditional socio-legal approach to research which looked first to investigating law in the books and history, and second, on the first-hand experiences with the law in practice. In chapters four and five, I build on chapter one, where I argued that systemic barriers and denials to health care for migrants with precarious status is underpinned by a dominant political rationality of racial capitalism. Specifically, I demonstrated that racial capitalism

helps legitimize denials to rights, such as the denial to health care for groups of migrants. This process takes place through multiple steps. Namely, systemic denials to rights for health care by employers, health care institutions and government agencies work to normalize delays, denials and barriers to care by recrafting who belongs in the process. In an interview with Lynn in Edmonton, she details her experiences fighting to get access to health care for her daughter, reflecting that "…My daughter belongs here, we belong here" (08/22). This dissertation argued that feelings of belonging, and the provision of health care entitlements are uniquely intertwined.

Interview findings irrefutability demonstrate that in the case of Toronto and Edmonton, medically uninsured migrants are at times subjected to a lower standard of care compared to the rest of society, because of their immigration status and lack of health insurance. In turn, this experience negatively impacts feelings of belonging for medically uninsured migrants. For example, in chapter four, Healthcare Coordinator 1, detailed how in the hospital context, they experienced a lack of testing and medically necessary follow up for medically uninsured patients, stating: "…I wonder whether or not we are giving them the best possible care that we could give for them" (Toronto, 10/21). In another example, in chapter five, Doctor 1 reflected on their experience stating: "The moment I'm being asked is it absolutely needed, it's not a place we're used to being…It's uncomfortable, right, because you might miss things, the care might be incomplete" (02/22).

In addition to various actors and institutions, government bodies across federal and provincial jurisdictions also utilize techniques of government through the application and intersection of restrictive health care policies and temporalized migration policies, which in practice, work together to create larger populations of medically uninsured migrants. While these actors (i.e., health care institutions, practitioners, government bodies, employers etc.) may hold different goals, interests, and problems, when they assemble around the issue of migrant health, a cultural norm forms that positions both the denial of health care as well as the increased billing of care for

medically uninsured migrants as an acceptable practice in both Toronto and Edmonton. The formation of these cultural norms is only possible because it is supported by an underlying ideology that positions differentiated and racialized labour and rights in Canada/ Turtle Island as something that is partly veiled and largely deemed publicly acceptable. These arguments are supported by qualitative interviews with participants who provided detailed accounts of their life experiences navigating health care in Canada or their work experience with medically uninsured migrants.

In chapter four – Toronto | Tkaronto, I provided a brief introduction to the city's Indigenous roots and the ongoing treaty obligations that govern the land, as well as the city's demographics and brief immigration histories. This introduction also included a brief history of Toronto's status as a sanctuary city and some of its local social movements. Next, chapter four provided an overview of the province of Ontario's key legislative changes concerning health care from the 1970s-present as well as the current provincial laws on OHIP access. This review demonstrated that universal health care in Ontario has always been politically contested and locally reinterpreted over time. In this section, Registered Midwife 1 (12/21) described how one local Toronto hospital had further interpreted the definition of residency at a narrower definition than the province, describing it as being limited to "your 30-month wait for PR." Otherwise, infants born to migrants whose legal status did not meet this definition were not provided with paid neo-natal intensive care after birth and were charged, despite their children being legally entitled to OHIP coverage at this time per provincial policy.

Chapter four was conducted and written during the era of Ontario's COVID-19 Temporary Billing Codes, as such, this chapter described participants' perspectives on "pre-COVID" and "since-COVID." Had the research fieldwork and writing continued past March 2023 when the billing codes were eliminated, a third category would have been required to capture this era. This chapter also highlighted the disconnect between federal immigration programs and provincial

legislation, whereby the province created different rules of health care eligibility for different temporary immigration programs. Ultimately, barriers to health care for migrants with precarious status were investigate and categorized by reoccurring empirical themes. This section identified key techniques of government identified in the regulation of migrant health care, which included: inconsistent billing practices, requirement of down payments prior to treatment, heightened facility fees by registering uninsured migrants as 'tourists' instead of as 'residents,' profiteering by specialists at rates above OHIP levels, inconsistent application of temporary billing codes (2020-2023), and the denial of health care cards to legally eligible newborns to name a few. To be sure, these techniques work to redraw the lines of sovereignty and borders in practice and work to recraft who belongs in the process (Pratt & Templeman, 2018). The resistance engaged in the redrawing of these lines was later discussed in chapter five.

