

Negotiating the boundaries of membership:

Health care providers, access to social goods and immigration status

On October 2nd, 2009 a seven year old refugee claimant suffering from a head injury was turned away from a Toronto area emergency room. At the time of the incident, the boy's health benefit card had expired, and he was awaiting its renewal. Unsure of her son's eligibility to care, the boy's mother called a health information line where she was assured by health officials her son would receive care. At the hospital registration desk, however, she was informed she needed to pay a fee before her son was admitted. She explains the incident in a *Toronto Star* news article,

The woman at the registration desk said to me, "No, if you want somebody to look at your son, you have to pay the service fee." She said it would cost us \$650...The woman then said to me, "I have to pay taxes. (My colleague) has to pay taxes. If you want service, you have to pay" (Keung 2009)

Because they could not afford the \$650 dollar fee, the family was denied access to emergency services and referred to a walk-in clinic. This example demonstrates the limited access precarious status migrants have to health services in Canada. It also demonstrates the different levels whereby access to healthcare is created, denied and negotiated. Frontline workers, nurses, doctors, health care institutions and bureaucrats all play a role in drawing the boundaries of access, often resulting in very different results. In this example, because the boy was a refugee claimant, he was legally entitled to some benefits in Canada. Furthermore, Canadian law states that emergency services cannot be denied to anyone (Elgersma 2008). While those services are not denied, some health care institutions require a fee for services rendered before a person sees a doctor. This is especially problematic when emergency services become one of the only forms

of health care for a number of precarious status migrants, particularly for those with no federal or provincial health benefits. Ironically, the boy's mother called a healthcare hotline *before* she took her son to the emergency room, perhaps anticipating she would be turned away. The contradiction between what she was told by the hotline operator and the emergency room clerk demonstrates the state of confusion in which the healthcare system finds itself in relation to precarious status migrants.

Another layer of access comes from the emergency clerk herself. Registration desks are the gateways to access healthcare and registration workers their gatekeepers. Yet they are not apolitical. The clerk draws on a framework of fiscal (and presumably moral) responsibility in her comment about paying taxes. She assumes that precarious status migrants do not contribute to the tax system that pays for provincial health insurance and that this supposed lack of contribution makes individuals ineligible to health services.

This paper has two overlying objectives. First, it analyzes the role of health care institutions and their workers in producing varying degrees of access to healthcare for precarious status migrants in Toronto. While these actions are important in and of themselves, the second objective is to examine what healthcare workers' varied and at times competing frameworks for understanding health and sickness tell us about the ways in which the boundaries of membership and citizenship are drawn. Thus, through their negotiations of care, health care workers also produce different notions of membership, disrupting binary assumptions about the boundaries that delimit who can be a member of society. I begin by briefly outlining the scholarship on citizenship and membership that informs this paper. I then move to discuss the ways in which healthcare workers negotiate access to care, and the limitations they face in doing so. Finally, I

discuss how these ideas and actions lead to varying frameworks of membership among healthcare workers.

On citizenship and membership

As Linda Bosniak (2009) argues, citizenship has been normatively understood in terms of binaries. One example is the notion that citizenship as either thin or thick. The former refers to citizenship as a status only, without rights or obligations. One can contrast this version to a thick notion of membership that incorporates “more robust, substantive conceptions—whether based on rights, democratic participation, or identity/recognition” (Bosniak 2009, p. 142). Thinking about the thick version approaches a notion of membership. Membership in this sense can include citizenship as status, but it does not have to.

Another iteration of the binary involves thinking about citizenship either as a demarcation of borders or a form of membership with it associated rights and obligations. However, as Bosniak (2006) argues, scholars oftentimes use an either or approach. That is, discussions of citizenship as a universal form of membership do not always take into account the experiences of “non citizens.” Alternatively, citizenship as a demarcation of borders (through passports, citizenship papers etc.) may not account for other ways in which people participate in communities. It is this division that needs to be examined when analyzing access to services for people deemed “non citizens.” People with this status of “alianage,” or what I refer to in this paper as precarious immigration status (Goldring et al. 2009), enjoy some rights as a result of their presence and participation in a territory, though those rights are often negotiated, and not guaranteed. One way to deconstruct this binary is to think about borders extending into the internal activities of the nation-state, territory, community etc. (Bosniak 2006). This takes into

account membership as rights, obligations, participation and recognition as well as a demarcation of status.

For example, in the case of Canada, while immigration policy and access to citizenship (or permanent residence) is regulated at a federal level through the Immigration and Refugee Protection Act (IRPA) and Citizenship and Immigration Canada (CIC), individuals create forms of membership through their actions/activism and presence in communities. Summarizing this idea of citizenship/membership, Bosniak (2006) states that “citizenship is not a unitary or monolithic whole: the concept is comprised of distinct discourses designating a range of institutions and experiences and social practices that are overlapping but not always coextensive” (p. 3). In that sense, citizenship/membership is negotiated and flexible at the same time that it is overseen by government and policymakers.

