Assembling the Politics of Noncitizenship: Local struggles to enforce and extend access to health care

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Abstract

Shifts in global migration are sparking powerful political clashes over the terms of membership for noncitizens that are characterized by complexity, diversity and multivalence. Local struggles over the rights and entitlements of migrants contribute political, procedural and cultural content to a broader reconceptualization of the boundaries between and content of citizenship and noncitizenship. In this article I draw on documentary evidence, fieldnotes and interviews to examine how a network of individual and collective actors – centred around healthcare professionals, community social service agencies and migrant-rights activists – rewrites the social and symbolic boundaries of noncitizenship as they enforce and extend access to health care for precarious noncitizens in Toronto, Ontario. I propose the concept of noncitizenship assemblages as a framework for understanding the contemporary politics of noncitizenship as multi-actor, multi-scalar contestations that may challenge or subvert the distinctions between citizens and noncitizens. Tracing the components through which health care for precarious noncitizens is assembled in a liberal welfare state expands the empirical base of knowledge on the politics of noncitizenship. The noncitizenship assemblages framework captures the heterogeneous and often incommensurable components of political contestation the produce membership. It motivates consideration of contingency, impermanence and conditionality in the production of the boundaries of noncitizenship.

Keywords: assemblages, boundary work, health care, noncitizenship, political contestation, politics of noncitizenship

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Shifts in the volume and character of global migration are sparking powerful political clashes over the scope and terms of membership for immigrants. Changes in global migration have led to myriad local and particularistic political struggles over the rights and entitlements of noncitizens. Here, premised on the understanding that citizenship and noncitizenship are co-constituted as discrete legal status categories and also interconnected social institutions (Bakan and Stasiulus 2005; Goldring and Landolt 2013), I examine the ‘politics of noncitizenship’ – multi-actor, multi-scalar contestations over the formal and substantive boundaries between, and content within, noncitizenship and citizenship. Contestation involves individual and collective actors working to expand, contract, or blur the social and symbolic distinctions between ‘us-citizens’ and ‘them-noncitizens’ in ways that challenge or reproduce social hierarchies (Lamont, Beljean, and Clair 2014). It takes place across different socio-spatial levels and may make visible and subvert the dominant social-spatial scalar order that assumes a clear isomorphism between national sovereignty and the regulation of citizenship (Williamson 2015).

The politics of noncitizenship are characterised by diversity, dynamism and complexity. They occur across different sectors including health care (Marrow 2012b; Willen 2012), education (Villegas 2017), criminal justice (Armenta 2017), and others. They play out through organized social movements (Fortier 2013), electoral politics (Varsanyi 2006), administrative procedures (Jubany 2017), routine encounters (Landolt and Goldring 2019), and heightened confrontations between citizens and noncitizens (Elcioglu 2015). Local struggles contribute legal, procedural, and cultural content to a broader reconceptualization of membership as they prompt changes in law, shifts in bureaucratic procedures, or the emergence of new slogans for rights extended or denied. These changes may be fleeting or permanent, and can touch the lives of a few individuals or an entire segment of the population. They may bring additional people into the legal citizenship domain (Coutin 2007; Ngai
or exclude previously included groups (Nyers 2018). They can also generate grey zones of legality and illegality such that citizens may experience noncitizenship, and noncitizens may in some situations resemble citizens (Agadjanian, Menjívar, and Zotova 2017; De Genova 2002; Menjivar 2006).

To understand the promise and limitations of the contemporary politics of noncitizenship, we need to consider how multi-actor, multi-scalar contestations produce systemic and conditional changes in the social and symbolic boundaries of noncitizenship. Scholarship on the politics of noncitizenship focuses on enduring structures and underplays the relevance of seemingly fleeting shifts in power relations; it privileges finite outcomes over the trajectories and pathways through which the boundaries of noncitizenship are regulated and contested. It focuses on organized and intentional forms of political contestation, but sidelines the small acts, contingencies, mundane routines and encounters. The socio-spatial categories and constructions used to regulate and contest the dominant political order are rarely examined (Gardner and Richards 2017; Williamson 2015). Addressing this research gap requires clarifying the relationship among heterogeneous components of contestation, considering the relevance of the unexpected and the mundane in social life and the interactions between systemic and conditional processes, and addressing socio-spatial scales as a dimension of regulation and contestation.