In chapter five – Edmonton | amiskwaciwâskahikan, like in the case of Toronto, I provided a brief introduction to the city's Indigenous roots and the ongoing treaty obligations that govern the land (i.e., Treaty 6), as well as the city's demographics and brief immigration histories. This introduction also included a brief history of Edmonton's Access to Municipal Services Without Fear motion and some of its local social movements, such as the 2016 McKenna Law campaign and the 2021 opening of the New Canadian Health Centre. This chapter provided a brief overview of Alberta's public health laws and the game of jurisdiction at play in the redrawing of boundaries from decentralized and then centralized health zones across the province, which are frequently a point of discussion from one provincial election to the next.

Further, the arbitrariness between health care eligibility for migrant workers across provinces became more evident. In Alberta, for all migrants with visas shorter than 12 months, such as the SAWP and TFW, the employer is required to pay for private health insurance. As a result, migrant workers have inconsistent health care entitlements within the province and beyond the province,

determined in policy by the length of their visa. Issues were identified with this model, such as certain employers obfuscating private health insurance details to avoid increased premiums or a higher risk of medical repatriation. Unlike Ontario, Alberta provided no funded health care for medically uninsured migrants throughout the pandemic, aside from the testing and treating of COVID-19. Additionally, at the time of research, Edmonton had no publicly funded or dedicated health care program for medically uninsured migrants.

Ultimately, barriers to health care for migrants with precarious status were investigated and categorized by reoccurring empirical themes. This section identified key techniques of government identified in the regulation of migrant health care, which included: inconsistent billing, profiteering by physicians as encouraged by their regulatory body, the Alberta Medical Association, the intentional obfuscation of private health care coverage by employers in the agricultural sector, and both the delay and denial of health care cards for Alberta-born infants to migrant worker parents, despite the province's passing of the Mckenna Law. To conclude, I argued that these practices and norms across both provinces and cities are supported by an underlying ideology of racial capitalism, namely the acceptance of differentiated and racialized labour and rights. Next, chapter five – Reform & Resistance, is centralized around the theme of reform and resistance for both cities, highlighting participant narratives and the use of litigation as only one possible tool of resistance among many.

Chapter six – Reform & Resistance, focused on reform and resistance possibilities, organized by Nicholls and Sorrell-Medina's (2023) categorization of undocumented migrant activism's central themes of framing, political opportunities, and organizations. As one example of political opportunities and multilevel mobilization strategies, this chapter documented the litigation history of Nell Toussaint domestically and abroad, arguing that the spillover effects of litigation efforts should not be overlooked, even in the case of negative judgements. While this case has yet to bring any materialized remedy to Toussaint's estate (at the time of writing), or any policy changes, despite

winning her case at the ICCPR, Canada is now witnessing a proliferation of attention to the exploitative aspects of its temporary migration programs and the precarity this creates. Most recently in 2023, a new class action lawsuit by workers tied to SAWP visas challenges Canada's "overtly racist policy objectives" (*Kevin Palmer and Andrel Peters v. The Attorney General of Canada*, p. 6), and in 2024, the UN Special Rapporteur on Contemporary Forms of Slavery presented his End of Mission Statement, concluding that Canada's temporary foreign worker program is a breeding ground for modern slavery (OHCHR, September 6, 2023, p. 1). Nonetheless, litigation efforts to date have failed to bring about policy change in support of expanding health care eligibility to migrants with precarious status, emphasizing the importance of reform and resistance efforts beyond the confines of state law.

Chapter six focused on privileging the experiences of interviewed participants to develop strategies for resistance and reform. Beginning with framing, this dissertation identified competing knowledges or rationalities from participant narratives aimed at disrupting racial capitalism as a taken for granted norm, which included: (1) firsthand story and rights-based framing, (2) economic framing or cost benefit analysis, and (3) consciousness raising of global asymmetries of power. Through the story telling of lived experiences, the systemic barriers impacting regularization and access to health care start to become unveiled. Likewise, framing access to health care based on physical presence, community membership and as a rights-based issue was largely supported by participants. Economic framing remained a popular approach by many health care providers to justify expanding health care access to medically uninsured migrants. To be sure, this framing was never positioned in isolation from other framings, but paired with other framings, such as rights-based framings. This is likely to be seen by care providers as a pragmatic approach for lobbying for policy change. Indeed, many health care providers in the Toronto-context did detail experiences with meeting with provincial government partners to push for expanded services, such as in the case

of the COVID-19 temporary billing codes. From this perspective, economic framing presents as a rational approach to assist in advocating for change. Nonetheless, this approach was strongly opposed to by those more heavily engaged in migrant justice movements, representing a diversity of views and approaches within the broader community working toward change. As activist Civil Society Group 1 put it, "…healthcare should be seen from the lens of a human right. Not economic, although there's an economic aspect to it. It's a basic right, no?" (Edmonton, 01/22). Lastly, many participants underscored the importance of framing health care barriers for medically uninsured migrants as the effect of a broader transnational issue. Specifically, they echoed Walia's (2012) positioning of precarious migrant in Canada as a crisis of displacement and immobility, in effort to challenge the effects and ideology of racial capitalism as a taken for granted norm in the government of migrant health as a form of resistance. From the perspective of this framing, the importance of consciousness raising on Canada and the actions of its registered corporations overseas in relation to displacement was seen as a crucial approach.