It is this interplay that leads Daiva Stasiulis and Abigail Bakan (2003) to conceptualize citizenship as a negotiated process,

Citizenship includes legal status, demanding formal national state certification, but citizenship is not reducible to legal status alone. Citizenship exists on a spectrum, involving a pool of rights that are variously offered, denied, or challenged, as well as a set of obligations that are unequally demanded. The terms and conditions of citizenship rights and responsibilities are the product of active and ongoing negotiation. This process of negotiation involves numerous actors, where human agency on the part of non-citizens operates through a combination of individual and collective strategies within a matrix of relationships and institutional practices over space and time (p. 2).

Because citizenship, or membership, cannot be reduced to immigration status alone, we can look at other processes and institutions to give us hints about its intricacies. Stasiulis and Bakan

describe this process as an active and ongoing negotiation. Although they examine the negotiations of migrant women workers in Canada, one can extend this process to those in charge of providing public goods: governments, institutions, policy makers and frontline workers. The result is a complex “matrix of relationships and institutional practices” that is also flexible and contingent. I find this framework of a flexible and negotiated citizenship/membership useful to analyze the role of healthcare workers working with precarious status migrants.

Method

The data for this chapter comes from three sources: scholarly and grey literatures as well as interviews from a research project that examined the opening and closing off of access for precarious status migrants in Toronto’s health and education sectors. The data collected consisted of interviews with key informants and two focus groups. Focus groups were organized according to two job descriptions in the healthcare field: frontline workers (those who engage with patients on a regular basis) and community liaison workers (those who worked in middle-management positions and had less interaction with patients). The first focus group brought together four frontline workers and the second was composed of five community liaisons. In practice these two groups are not always mutually exclusive, but the division is useful as a way to capture the relationship between individuals’ strategies and policy positions and their different institutional locations. In other words, the division allows us to ask whether institutional location produces different frameworks for access. Respondents were asked about their experiences working with, or creating access for precarious status migrants and the limitations they faced in the process. Interviews and focus groups were transcribed and coded according to themes. Because all respondents elected to remain anonymous, no identifying information is used.

The landscape of access to healthcare for precarious status migrants

Although access to health care for precarious status migrants in Canada is largely under the radar, there have been some discussions and research on the topic. They include guidelines as to who can legally receive healthcare benefits (Elgersma 2008); general discussions of the situation (Caulford and Vali 2006; Berinstein et al. 2006; Bernhard et al. 2007); case studies of the effect of limited access on precarious status migrants and healthcare workers (Rousseau et al. 2008; Simich et al. 2007); the costs incurred when seeking health care (Morris 2009); the effects on treating particular illnesses (Committee for Accessible AIDS Treatment 2006); or particular populations (Oxman-Martinez et al. 2005); and plans to improve access (Community Health Centres of Greater Toronto 2008). Less research has been conducted on the role of health care workers in negotiating various degrees of access, particularly in relation to questions of membership.

There are two governmental bodies that have jurisdiction over health care access for precarious status migrants, the health care and immigration systems. Although Canada has a “universal health care” system, there is not a clear cut process whereby those without state sanctioned immigration documents to live and/or work in Ontario automatically receive benefits. Instead, coverage is piecemeal and does not account for people moving in and out of certain types of precarious status. Although all citizens and permanent residents in Canada receive health care through provincially organized systems (in Ontario this is the Ontario Health Insurance Plan, OHIP), newly arrived permanent residents in Ontario have to wait three months before they become eligible. With a few exceptions, during those three months permanent residents are uninsured. Alternatively, unlike citizens and permanent residents whose coverage is provincially managed, convention refugees and refugee claimants receive health coverage

through the Interim Federal Health Benefits Plan (IFH). While this plan provides a number of services, it is not as extensive as provincial health plans. Finally, precarious status migrants who are not refugee claimants or have coverage through a work permit are not eligible for IFH or provincial health plans. And, as the story above exemplifies, being eligible for a health plan does not guarantee care.

Therefore, for those without coverage, health care is dependent on the discretionary decisions of health centers, clinics or hospitals. One notable exception is a clinic in Toronto that specifically treats and advocates for the uninsured (Caulford and Vali 2006). Other health care providers that choose to open up access for precarious status migrants have to reorganize budgets or be creative in their strategies. For instance some of Ontario's Community Health Centres (CHCs) receive funding to treat "uninsured" patients. In the health care sector, the term "uninsured" refers to anyone ineligible (temporarily or permanently) to provincial or federal health plans including anyone whose health card has been lost or stolen and those who have never applied for a health card. In a context in which the population of uninsured precarious status migrants is growing, uninsured is often used interchangeably with precarious status in the sector. The term is also less contentious than "non status" or precarious status, making it a more palatable option for some advocates, particularly in anti-immigrant contexts.