In this paper, I use the concept of noncitizenship assemblages (Landolt and Goldring 2016; Villegas 2012) to examine the struggle to enforce and extend access to health care for precarious noncitizens in Toronto, Ontario. I have two main goals. First, I extend the empirical base of knowledge by examining the relatively less-known Canadian context, focusing on a dimension of social citizenship – access to health care – that is central to national identity and synonymous with full citizenship. Canada’s public medical insurance system is a politically charged arena of social policy: funding
formulas, fiscal efficiency, equitable access to care, hospital wait times, and talk of a two-tiered system are all fodder for provincial and federal elections. In turn, government legislation, sectoral regulations, professional codes of conduct, and union contracts delineate the nature of hierarchically nested relations across bureaucracies and healthcare delivery sites, as well as defining expectations of conduct within and across status groups. The healthcare system offers minimal room for autonomy; it is symbolically charged, highly bureaucratic, and hierarchical. It is also a sector in which the scalar isomorphism of nation-state and citizenship is explicit, cutting through the entire regulatory corpus and palpable in the daily practice of care. Overall, it is a rich context for strategic analysis.

My second goal here is to further develop the concept of noncitizenship assemblages as a framework for understanding the politics of noncitizenship as multi-actor, multi-scalar contestations. I trace how a network of individual and collective actors – centred around healthcare professionals, community social service agencies and migrant-rights activists – negotiates and rewrites the social and symbolic boundaries of noncitizenship as they enforce and extend access to health care for precarious noncitizens.

The next section presents the theoretical framework and research methods for the article. It is followed by an analysis of the assemblages of noncitizenship through an examination of four analytically distinct components through which access to health care is assembled: the intersecting laws and regulations that give precarious noncitizens conditional access to health care; the multi-actor social networks through which access is enforced and extended; the membership narratives and frames of deservingness circulated within the network that inform regulation and contestation; and the deployment of discretion that mediates the decisions and encounters through which healthcare rights and entitlements for precarious noncitizens are eroded and/or enforced, contracted and/or extended.
The discussion draws links across the four components, mapping how the politics of noncitizenship are assembled. The conclusion considers how the case study contributes to our understanding of political contestation as it is emerging in a new era of global migration.

**Theorizing the politics of noncitizenship**

Political contestation takes many forms, and is central to the expansion, retraction, and blurring of the legal and substantive boundaries between citizenship and noncitizenship. It includes social movements engaged in direct-action border politics (King 2016) and municipal government ordinances meant to close off or extend the ability of precarious noncitizens to participate in the life of the city (Ridgley 2008). In private and public sectors, organizations have instituted non-compliance and ‘Don’t Ask, Don’t Tell’ policies and procedures that seek to extend or restrict the rights and entitlements of precarious noncitizens (Villegas 2013a). There is also considerable room for agency and discretion as both citizens and precarious noncitizens claim access to rights, safety, and livelihood in competing and complementary modalities. They may cross militarized borders (Martínez and Ward 2018), join migrant-rights movements (Abji 2017; Pallares 2015), enroll nonstatus children in school (Landolt and Goldring 2019), build camp settlements (Rygiel 2011), or organize protests at immigrant detention centres (Montange 2017). Through these actions, citizens and noncitizens make themselves visible or invisible, mobilize for recognition, and claim their right to participate in redefining or upholding the boundaries between and content of citizenship and noncitizenship.

The available literature suggests two approaches to the politics of noncitizenship. One approach focuses on the structural and contextual factors that produce variation across sites of contestation. For example, demographic factors such as the proportion of authorized to unauthorized migrants, the
concentration of single country-of-origin groups in contrast to contexts of hyper-diversity and the pace of change in the labour market are all associated with an increase in local political struggles over the terms of membership (Thangasamy 2010; Varsanyi 2010). Differences in urban histories of immigration and civic engagement structure the character of mobilization and its ideological tone (de Graauw and Vermeulen 2016). Researchers have also focused on the scope of political autonomy granted by inter-jurisdictional governance enables local action to welcome or repel noncitizens (Gleeson 2013; Marrow 2012b; Miriam J. Wells 2004).