With respect to political opportunities, participants shared multilevel mobilization strategies as well as supported an approach of 'winnable battles.' This approach required mobilizing politically across jurisdictional levels at different times, as well as taking a pragmatic approach based on the political party in power at the provincial level. For example, in Edmonton, participants discussed the importance of first gaining a health care centre for state sponsored refugees first and then using that as a platform to later advocate for care for other groups of migrants, such as community-sponsored refugees and medically uninsured migrants. In Toronto, this approach was also demonstrated with respect to a focus on pregnant people and infants first as a more politically acceptable proposal. These approaches in both Edmonton and Toronto were expressed by health care providers with many years of experience working in the field as well as mobilizing politically.

Lastly, this dissertation expanded on Nicholls and Sorrell-Medina's (2023) third category, organizational support, and added the importance of individual actors and mutual aid networks to the movement in support of health care for medically uninsured migrants. All three categories were identified as meaningful to supporting change. For example, while organizations provide sources of funding to movements, and in part, help bring legitimacy with respect to communicating local needs to provincial funders, mutual aid networks and individual actors were identified as also bringing significant value. For example, mutual aid networks in Edmonton were influential in bringing awareness and getting media attention for the adopted Mckenna Law. Likewise, individual actors were successful in multiple ways. In the case of Edmonton, a local doctor secured free private imaging for their uninsured patients, and local politicians were occasionally successful in securing temporary health care coverages for medically uninsured patients experiencing serious illness.

Having provided a summary of key findings across chapters, the following section provides an overview of research limitations experienced.

7.2 Limitations

This doctoral dissertation undertook all its interview recruitment and interviewing during the first two years of the COVID-19 pandemic. Most businesses were closed for months at a time, and universities shifted to remote only operations and all in-person interviewing was canceled by university ethics protocols. At the same time, health care practitioners and their offices and institutions were operating at their maximum capacity, with limited resources and time to allocate to research participation. This proved difficult for interviewing and recruitment, from both an ethical and a practical standpoint. During the pandemic, many medically uninsured migrants continued to be ineligible for government benefits yet continued to work in labour intensive and customer service fields, such as cleaning, manufacturing, farming, and restaurants rendering them even more

vulnerable and potentially in need of care. With the restriction of in-person recruitment and interviewing, paired with provincial lockdowns, recruitment of migrants who were medically uninsured also proved challenging during this time. As a result, a smaller number of interviews were conducted (n=30) than what was originally planned. Having addressed the key research limitations, the following section provides a reflection that compares and contrasts some of the key findings in Toronto and Edmonton.

7.4 Reflection: Toronto & Edmonton

In chapter three, I described the methodologies for this doctoral research project and identified that a comparison between Toronto and Edmonton was not intended to highlight one city's or province's response as better or worse than the other, but to wholistically understand the differences and the contributing factors that create barriers to health care or opportunities for change in both locations. Specifically, this approach required a focus on the differences as much as the similarities in both locales, as well as stretching the imagination as to what else might be possible (Nelken, 2010). This section reflects on key differences and similarities across both cities.

The most significant difference between the two cities was the presence or lack thereof dedicated health care clinics for medically uninsured migrants. In the province of Ontario, many of the provinces 75 Community Health Centres (CHCs) have dedicated fundings for servicing uninsured patients. Beyond CHCs, Toronto also has multiple clinics dedicated to providing care to uninsured migrants and refugees, such as the Non-Insured Walk-in Clinic, FCJ Refugee Centre's walk-in clinic, and the Canadian Centre for Refugee and Immigrant Health Care to name only some of the more prominent clinics in the region. Each of these free clinics for medically uninsured migrants as well as Toronto's CHCs have slightly different eligibility criteria as documented in chapter four. For example, as discussed in chapter four, one CHC employee shared that at their workplace, uninsured migrants were required to meet with a social worker to discuss their

regularization process, and that a dedicated social worker would determine funding and service eligibility. Other community clinics had no requirements of regularization efforts for their patients. Each medical office also had a different allocated budget per patient for specialized medical services required, such as lab work or diagnostic testing. Even across the city of Toronto, access to health care for medically uninsured migrants is uneven, with differing and restricted hours of operations, eligibility, and funding access across clinics.