The funding CHCs receive is the most often used example of an opening for access for precarious status migrants in Toronto. Because the use of those funds is discretionary, CHCs have the power to use the funds to treat any uninsured patients they see. Although "uninsured" funds are largely regarded as an opening, not all CHCs use that money to treat precarious status migrants. CHCs also have the power to refuse some individuals treatment if they do not fit into the categories defining their catchment (defined both in terms of living within the geographical

borders the CHC serves and the person's immigration status who reside in a different geographic region). Furthermore, as I will discuss later, the funding provided is limited and is often not enough to meet the health care needs of individuals. CHCs, like emergency rooms, can be the first place that precarious status migrants seek care. However, they are not equipped with the healthcare technology and long-term facilities to treat patients with more complicated needs. As a result, some CHCs have created specific arrangements with nearby hospitals that allow them to refer CHC members for more specialized care, often at the cost of the CHC. The arrangements also allow CHCs the use of a number of free hospital beds each year.

Some hospitals have also created internal policies to provide better care for precarious status migrants. These include making immigration status a part of the equity agenda, as well as strategizing on concrete ways to increase access. However, as stated above, there are a few limitations to these informal and formal policies. First, the level of need often surpasses the ability to provide care, particularly for free services. One example is reports of long waiting lists at the few CHCs that openly advertise access for precarious status migrants. Second, those who are not patients at partnering CHCs do not have access to CHC-hospital benefits. Finally, a number of these arrangements and policies are informal and contingent, making it difficult to maintain them on a permanent basis. Therefore, the responsibility of negotiating access often falls on specific health care workers and case-by-case strategies.

Frontline workers

The frontline workers who participated in the project work in hospitals, clinics, and other community organizations around the city. Many had previous experiences working with marginalized populations and those with limited or no access to healthcare. However, the social and political context in which they carry out their work in terms of precarious status migrants is

fragmented. There are several reasons for this. First, their ability to provide access depends on provincial and federal health care policies, which as stated above, exclude a number of individuals. A second impediment comes from their place of work. Some health care centers (clinics, hospitals etc) have clear policies and mission statements to provide care to uninsured or not fully insured patients. Others may not have anything written down but there may be an unspoken understanding about who receives access. While no respondents identified working in a context of complete exclusion, they did identify places in the city that turned precarious status migrants away. Finally, while there may be written or unspoken directives to serve precarious status migrants, all health care centers also have to negotiate a climate of limited resources and increased hostility toward precarious status migrants. The question of who has the right to care, and the link between deserving care and being a tax paying member of society – with the assumption that precarious status migrants are not – has become an increasingly commonly position in the sector. For instance, frontline workers all identified regular instances of discrimination and overt racism towards precarious status migrants.

In this troubled context, frontline workers develop several strategies for providing or increasing access to healthcare for precarious status migrants. These are important because they exemplify not only the intricate tactics frontline workers mobilize to provide access, but also how their actions shift the boundaries for membership. In this process, the lines for inclusion have the potential to become more fluid.

One factor influencing frontline workers to negotiate access is their belief in a social determinants approach to wellbeing. This approach takes into account the fact that social factors can affect a person's ability to become healthy. According to Public Health Canada (2010), factors include "income and social status, social support networks, education and literacy,

employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender [and] culture.” Scholars have refined this framework to include precarious immigrations status as a factor that determines/affects wellbeing. For instance, Oxman-Martinez et al.,(2005) argue that “[m]igrants without secure immigration status ... face heightened barriers in accessing services and protecting their physical and mental health. These barriers...include such things as ineligibility for public services, social isolation, racism within the health system, and employment conditions” (p. 250). For frontline workers a social determinants of health approach includes taking into account their clients’ other needs and concerns, including immigration issues.

Taking this framework into account, the first strategy frontline workers use is to network with other healthcare workers. These relationships allow them to stretch their resources beyond their workplace, finding for instance an extra hospital bed or a physician willing to work pro bono. One respondent explained it this way, “there’s a core group of us...each person knows a huge network...it’s very informal...we don’t go looking for them, it’s also mercenary.” In order to be part of the network members have to be reliable and have similar opinions for who is eligible to care because participating also implies a degree of reciprocity. Contacts must be ready to return the favor in order to keep the relationship going. Building these relationships takes time, particularly because the sector experiences a large amount of worker turnover. This means some people do not stay at their position long enough to join a network and that those who are part of network and leave are sorely missed. However, being part of a network does not guarantee success. For instance, one respondent said, “I got a long history of knowing who to phone and can *usually* get the phone call taken” (emphasis mine). However, the worker

understands that there is a limited amount of favors she can expect from each of her contacts. As I will discuss later, this leads frontline workers to make difficult decisions as to who receives care.