A second approach focuses on discursive and organizational conditions to explain variations in the substantive boundary work of citizenship and noncitizenship. Research focusing considers how gatekeeper discretion in bureaucracies produces variations in experiences of noncitizenship and citizenship (Alpes and Spire 2014). Others consider the institutional cultures and professional codes of conduct in shaping the institution-specific interpretation and application of fiscal and policy directives (Jubany 2017; Portes, Light, and Fernández-Kelly 2009; Satzewich 2016). They point to gender, class, racialization, and other markers of social location as mediating the practice of discretion and narratives deservingness (P. Villegas 2018). Media coverage also informs the local interpretations of policies and regulations (Jubany 2017; Park 2011).

The available literature has several limitations in its conceptualization of political contestation. The focus on contextual and structural factors is overly static. It homogenizes local sites as either welcoming or hostile towards migrants and noncitizens, and does not account for the uneven and disputed production of local responses. Analysis of discretion emphasizes the changeable dynamism of face-to-face encounters. It does not offer a thorough examination of the relationship between the contingencies of routine encounters and the emergence of more stable patterns of discretion. Few
studies have considered the ways in which contestation over the formal and substantive boundaries of citizenship and noncitizenship are scalar: i.e., that what is actually being contested is the dominant socio-scalar arrangements that naturalizes the national scale as the basis for appropriately regulating the terms of membership (Xiang 2013).

Assembling the politics of noncitizenship

Scholarship on assemblages offers a methodological and conceptual starting point for attending to the politics of noncitizenship as multi-actor, multi-scalar contestations that produce systemic and contingent shifts in the legal and substantive boundaries between citizenship and noncitizenship. Assemblages can be used to frame social life as being constituted dynamically by heterogeneous materials: collective and individual, material and discursive components that come together to produce complex configurations of power (Ong and Collier 2005). Components may have different temporal and spatial scales and operate under constant negotiation, and the relationships between them are not always logical or straightforward (DeLanda 2006; Villegas 2015). As components are assembled, they produce different, often indeterminate, multi-scalar effects and interactions. The assemblages framework emphasizes the incommensurability and fragility of social life, while attending to its hierarchies and inequalities. It is compelling because it intervenes in naturalized understandings that privilege structured and finite outcomes, and motivates consideration of conditionality (Goldring and Landolt 2013) and unexpected (Saldanha 2012).

The politics of noncitizenship can be conceptualized in terms of multi-scalar assemblages of social actors, institutions, regulations, objects, texts, and non-human actors and etcetera. that, as they come together, regulate, erode and subvert the formal and substantive boundaries between citizenship and noncitizenship (Goldring and Landolt 2013; Landolt and Goldring 2016). It involves four
analytically distinct components. The first is laws, policies, and organizational procedures that unevenly regulate the social and symbolic boundaries between citizenship and noncitizenship. The second is individual and collective actors connected through social networks. The third is narratives of membership and frames of deservingness: these malleable symbolic components – scripts of national identity, sovereignty, moral character, deservingness, etc. – are produced and altered across scales, institutional settings, and over time. The fourth component involves individual agency, specifically discretion – the permissive and arbitrary power to do or not do something – and social learning or observations and understandings accrued through relationships and experiences over time. Through social learning and discretion, the social and symbolic boundaries between citizenship and noncitizenship are narrowed and extended. Discretion is deployed through routine and mundane encounters mediated by established and emergent narratives of membership and frames of deservingness. I apply the assemblages framework to consider the heterogeneous components thread together in the work of enforcing and extending access to health care for precarious noncitizens in Toronto.

**Research Methods**

For this discussion, I draw on a subset of data collected as part of a multi-year collaborative project on health care and K-to-12 education as sites of access to entitlements for precarious noncitizen families. This project involved two phases of data collection over a period of eight years: the first phase was undertaken from 2009 to 2012, and the second from 2014 to 2016. Research has included interviews with individuals in a variety of roles within government ministries and public sector workplaces, non-profit community organizations, and grassroots migrant and worker rights groups. It
has also involved the collection of documentary evidence, including reports from workshops and symposia, policy papers including those of professional associations, and educational and advocacy materials. My own field notes taken during public rallies and symposia complement my analysis of these public records.