As discussed in chapter five, in Edmonton, at the time of research, there were no agencies identified with dedicated funding for uninsured patients. Unlike Toronto, civil society groups and NGOs were required to take on the additional labour of navigating urgent health care to a much larger degree compared to organizations in Toronto, by networking and arranging medical appointments with a select few individual doctors across the city offering pro-bono and unadvertised care through word of mouth. While one doctor was able to secure free lab work from a private clinic for his referred uninsured patients, this service appeared to be more limited compared to Toronto where CHCs and clinics have annual dedicated budgets per patients to cover testing city wide. In Edmonton, it is very likely that medically uninsured migrants are disproportionately denied access to urgent care due to lack of dedicated services in comparison to Toronto. Even migrant workers who immigrate to Canada under the very same temporary federal immigration programs that on paper offers at least some access to health care but who end up residing in different cities or provinces, will end up with different access to health care services, and ultimately, a different application of rights in reality, putting them at greater risk of precarious status.

While both cities had a different range of health care services available for medically uninsured migrants, both cities nonetheless had the same issues with the denial of health care for cancer patients and other palliative /end-of-life care. Medically uninsured migrants in Canada are being denied cancer treatment across the country, with multiple documented examples in both

Toronto and Edmonton. What is worse, interviewees thought that the denial of cancer treatment was believed to have resulted in the premature death of uninsured patients in both cities. For example, one passage from a doctor in Toronto had shared: "I feel like, you know, sometimes through a lot of advocacy people have gotten care, I don't know specifically about radiation. But sometimes not, and people have died" (Doctor 6, Toronto, 04/22). In Edmonton, interviewees shared similar experience. For example, as one doctor described it: "…so the one patient I'm thinking of who had that emergency, she had very severe symptoms and then they treated her symptoms, but they did not treat the cancer" (Doctor 3, Edmonton, 04/22).

Overall, it is evident that the lives of migrant workers in Canada, many of whom are racialized, are being devalued in comparison to Canadian citizens and permanent residents, whose access to cancer care is not predetermined by their current employment contract. This devaluation of migrant life is only possible because of the process of dehumanization through racial capitalism, whereby racism both manages and legitimizes differentiated labour and in turn, legitimizes the denial of rights (Kundnani, 2020). Because these processes and intricacies are partly veiled from the general population, many interviewed participants argued for the importance of storytelling and sharing of first-hand accounts of medically uninsured migrants' experiences in their efforts to access health care. It is hoped that these stories and experiences will begin to unveil racial capitalism and its processes, as well as raise consciousness on the global asymmetries of power, thus igniting a political will to bring about change.

Another significant difference across both provinces was the stark contrast in advice provided by the regulatory body of doctors. The difference of approaches by medical regulatory bodies in both provinces highlight the ways in which health care access for medically uninsured migrants operates within an assemblage of overlapping practices across multiple jurisdictional levels and institutions. As described in chapter five, in Alberta, the Alberta Medical Association (AMA)

refers to uninsured patients as "out of country patients" and makes no distinction between tourists and residents who are uninsured. The AMA (2020) also directs its members to bill uninsured patients two to five times the AHCIP rate, and further interprets immigration law, providing doctors with information on those who "do NOT have legal status to remain in Canada…" (emphasis in original text, p. 1). It is unclear why the AMA provides guidelines interpreting immigration law by outlining which patients have legal entitlement to remain in Canada and which do not rather than keeping to which patients have legal entitlement to AHCIP, as immigration status is irrelevant to the care doctors provide. This guideline and advice provided by the AMA helps explain in part why participants report uninsured migrants being charged rates significantly higher than those established by AHCIP.

This issue of profiteering off uninsured migrants was also documented widely across Toronto, however, the College of Physicians and Surgeons of Ontario (CPSO) officially takes a different stance, stating in their 2017 policy "Uninsured Services: Billing and Block Fees," that a physician must not charge "b. any amount in excess to what OHIP has paid or will pay" (p. 1). Further, it is technically considered professional misconduct if physicians charge fees considered excessive. Nonetheless, it is important to emphasize that despite the CSPO's (2017) policy, profiteering across Toronto remains active in practice, bringing into question what avenues are available for pursuing professional misconduct claims, who may submit such claims, and whether these remedies are at all helpful for uninsured patients who have already been forced to pay substantially to access care. Further research needs to determine whether pursuing these claims, possibly assisted by an advocacy organization, is a fruitful avenue of resistance.

At the same time, the CPSO (2017) further advises members to must consider whether "…it would be appropriate to reduce, waive, or allow for flexibility in the amount owed based on compassionate grounds" (p. 1). Such guidance of being flexible with uninsured patients and

introducing the idea of reducing or waiving fees was absence in the AMA's guidance. All in all, the guidance provided by each regulatory body introduces a new level of governance in migrant health that necessitates further attention and advocacy across provinces and territories, given the widespread issue of profiteering off of uninsured patients.