A variation of this strategy is when frontline workers make informal referrals. This practice needs to be understood in a context whereby frontline workers are overworked and burdened, having to prioritize who receives care. In that case, those who do not receive care may be advised of other clinics or places where they may be more successful. Informal referrals can occur in conjunction with formal ones, increasing the possibility that a patient may find health care. However, because referrals (and networking as a whole) are informal, they never come with a guarantee of access. In that sense, this practice highlights how access to healthcare is in large part predicated on precarious status migrants' ability to strategize and build their own networks.

The second strategy is to negotiate with healthcare organizations on behalf of individual clients to waive fees and reduce the price of services. In some instances, the strategy is stable, as in relationships between CHCs and hospitals that provide a number of free beds per year. In that scenario, a route for action is in place, though similar to the networking strategy, it is not guaranteed or unlimited. At other times, the pathway can be unstable and time consuming.

Community liaison workers

In contrast to frontline workers, community liaisons include middle management staff and those involved in diversity and equity work within health care organizations. For this reason, liaison workers do not necessarily see patients day to day. Instead they act as bridges between management, frontline workers and other organizations, committees, and networks. In

this context, community liaisons perform two key roles to negotiate access: their work as “internal advocates” and their sectoral networking.

As internal advocates, community liaisons draw on institutional histories and vision statements to try to advocate for an agenda of access within institutional frameworks that increasingly emphasize efficiency, risk management and fiscal responsibility. In order to do so, they participate in meetings and strategizing sessions where they place the issue of uninsured clients and /or precarious status migrants on the table.

Alternatively, their sectoral networking allows them to go beyond the immediate restrictions of their own institution to forge relationships with other players in the sector and coordinate conversations. In that sense they can disseminate existing strategies and push for concrete procedural improvements on the frontlines of care. There are a number of ways this occurs. One example is the organization of formalized networks that come together to discuss strategies and policy directives regarding uninsured and precarious status patients. One such network brings together people working or engaged with Community Health Centres in Ontario (Community Health Centres of Greater Toronto 2008). Another brings a variety of different advocates and healthcare workers interested in the topic (Women's College Hospital 2010).

The strategy for these networks is to advocate for better access. They include the creation of informational and policy documents (Gardner 2008; Community Health Centres of Greater Toronto 2008) and organizing conferences (Women’s College Hospital 2010). They also work on targeted approaches such as advocating equal rates for services rendered, regardless of immigration status. The issue of fees is a good example of their work because it demonstrates a multilevel process in which access becomes restricted. Physicians treating patients under a provincial health plan charge the government specific rates for services. However, they are not

regulated to charge those same rates when working with uninsured precarious status migrants, since the government does not pay for those services. Respondents reported hearing of physicians who charged as much as three times the going rate. Therefore, within their networks community liaisons are working to push for standardized rates, so that uninsured clients are not overcharged. A related issue is that of double billing. In this example it is not only physicians who become involved, but also hospitals and collection agencies. Patients may be billed separately by the physician and hospital, creating confusion, and added stress. One respondent working at a hospital explains the process:

As I understand it...the physician has to follow up for their payment and then the hospital follows up for their payment. One of the key complaints that we heard from folks...[is that they] will end up getting two different bills which completely confuses them too. So for some folks it's not an issue about paying but it's the process and administration."

When patients are not able to pay the exorbitant fees in the allotted time, some hospitals employ collection agencies, adding to the stress and confusion.

Limitations

It is worthwhile to talk about some of the limitations to frontline workers' and community liaison's current strategies because they may help identify avenues for immediate procedural improvements. Furthermore, in the same way strategies to provide access make the boundaries for membership less strict, the limitations frontline workers and community liaisons experience foreclose some of those opportunities, reminding us that negotiated citizenship/memberships is contingent and often temporary.

One limitation is the lack of resources. Resources in this sense are more than just funds, they include time and contacts, though they are linked to limited funding. Resource limitations

range from those experienced within a specific health care organization (the cost of procedures, increasing number of clients) to those that involve networking (creating and maintaining networks and lack of resources to do large scale advocacy). Time is also an important resource. The time it takes to generate contacts and networks and the stress of knowing the limits of what they achieve means frontline workers and community liaisons are often overworked and overburdened. Furthermore, the lack of resources forces healthcare workers, clinics and hospitals to make discretionary decisions about who should have access and the types of services that access entails. Such decisions can be based on a range of criteria – the nature of the immediate healthcare demand (e.g. a work injury, late term pregnancy or cancer diagnosis) and/or the type of status the person has (refugee claimant versus visa overstayer).