This paper focuses on focus group and key informant interviews with 20 individuals working in the healthcare sector. Respondents were first- and second-generation immigrants from across the globe, and two-thirds of them were persons of colour. They worked in hospitals, community health clinics, Toronto Public Health, and one volunteer-run health clinic that has served precarious noncitizens since 1999. They had many years – often decades – of experience in the healthcare sector and social service organizations. Many had moved from frontline practice to management positions and back, and had worked at a variety of organizations. They had extensive experience working with different vulnerable populations including street-affected persons, HIV-positive populations, and families living in poverty.

Interviews explored the enforcement and extension of access to health care for precarious noncitizens, with themes including the political and policy landscape in which they carried out their work, strategic planning, networking, alliance building, and health care workers’ day-to-day practice. Given their trajectories and the nature of their civic and political commitments, respondents shared a variety of experiences and understood the issues from different perspectives. Overall, interview data reflects the perspectives of three types of professionals within the healthcare sector: those engaging in frontline practice, clinic and hospital management, and policy and political advocacy.

The politics of noncitizenship in Toronto

Canada’s precarious noncitizen population includes migrants in many legal status categories that have temporary and partial rights and entitlements and are deportable (Goldring, Berinstein, and
Bernhard 2009). It includes temporary migrant workers in different migration programs organised into Temporary Foreign Worker programs on the basis of skill categories and industries (mining, agriculture, food services, etc.), care workers in the Live-In Caregiver Program, international students, refugee claimants, unaccompanied minors, denied refugee claimants, tourists and visa over-stayers, as well as seniors in the Super Visa\textsuperscript{iii} program, among others. This population is socially and demographically heterogeneous, and comes from all over the world with different migration histories, educational levels, and family structures. Precarious legal status trajectories vary considerably between individuals. For some, the trajectory from precarious legal status to citizenship has been relatively straightforward; others are authorized to live in Canada for extended periods, but are permanently ineligible to transition to permanent residence. Still others must navigate various forms of precarious legal status or may lose authorized status altogether for an indeterminate length of time (Goldring 2014).

In Toronto, the work to enforce and extend precarious noncitizen access to health care has occurred as part of a broader shift in the city’s social and political character. A demographic change has been central to this broader transformation. Beginning in the 1990s, an overhaul of federal immigration policy expanded the scope of temporary migration streams within the immigration system. Nationally, the temporary migrant population doubled between 1990 and 2012, for a total of 1.1 million people (Landolt 2017).\textsuperscript{iv} Data for the Toronto Census Metropolitan Area for the period 2000–2015 also show a doubling of the authorized temporary migrant population, from 74,000 to 140,000 (Government of Canada 2016).\textsuperscript{v} There is also a sizeable nonstatus population, estimated at between 100,000 and 250,000 (Jimenez 2003).\textsuperscript{vi}
Changes in urban governance have also been important. After the 1998 amalgamation of the regional municipality of Metropolitan Toronto and its six constituent municipalities into the Greater Toronto Area, the municipal, provincial, and federal governments established a formal framework of collaboration on immigration issues. In 2006, they created a forum to discuss shared immigration policy concerns, coordinate research activities, and share information. Vertical collaboration, increased data collection and information sharing intensified the effects of federal and provincial legal status-based eligibility restrictions on services and entitlements (Magalhaes, Carrasco, and Gastaldo 2010). The greater capacity for scrutiny shaped the procedures of neighbourhood-based organizations and the practices of frontline workers.