Another barrier identified in both cities demanding further attention is the denial and barriers for provincial health care cards for newborn infants. In the case of Ontario, all Canadian-newborn infants are entitled to health care cards regardless of their parent's status, provided their parents are residents of Ontario. Nonetheless, interviewed participants raised concerns with existing barriers for accessing health care cards, citing examples of hospitals that opt against directly submitting the Ontario Health Coverage Infant Registration form on behalf of the parents, leaving parents to go to Service Ontario directly to register. The issue is much greater in Alberta, despite the province's later adoption of McKenna Law in 2016, which provides health care for Canadian-born infants provided their parents are residents of Alberta. Two interviewed migrant participants in Edmonton disclosed encountering barriers to accessing health care cards for their Alberta-born infants, and in the case of Valentina, she was repeatedly told her child was ineligible for a health care card when applying at the government office for weeks.

To make matters worse, the infants of migrants with precarious status across Canada have often been born into debt. In the case of Lynn in chapter four, she shared her hospital experience stating, "I just gave birth to her at that time, then she owes already. She has already a debt to pay, you know" (08/22). While in Toronto, the barrier for health care cards for Canadian-born infants is encountered by hospitals, in the case of Alberta, the barrier appears to be experienced by participating AHCIP registries and their interpretation of provincial policy. In both contexts, Canadian-born infants are experiencing either barriers to health care cards or the denial of health care coverage all together. This example brings to light the importance of socio-legal investigations,

looking beyond law in the books and researching how law is experienced in practice, shining light on barriers and denials of care that would otherwise not be visible. A final reflection on similarities and differences between the two locales is offered in chapter six, which closes with a discussion of potential approaches to reform and resistance.

Participants across both cities largely shared the same recommendations for opportunities for reform and resistance. More similarities and differences existed across professions and interview type, rather than across cities. For example, doctors were most likely to express a desire with using economics and cost-benefit analysis as a frame for advocating for funded health care for uninsured patients. Participants who were more strongly connected to migrant justice groups were more likely to discuss the importance of consciousness raising about global asymmetries of power. Nevertheless, it is important to note that many participants engaged with migrant justice groups were also health care providers themselves.

One noticeable difference between the two cities was an apprehension in the Edmonton context to criticize the provincial government or the party in power at the time of interviewing. While Edmonton participants did discuss the role of the provincial government in creating barriers for migrants in their efforts to access to health care, and at times a dissatisfaction with the party in power, they were more careful and specific when addressing politics. In the Toronto context, interviewed participants rarely held back their views of the political party in power at the provincial level, and were more open with their political criticisms across interviews. It is possible that because Toronto has a larger network of community organizations supporting uninsured migrants, and longer-term funding already exists at the provincial level for CHCs, there were more feelings of security among participants in expressing their political concerns. In the Edmonton context, no base line of funding or services exist for medically uninsured migrants, and only recently did Edmonton secure its first clinic for government sponsored refugees. This political carefulness may be in line

with the "winnable battles" or pragmatic approach, whereby participants are working in a provincial political system that already has a public reputation of being less welcoming of immigrants, which was spearheaded from its former premier, Jason Kenney (2019 to 2022), who prior to that, had served as Canada's Minister of Immigration (2008 to 2013). These similarities and differences across Edmonton and Toronto particularly helpful for addressing research implications and future research.

7.5 Implications & Recommendations for Future Research

This dissertation's findings bring attention to the fact that access to health care is not even across cities nor provinces, necessitating further research attention on regional differences across Canada and its provinces and territories. Differences across cities also underscore the importance of securing dedicated funding for the provision of health care to medically uninsured migrants. Many uninsured patients continue to go without access to health care in both cities, though this injustice is substantially greater in the case of Edmonton where no dedicated funding or advertised clinic exists. Nonetheless, free clinics with dedicated hours in Toronto were identified as insufficient in themselves, when specialized health care services and certain treatments and testing, such as cancer care and MRIs are made inaccessible across the country for uninsured patients without payment up front.

The similarities and differences across Toronto and Edmonton are helpful for identifying the different actors and institutions at play in the governance of migrant health, from provincial policies to health care regulatory bodies. This helps uncover new sources and locations where advocacy efforts could in turn be directed upon. More specifically, while much attention has been paid to mobilizing the courts to bring about change in this area, the findings of this dissertation further bring attention to the importance of mobilization for change outside of the courts. Nell Toussaint's case documented the limitations of court interventions at this time, with no remedy having yet been

paid to her estate nor any policy change for health care services for uninsured migrants. Nonetheless, litigation has spillover effects which may encourage newer litigation challenges over time which may one day lead to positive change. In addition to further research on regional differences across Canada, future research may consider drawing on alternative health care models from other states as a source of inspiration for policy change whereby health care is largely available to those with temporary resident permits, such as in Ecuador, Uruguay, Dominican Republic, Guyana, Chile, Brazil, and Argentina to name only a few (Gandini and Selee, 2023).