Another limitation involves the transient nature of government. While some liaison workers felt that the best way to improve access was to advocate at regional and provincial levels, the constant shifting of ministerial cabinets and their objectives makes it difficult to make long term policy changes. Each time the officials change, their policy directives may also change and advocates have to start from scratch. Job turnover also affects advocacy at smaller scales when leadership changes within CHCs or hospitals. For instance, community liaisons referred to a management shift in some Toronto hospitals that had previously been run by religious orders. The shift not from nuns to lay CEOs and management involved a conceptual shift between hospitals as sanctuary zones invested in religious ideas of charity, to a framework of financial responsibility.

A final limitation is the Canadian immigration system. As part of a social determinants of health approach, frontline workers and community liaisons often teach themselves about

immigration processes in order to better serve their patients. One frontline worker explained it this way:

One of the things I think that a lot of us...we get frustrated with the immigration system...so for the worker too, it's so, it's a bit overwhelming as well to work with this population...[the] needs that your client has but they can't access...it's awful...and the limitations...there are real limitations.

Having to engage with immigration and other social service systems extends the role of health care workers into the jurisdiction of settlement and social workers. This means having more work and stress. It also means having to decide where to place themselves within an immigration debate that includes with an increasingly exclusionist immigration system. Finally, their newly acquired knowledge may solidify the boundaries of access, particularly in relation to specific types of precarious status.

Redrawing the boundaries of membership

While the strategies and limitations health care workers experience point to the opening and closing off of access for precarious status migrants in Toronto, they also point to larger ideas of membership. Put differently, as I described above, through their negotiations and practices, healthcare workers actively participate in drawing and redrawing the boundaries of access and quality of care, and consequently the boundaries of membership. Another way to discern this process is to analyze the frameworks and parameters for inclusion (both in terms of health and immigration) articulated by respondents.

In interviews and focus groups respondents discussed a range of often competing proposals and ways of talking about health, sickness and access. Sometimes variation was a function of a person's institutional location, at other times it was their recounting of how they

hear others in the sector talk about this issue, and at other times the same person articulated different positions or frameworks during the course of the conversation. These varying and often competing frameworks do not only address formal or “legal” citizenship (having a Canadian passport or permanent residence versus more precarious forms of status), they also take into account other forms of membership including participation in a community, length of residence and access to social goods.

We can think about this variation using a two-axis diagram (appendix 1). The first axis represents a continuum of different ways conceiving health and wellbeing. At one end is a social determinants of health approach where health is a function of the distribution of resources in society. At the other end of this axis is a biomedical version of care. This version not only differentiates between who can have a health card or not, it also fragments the body. More precisely, this version stops at the neck or goes from the neck down. As respondents explained, dental coverage and mental health are not part of the policy discussion, even though healthy mouths and good mental health are an important part of wellbeing. While no respondents used a strict biomedical framework to provide care, it is important to note that to the extent that the Ontario Health Insurance definition of coverage continues to be used as a baseline, health care provision in the province draws on a fairly narrow version of access, irrespective of immigration status.

Frontline workers and community liaisons fell in slightly different points along this axis, not because one group was more open to access than the other, but because their institutional locations lead them to different lenses for understanding access and strategies to obtain it. As stated above, frontline workers described social determinants of health as an important framework to understand health and sickness. Within this framework, everyone has the right to

access public goods to be healthy. Wellbeing encompasses more than just medical care. It also includes a more comprehensive idea of healthy bodies (including the mouth and mind), the need for interpreter services, decent housing, legal aid and a range of income security issues.

Frontline workers envisioned themselves as being more attuned to the needs of uninsured clients and therefore had specific solutions to improve health disparities. One respondent proposed the following

give everybody a bloody health card...if you can tell other groups that the more grassroots the organization...that the closer folks are to the situation the better the grasp and that's where the wisdom lies and where the solutions...they can see the solution...I think the answers would be to the people who are funding these things...think about how the social determinants of health play out for folks who do not have a health card...all of the other social determinants of health start to be affected...

The respondent identified the health card as a starting point for membership, something she feels those who have the power to fund health care programs do not see. Giving everyone a health card means no differential treatment in terms of identification (though of course this does not guarantee differential treatment will not occur on the basis of other factors).