Within this context, a new cultural politics of immigration and membership began to be articulated, recognizing legal status precarity as a distinct form of vulnerability and an obstacle to full membership (Abji 2016). At first, organizations and individual frontline workers continued to try to make room for precarious legal status migrants within their existing practice, without changing policies and procedures, but clearly at odds with the eligibility mandate of funders and government policy. They worked under the radar to bypass formal eligibility criteria. Eventually, having to deny access to an increasing proportion of service users, organizations began to question long-held assumptions about Toronto as a welcoming city for immigrants. Complicating the situation was the fact that while some organizations wanted to ‘make room’ for precarious noncitizens, many others did not and preferred to respect the limitations placed by funding. Indeed, there was mounting evidence of mistreatment within the healthcare system: disrespectful intake procedures, refusal to serve, poor follow-up, overbilling, humiliating encounters, harassment, and unpredictable treatment – all of which caused fear, uncertainty, and avoidance among precarious noncitizens.
Responding to these changes, in 2004, a loosely connected network of more than 40 organizations was formalized into the Don’t Ask, Don’t Tell coalition with the goal of making policy and procedural changes across different sectors and organizations to enforce and extend access to entitlements to precarious noncitizens (Berinstein et al. 2006). The Don’t Ask, Don’t Tell coalition included unions, social service agencies, legal professionals, faith-based groups, and grassroots organizations including No One is Illegal, Justice for Migrant Workers, and the Ontario Coalition Against Poverty, among others. Their work has been far-reaching and has led to the following policy changes: a temporary Don’t Ask agreement with the Toronto Police Services Board (2006–07) and the passage of a Don’t Ask, Don’t Tell policy within the Toronto District School Board in 2007. In 2013, the former Don’t Ask, Don’t Tell coalition, renamed as the Solidarity City Network, successfully campaigned for the passage of a Sanctuary City policy by the municipal government. The new policy specifies that all Toronto residents are eligible for city-funded programs and services regardless of status (Hudson et al. 2017).

**Assembling access to health care for precarious noncitizens**

Toronto is one of many cities and places worldwide where access to healthcare has emerged as a site of struggle over the rights and entitlements of precarious noncitizens (Castañeda 2013; Huschke 2014; Marrow 2012a; Villegas 2013b; Watters 2007; Willen 2012). My analysis of this arena of contestation is organized around the four components through which precarious noncitizen access to health care is assembled. I begin by identifying the regulatory framework that organizes access and consider how this intersects with the precarious legal status trajectories of migrants. This is followed
with a discussion of social networks, scripts of membership and deservingness, and their deployment through discretion.

*Intersecting regulations of the medical insurance system and the immigration system*

Canada’s multi-jurisdictional healthcare system organizes the precarious noncitizen population into two groups with different modalities of access and delivery. One group is entitled to variable forms of less-than-full and conditional healthcare coverage based on the precarious legal status category they occupy. Refugee claimants, for instance, are entitled to primary care but cannot access specialist care. Their coverage is managed through the Interim Federal Health Program (IFH). International students and Temporary Foreign Workers (TFWs) are eligible for provincial healthcare coverage: in Ontario, this is known as the Ontario Health Insurance Plan (OHIP). However, Temporary Foreign Worker eligibility only begins after six months of full-time work in the province. Precarious noncitizens covered by the IFH or OHIP can access health care through any institutional contact point: a hospital, walk-in clinic or individual doctor’s office. They are required to present a valid health card at each visit.

The second group is known as ‘the uninsured’ and includes a variety of legal status categories. It includes new permanent residents who on receipt of PR are required to wait three months in Ontario before accessing OHIP. The uninsured also includes individuals who are ineligible, such as migrants on the Super Visa and tourist visa holders. It also includes rejected refugee claimants and all other nonstatus migrants. Oddly enough it also includes citizens who have lost their health card and cannot provide the proof of residence required to acquire a new health card. The uninsured can access care at provincially funded community health clinics (CHCs). They may also access care through ambulatory clinics offered by Toronto Public Health. They cannot be turned away from a hospital if their condition
is deemed a medical emergency. They will be billed for services and must demonstrate capacity to pay at intake.

The intersecting regulations that govern precarious legal status and the medical insurance system generate formal lapses in access to health care, at the same time that contact with the health care system can affect precarious legal status trajectories. Migrants may move toward greater legal status security – from refugee claimant to recognized refugee and eventual permanent resident – at the same time that they temporarily move toward less healthcare coverage, because the shift to permanent residency requires a three-month wait without medical coverage. A refugee claimant may begin treatment for a chronic or serious health condition (e.g., diabetes, cancer, depression), but treatment will stop if the individual’s refugee claim is rejected. Injured Temporary Foreign Workers are eligible for medical treatment but depending on the restrictions on their work permit will lose the right to be present in Canada and be deported if they are unable to perform the duties of their job because of injury (Hennebry, McLaughlin, and Preibisch 2016). Clinic and hospital staff also have the right to request an immigration status check from the Canadian Border Services Agency for uninsured health seekers; while they may secure access to healthcare, detection and deportation may ensue.