Ultimately, the future for health care justice demands that all migrants living across Canada be granted access to public health care services without discrimination based on immigration status, race, or employment type. Under the current temporalized immigration regime, failure to move beyond the confines of health care insurance tied to employment hours, work contracts or immigration status is a failure to move beyond the detrimental effects of racial capitalism. As documented throughout this dissertation, the effects are vast, from discriminatory care to premature death. Health care justice in Canada also necessitates both reforms to Canada's increasingly temporalized immigration programs in tandem with its health care laws given the lived and material effects of their intersections. To conclude, as Lynn shared in her recommendations for Canadian governments,

> …healthcare must be inclusive to everyone, because healthcare is a necessity. I mean it's a human right, everybody must have access to healthcare. Doesn't matter what is the status, the gender or race…I mean they [undocumented workers] paid everything, they process the papers legally, they went in Canada. It just so happened that there's a lot of unforeseen misfortune that they have encountered despite that they're undocumented. But they [government] forgot that they came here legally, they pay taxes and everything. I mean they are not a burden to any Canadian. Even after now even though they're undocumented we are still paying taxes to the house that we're renting, to the clothes that we're buying, to the food that we're buying, right. How come we are neglected to the healthcare system? Yeah, no one should be left behind because if everybody needs healthcare, everybody gets access to healthcare (08/22).

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Appendix A.

Interview Guide – Migrant Participants

1. Can you tell me a bit about yourself? (Follow up: How long have you been in Canada? Are you here with any family members?)
2. What are some of the reasons you left your home country?
3. What does your everyday life look like?
4. What has been your experience with immigration applications in Canada?
5. How has your experience been with health care access?
6. Have you ever been denied services because of the fees?
7. Are there any free clinics in your community?
8. Have you ever delayed getting treatment/care because of your immigration status?
9. What changes would help make things better for migrants here in Canada?
10. Are there any questions I haven't asked yet that you think would be helpful to know?

Appendix B.

Interview Guide – Health Care Practitioners

1. Could you describe your current role and some your previous work experience in the healthcare sector? What type of healthcare organization do you work in?

2. Can you describe your experience working with uninsured migrants? Can you describe it in more detail?

3. Have you observed any trends in the healthcare needs of uninsured migrants?

4. How does your office manage billing and fee collection for uninsured migrants?
    a. How are the rates established?
    b. Does your office charge the same rates as the provincial public health insurance rates? (Why/ why not?)
    c. Does your office have a discretionary fund, if so, is it ever used for uninsured migrants?
    d. Do you have specific labs or specialists you direct patients too who accept uninsured migrants? How did your office establish or identify which specialists who would charge a lower rate or be willing to see the patient?

5. Do you belong to any medical associations or professional networks, and if so, have there been discussions around healthcare access or fee structures for uninsured migrants?

6. In your personal opinion, do you have an ethical responsibility to provide <u>emergency</u> healthcare services to uninsured migrants?

7. In your personal opinion, do you have an ethical responsibility to provide <u>preventative</u> healthcare services to uninsured migrants?

8. To the best of your knowledge, what are some of the reasons that the uninsured migrants you have provided care for are uninsured? *(i.e., probe: new residents to Canada, in between work visas, etc.)*

9. Have uninsured clients shared any negative experiences with you or reported experiencing any discrimination in their attempts to access health care elsewhere?

10. Do you personally believe that uninsured migrants should be entitled to OHIP coverage? (why/why not)

11. Do you believe the current provincial healthcare program is sufficient when it comes to supporting migrants, or would you recommend any changes? If so, which changes?

12. What are the main laws that you say most govern the rules of your day-to-day practice?

13. Does your office accept patients who are insured by the Interim Federal Health Program (refugee patients)? (move towards end)

14. Are you familiar with the <u>Governing Law and Jurisdiction Agreement</u> and if so, do you use it in your practice? (Canadian Medical Protective Association CMPA)

15. Are there any questions I haven't asked yet that you think would be helpful to know?

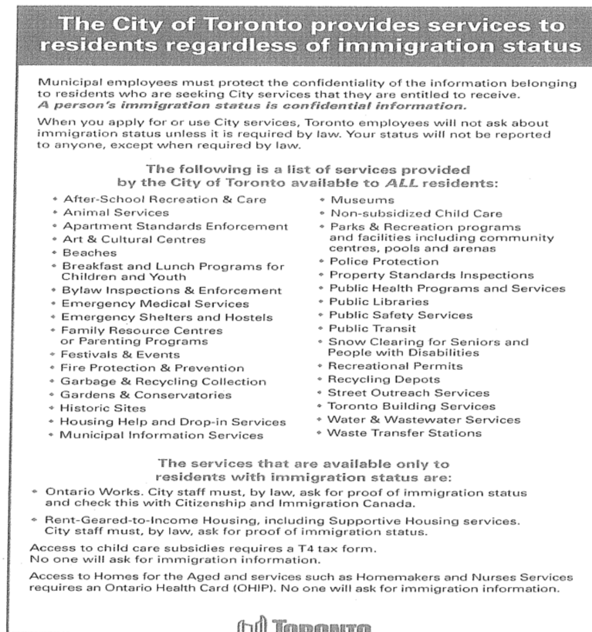
Appendix C.