The respondent also referred to a common quandary in the sector, how to move forward to advocate for change. Although both frontline workers and community liaisons agreed that some type of change was necessary, there were differing opinions as to how to proceed. The respondent quoted above identified her work as grassroots. She felt that seeing patients on a day to day basis gave her and her colleagues inside information on how to improve the situation. This is where institutional location leads to differing ideas for change. A grassroots approach was important for frontline workers because they felt institutional and policy changes might

eradicate, or at least erode existing networks, loopholes and strategies. Liaison workers understood the fear, though they also felt that the status quo was not the answer. They were more interested in thinking of ways to frame the issue to make it appealing for decision makers (Executive directors, hospital CEOs, policy makers etc.) to take up the issue. This means focusing on concrete and winnable policy directives. A report to the Toronto Central Local Health Integration Network (LHIN), one of the regional bodies that oversees health care in the province of Ontario, outlined a number of health equity issues in the city's health care provision, including access for "non-insured people" (Gardner 2008). The report consulted with a local network organized under the Women's College Hospital, for its recommendations, which included the creation of "consistent policies and procedures" to ensure equitable treatment for all patients, as well as "systematizing and extending existing ad hoc arrangements" (Gardner 2008 p. 22).

There are at least two concerns with the creating more systematic policies vis-à-vis precarious status migrants and health care. First, whatever policy becomes adopted, regardless of whether it opens up access, will concretize access in a more systematic manner, making loopholes and strategies less viable. This means that health care providers, particularly frontline workers, may have less flexibility in their actions, roles, and advocacy. Second, it will solidify the terms for inclusion and exclusion. In terms of membership, once boundaries become solidified community understandings of membership, including those of frontline and community liaison workers may also change. While the move is not permanent, policies set a precedent, and therefore a framework to work with that also set the rules for action/ reaction.

Not surprisingly, the issue becomes more complex with a second axis of membership. The second axis represents a continuum of membership that takes into account immigration

status. At one end of the continuum is a version of membership that sees the citizen and permanent resident – people with fairly secure immigration status – as *rightful* members of society. Under this framework, membership is predicated on immigration status. Therefore, healthcare and other public goods are a right or entitlement only for the citizen or permanent resident. At the other end of the continuum is a notion of membership in the community based on residence – someone who lives and works and participates in society regardless of immigration status. This version of membership based on residence means granting full access to healthcare to anyone who regardless of immigration status is a contributing member of society, broadly defined. At this end of the continuum the question of formal immigration status becomes irrelevant.

While it is important to see the two axes layered onto each other, reconciling the two is not a clear cut process. Even for those who conceptualize access within a framework of universal access to healthcare, when immigration status comes into play, perspectives may change. Respondents articulated very different notions of membership framed as immigration status. Of course none of them thought that healthcare should be limited to citizens and permanent residents but that did not mean they all thought that everyone who is “here” (i.e. a resident) should have the right to healthcare based on residence. At one point, frontline workers discussed a “no borders” framework that grants everyone a health card and freedom of movement. Later in the focus group the range of access narrowed as they referred to health care providers who choose to only work with recently arrived (uninsured) permanent residents or refugee claimants. These groups were more likely to stay in Canada on a more permanent basis, something which seemed to matter as the interview continued.

In fact, both frontline workers and community liaisons were reluctant to include migrants classified as transient into their scheme for access. This is the limit or boundary for negotiated citizenship and where the “no borders” approach broke down. Transient migrants were conceptualized as newly arrived and less likely to remain permanently. The category that best encapsulates these ambiguities and anxieties is that of the “visitor”. Respondents rejected the idea that their mandate might include visitors. In one breadth respondents linked “the visitor” with medical tourism from the US and in another with a person who was likely to overstay their visa or was here to stay. One community liaison explained how medical tourists are imagined,

Well visitors could include people who came without health insurance and medical tourists. Like at one meeting we were at...they were talking about people arriving at the airport jumping in a cab and driving straight to the emerg...again I don't think these numbers are huge but because they become they typical threat when they are mentioned.. and then the arguments within government about the 45 million south of the border without medical coverage...it is a hard thing to respond to when you are challenged that way.

Although the respondent explains that the numbers are not large, he draws on the mobilization of moral panic that depicts Canada's southern neighbor (and potentially the whole world) as likely to infiltrate an already under attack universal health system. The picture drawn does not take into account the day to day difficulties experienced by visitors when trying to access healthcare. Because visas usually allow visitors to stay in the country for six months, ironically, visitors might have to fall into more precarious forms of status in order to be *considered* for access into a system that does not guarantee care, especially without a provincial health insurance card (permanent resident or citizenship status).

Frontline workers voiced similar concerns about visitors. Some felt that visitors could be potential medical tourists, while others were restricted by their superiors in not treating visitors.

One frontline worker explained it,

we do have a couple of policies and that's no visitors and no students... there's an enormous amount of pressure... [we have to] call the finance department., call the social work department... that's a lot of phone calls... first question, is she a visitor... somebody that has... if they are on an active visitor visa... they arrived pregnant... if you're going to give birth... the pervasive feeling is well if you arrived pregnant who did you expect...