Interview Guide – NGO's and/or Civil Society Group Members

*Questions are more open ended and tailored to each interview with an NGO employee or civil society member based on their group/organization and the work that they do. This guide includes preliminary questions only.

1. Could you describe your current role and some your previous experience?
2. What type of health care organization do you work in and can you tell me a bit about it?
3. Have you observed any trends in the health care needs of medically uninsured migrants?
4. What are some of the specific issues you see in your work when it comes to health care access for medically uninsured migrants?
5. How does your org deal with billing for uninsured migrants?
6. To the best of your knowledge, what are some of the reasons why people migrants are medically uninsured? (i.e., failed refugee claim etc.)
7. Do you believe uninsured migrants should have access to provincial health care coverage?
8. What are some of the strategies you use in your own work or office to help overcome issues to access?
9. What do you think is needed to help change /improve healthcare access?
10. Is there anything I haven't asked you yet, that would be helpful to add?

Appendix D.



The City of Toronto provides services to residents regardless of immigration status

Municipal employees must protect the confidentiality of the information belonging to residents who are seeking City services that they are entitled to receive.
A person's immigration status is confidential information.

When you apply for or use City services, Toronto employees will not ask about immigration status unless it is required by law. Your status will not be reported to anyone, except when required by law.

The following is a list of services provided by the City of Toronto available to *ALL* residents:

- After-School Recreation & Care
- Animal Services
- Apartment Standards Enforcement
- Art & Cultural Centres
- Beaches
- Breakfast and Lunch Programs for Children and Youth
- Bylaw Inspections & Enforcement
- Emergency Medical Services
- Emergency Shelters and Hostels
- Family Resource Centres or Parenting Programs
- Festivals & Events
- Fire Protection & Prevention
- Garbage & Recycling Collection
- Gardens & Conservatories
- Historic Sites
- Housing Help and Drop-in Services
- Municipal Information Services
- Museums
- Non-subsidized Child Care
- Parks & Recreation programs and facilities including community centres, pools and arenas
- Police Protection
- Property Standards Inspections
- Public Health Programs and Services
- Public Libraries
- Public Safety Services
- Public Transit
- Snow Clearing for Seniors and People with Disabilities
- Recreational Permits
- Recycling Depots
- Street Outreach Services
- Toronto Building Services
- Water & Wastewater Services
- Waste Transfer Stations

The services that are available only to residents with immigration status are:

- Ontario Works. City staff must, by law, ask for proof of immigration status and check this with Citizenship and Immigration Canada.
- Rent-Geared-to-Income Housing, including Supportive Housing services. City staff must, by law, ask for proof of immigration status.

Access to child care subsidies requires a T4 tax form. No one will ask for immigration information.

Access to Homes for the Aged and services such as Homemakers and Nurses Services requires an Ontario Health Card (OHIP). No one will ask for immigration information.

TORONTO

The City of Toronto. (2004). The City of Toronto provides services to residents regardless of immigration status.

For a current version of services, see the City of Toronto's website: https://www.toronto.ca/city-government/accountability-operations-customer-service/long-term-vision-plans-and-strategies/access-to-city-services-for-undocumented-torontonians/

Appendix E.
Toronto: Health Care Institution Types & Payment Models

1. Non-Profit Medical Clinics	Toronto and surrounding neighbours have a few medical clinics that migrants who are medically uninsured can utilize for free access primary care, including the Non-Insured Walk-In Clinics (NIWIC) by Access Alliance (walk-in and appointment based), the Primary Health Clinic at FCJ Refugee Centre (appointment only), and the Community Volunteer Clinic at the Canadian Centre for Refugee & Immigrant HealthCare in Scarborough (appointment-only), and Free Clinics hosted by the Muslim Welfare Centre in Scarborough and Mississauga to name the primary organizations. Each location has a different organizational structure, typically operating with volunteer service providers or on very limited funding. Each location also has different appointment types, operating on different dates, and have slightly different eligibility criteria as interviewees will discuss. Due to waiting lists and catchment requirements of CHC's, many medically uninsured migrants access non-profit or volunteer based medical clinics while waiting to become a patient at their local CHC.
2. Community Health Centre's (CHCs)	Ontario's Community Health Centre's have specific funding that allows them to provide health care services and accept medically uninsured migrants as patients. As one doctor described, typically, the "…the community health centers mandate is that they are generally targeting marginalized populations and those can be defined in any number of ways. But in the Toronto area it is largely based on income, so a large percentage of our patients are low income…" (Doctor 2, Toronto, 10/21). Physicians and staff working at CHCs are compensated under the "Salaried Model" and do not bill OHIP for fee-for-service (HealthForceOntario, 2019). Every interviewee I spoke to who works at CHCs indicated their centre has specific funding allocated for working with medically uninsured migrants, including discretionary funding to cover additional services needed (i.e., lab work etc.).

3. Family Health Teams (FHTs)	Many physicians in Ontario work collectively with nurses and nurse practitioners on inter-professional teams under the FHT model. Similar to CHC's, staff are paid by the Blended Salary Model, which includes the majority of income coming from salary (no fee for service billing). It is unlikely that FHT's accept new patients who are medically uninsured, as one doctor reported: I think they would try to connect to a community health center that did have a budget…It's supposed to be this process of inter community health center transfers. How that works is they're supposed to help each other out in that way… The ministry has prevented people without health insurance or and the marginalized if they have a health card from signing up with a family health team. They prevented anybody with IFH or with government assistance…PSRs, any of those from joining a family health team, they will not allow it (Doctor 2, Toronto, 10/21). There are a few exceptions of FHT's that service medically uninsured patients, such as the Inner City FHT which services persons experiencing homelessness who may be medically uninsured.
4. Solo-Practitioners & Family Medical Centres	Both solo-practitioners (e.g., Comprehensive Care Model) and Family Medical Centres (e.g., Family Health groups of three or more physicians) are both compensated through primarily Fee for Service (e.g., salary from predominantly billing OHIP). These health care providers have the discretion to accept or deny patients who are medically uninsured for any reason, however, typically charge for each service provided as they cannot bill OHIP and are not salaried like CHCs and FHTs.
5. Hospitals	Healthcare providers working within hospitals fall under multiple compensation models. The majority of physicians operate under the Fee for Service (e.g., salary from predominantly billing OHIP), nonetheless, some physicians are compensated through salary or alternative funding models. Often, academic hospitals will receive compensation through Alternative Payment Arrangements. As one physician interviewed

	reported "…the way I work (in) hospitals, I'm on salary so I never got a per diem so. Whoever I see and whatever their status is, is kind of invisible to me" (Doctor 2, Toronto, 10/21). Medically uninsured patients are typically required to pay a deposit and deal with billing upon admission to most hospitals in Toronto, often prior to receiving services. Fees vary greatly from one hospital to the next.
6. Independent Contractor Midwifery & Birthing Centres	The majority of midwives in Ontario receive their salary through an agreement made between a midwifery practice group (MPG) and a payment agency. Funding is allocated from the Ontario government to the payment agency, and then to the MPG. The MPG has to guarantee a certain number of births will be delivered by each midwife (i.e., 40 per year per midwife). As one interview midwife explained MPGs "…fill their caseload in order to get paid cause then they bill for those cases once they discharge at six weeks. So, they're always, like, getting paid for work that they did last year kind of, it's a constant. So, if they hold a spot for late to care people, they're taking a risk that they might not fill it" (Registered Midwife 2, Toronto, 01/22). While independent contractor midwives are able to use Ontario funding to deliver for medically uninsured patients and many do, their funding model may discourage some from doing so, since they need to guarantee their patient will attend all required appointments or they will not receive any payment, even partial, for the services they have provided. Midwives working in CHC's however are able to avoid these payment issues and take on more medically uninsured patients due to their salaried positions.

Appendix G.

Edmonton's Health Care Institution Types & Payment Models

1. Medical offices associated with Primary Care Networks	As of 2023, Alberta has 39 Primary Care Networks (PCNs) (interdisciplinary health teams) who work with AHS to provide primary care (Primary Care Networks, 2024). PCN's in Alberta are advertised as a way to reduce hospital admissions and emergency costs by improving access to health care across the province (Primary Care Network, 2024). In 2022, roughly 3.8 million residents of Alberta (e.g., more than half the province's population) were associated with a local PCN (Government of Canada, 2021-2022, p. 1). It is important to note that in some cases, non-profit organizations and physicians can enter into an agreement with AHS to operate a PCN, with funding coming from the Ministry of Health. PCN's also have the ability to provide different programs to meet the local needs of their patients. *No primary care health care institutions in Edmonton receive provincial funding to provide health care to medically uninsured migrants.
2. New Canadians Refugee Clinic	Opened since 2022, this clinic provides health care services to government sponsored refugees only at this time.