The figure of the visitor encapsulates many fears. In a framework where membership is conceptualized as participation, obligations and rights (as opposed to only status), temporariness can mean a person will not fulfill their obligations to the community. Thus they are imagined to produce a cost they may not be able to pay back. While some frontline workers explained that they did have many cases of “medical tourists,” as in the example of the liaison worker, the image and what it represents is powerful. In conjunction with that image, the image of the pregnant medical tourist is also very powerful because the end result is a Canadian citizen who will not participate in Canadian membership practices.

One way to “counter” the argument would be to include visitors in the list of “uninsured” patients health care workers see. However, while being a positive move, the approach is incomplete in that it does address the variations in status migrants face. Thinking about the concept of precarious immigration status might be a better alternative to move away from a binary framework of permanence or temporariness. Precarious immigration status emphasizes the dynamic character of immigration status categories – rules change and peoples’ strategies for building their lives also change. Given this fluidity, the refugee claimant can become non status.

Alternatively, the visitor can become the refugee claimant and maybe eventually the person with a three month wait. This fluidity of experience leads to a fluidity of membership.

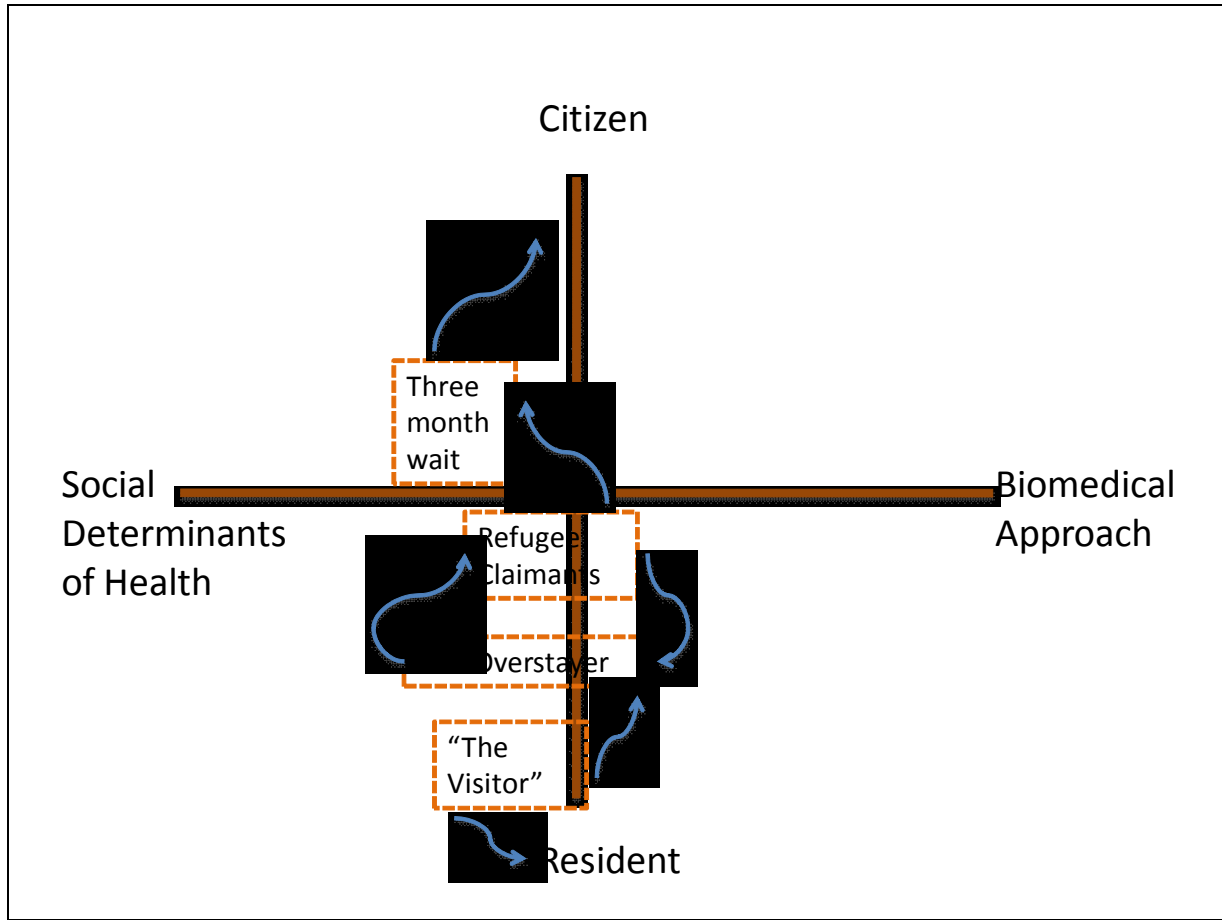
Respondents focused on a migrants' status at the moment of treatment and not that fluidity. While this makes sense in terms of healthcare worker's day to day work and the type of screening they do, it becomes limiting when understanding that status and access change over time (and not always in a trajectory from less to more secure status). Extending the frame of reference to include different pathways and categories of immigration status leads to a more diffuse, or web-like notion of membership, one that is not dependent on length of stay or documentation, but other forms of participation and rights. Such a framework makes the boundaries between access and exclusion less solid and lead to more comprehensive approach to institutional change.

Conclusion:

This paper outlines some of the strategies health care workers mobilize to open up access for precarious status migrants. Workers negotiate access to healthcare and in the process make the boundaries for understanding membership and citizenship more flexible. As Stasiulis and Bakan (2003) argue, this process is negotiated, that is, there are formal and legal structures that affect how membership is understood and felt. Frontline workers and community liaisons experience this in terms of the institutional limitations they face in negotiating access. They also mobilize less flexible frameworks of membership, particularly in the figure of the visitor, who encompasses fears of fraud, particularly in a context of fiscal responsibility and permanence in Canada. As I have argued, the concept of precarious immigration status moves us away from having to decide who can become a member by pointing to the variations of status a person can have across time. While access and secure immigration status are not guaranteed, taking into

account the variability of immigration status forces us to think about more negotiated and contingent forms of membership and therefore makes it more difficult to draw boundaries of membership. .

Appendix 1



References

- Berinstein, C., Nyers, P., Wright, C., & Zeheri., S. (2006). Access not fear: Non-status immigrants and city services report prepared for the 'don't ask, don't tell' campaign (pp. 1-25). Toronto, Ontario.
- Bernhard, J., Goldring, L., Young, J., Berinstein, C., & Wilson, B. (2007). Living with precarious legal status in canada: Implications for the well-being of children and families. *Refuge: Canada's Periodical on Refugees*, 24(2), 101-114.
- Bosniak, L. (2006). *The citizen and the alien : Dilemmas of contemporary membership*. Princeton, N.J.: Princeton University Press.
- Bosniak, L. (2009). Citizenship, noncitizenship, and the transnationalization of domestic work. In S. Benhabib, & J. Resnik (Eds.), *Migrations and mobilities : Citizenship, borders, and gender* (pp. 127-156). New York: New York University Press.
- Caulford, P., & Vali, Y. (2006). Providing health care to medically uninsured immigrants and refugees. *Canadian Medical Association Journal*, 174(9), 1253-1254.
- Committee for Accessible AIDS Treatment (2006). Status, access & health disparities: A literature review report on relevant policies and programs affecting people living with hiv/aids who are immigrants, refugees or without status in canada. Toronto.
- Community Health Centres of Greater Toronto (2008). Community health centres, hospitals and people without health insurance. Toronto.
- Elgersma, S. (2008). Immigration status and legal entitlement to insured health services prb 08-28e. (pp. 1-11). Ottawa: Library of Parliament, Political and Social Affairs Division.
- Gardner, B. (2008). Health equity discussion paper. Toronto: Toronto Central LHIN.
- Goldring, L., Berinstein, C., & Bernhard, J. (2009). Institutionalizing precarious migratory status in canada. *Citizenship Studies*, 13(3), 239-265.
- Keung, N. (2009). Clerk fired after boy, 7, sent from er. <http://www.thestar.com/article/714042>. Accessed August 5 2010.
- Morris, C. (2009). Your money or your life: In a country with supposedly universal coverage, some of the most vulnerable must pay cash for health care. It costs them their livelihoods -- and sometimes their lives. http://www.thismagazine.ca/issues/2009/03/immigrant_health_money_life.php. Accessed June 12 2009.
- Oxman-Martinez, J., Hanley, J., Lach, L., Khanlou, N., Weerasinghe, S., & Agnew, V. (2005). Intersection of canadian policy parameters affecting women with precarious immigration status: A baseline for understanding barriers to health. *Journal of Immigrant Health*, 7(4), 247-258.
- Public Health Agency of Canada (2010). What determines health? . <http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php>. Accessed August 5 2010.
- Rousseau, C., ter Kuile, S., Muñoz, M., Nadeau, L., Ouimet, M.-J., Kirmayer, L., et al. (2008). Health care access for refugees and immigrants with precarious status: Public health and human right challenges. *Canadian Journal of Public Health*, 99(4), 290-292.
- Simich, L., Wu, F., & Nerad, S. (2007). Status and health security: An exploratory study of irregular immigrants in toronto. *Canadian Journal of Public Health*, 98(5), 369-373.

Stasiulis, D. K., & Bakan, A. B. (2003). *Negotiating citizenship : Migrant women in canada and the global system*. Houndmills, Basingstoke, Hampshire ; New York: Palgrave Macmillan.

Women's College Hospital (2010). Women's college hospital network on uninsured clients. <http://www.womenscolleghospital.ca/programs/network-on-uninsured-clients.html>. Accessed August 5 2010.