*Building a network to enforce and extend access*

Beginning in the 1990s a mix of social service professionals and health care workers began networking to facilitate the enforcement and extension of health care access for precarious noncitizens. The network has evolved over the years and connects individuals and institutions across the healthcare system and beyond. One starting point has been formal partnerships and agreements across different sites of the health care system. Community health clinics have established partnership agreements with hospitals and individual doctors for pro bono services to extend their capacity to offer primary and
specialized care to precarious noncitizens. These often began as impromptu pleas and negotiations, and later morphed into formal partnerships. One midwife explained how her CHC was able to secure a hospital partnership in the late 1990s:

‘We had so many nonstatus women back in the day...We went to talk to them [the hospital] and said, “we’ve got all these women and they can’t afford to have their babies in the hospital and they shouldn’t be having their babies at home for medical reasons,” … We ended up … coming up with this whole program where they could give us twenty-five free treatments a year.

The matter-of-fact focus on medical need opened up the possibility of extending access to specialized care for nonstatus pregnant women.

Informal resource sharing has been central to the frontline practice of the network. Practitioners leverage their experience, reputation, and professional contacts to move precarious legal status healthseekers through the referral-based medical system (Villegas 2013b). A Toronto public health nurse explained the mechanics of the informal referral system:

‘What we end up doing, all of us, is we end up phoning each other and begging each other...It is all about those partnerships and relationships…and we sort of pull people in, anyone who is like-minded. In this work...it is who you know, who did you call and who will take your call. It is very true, who will take your call. But is also: you build your own reputation.

Healthcare workers also develop professional networks with individuals in other sectors and draw on these relationships to extend the supports they provide. Through this patchwork of contacts, precarious noncitizen health seekers may also access other entitlements.

‘Outside the boundaries of this thoughtfully constructed patchwork of supports, frontline worker advocacy ranges from keeping a watchful eye on patient-doctor interactions to ensure appropriate care,
to tense confrontations with racist or hostile healthcare professionals. A nurse recounted one particularly difficult experience of trying to get a patient admitted to the hospital ward:

I had women who … had her placenta starting to come off the wall of her uterus so she was in [the hospital] and then she was discharged when the bleeding slowed down. …She phoned me one night when the bleeding had started again…So I took her [again] and the obstetricians who was on call said, “where she is from,” and I said “I am not telling you where she is from” and she said, “well why doesn't she have OHIP?” and I said, “well I am not going to tell you that either. It’s none of my business. I provide clinical care, so you provide clinical care.” So we ended up this far from each other just shouting…And she finally stormed down the hall to go see her, and then she came back and she said, “Tell me where is she from before I walk in that room.” I said, “I think her home country is Jamaica”. …She went back down the hall, into that room and discharged that woman, and I had to take her to another hospital.

The capacity to advocate for the enforcement of precarious noncitizen health entitlements requires ongoing, off-the-clock and often intimate relations of trust between healthcare professionals and precarious noncitizens. In this absence of these relationships migrants who seek health care are at risk of experiencing an erosion of rights and entitlements.

In 2007, after more than a decade of low-level partnerships and relationship building, healthcare professionals came together to coordinate their work through the Collaborative Task Force on Uninsured and Undocumented Clients (CTF), renamed the WCH Network on Uninsured Clients (WCH-NUC) in 2009. Spearheaded by the Women’s College Hospital’s Women’s Health Community Advisory Panel, the WCH-NUC has brought together a diverse set of institutional actors, based within and outside of the healthcare system. It has expanded and strengthened relations among frontline and
management staff in healthcare organizations and immigrant settlement and social service
organizations, as well as researchers, public policy advocates, and grassroots migrant-rights and anti-
poverty activists. WCH-NUC member organizations have variable degrees of freedom with regard to
provincial and municipal government funding and policy directives. They sit at the WCH-NUC table
with different political priorities and experiences: some are embedded in grassroots migrant-rights
organizations and focus on direct action politics, and others have worked to open channels of
communication with hospital CEOs and ministry bureaucrats and elected officials.

The WCH-NUC has facilitated cross-sectoral dialogue within its membership to identify best
practices for serving the precarious noncitizen population, and to identify gaps in evidence that should
be filled to generate more effective, system-level advocacy. It has set strategic priorities for policy and
procedural change within healthcare institutions (hospitals and community health clinics) and in
government policy. It has encouraged new approaches to political advocacy and policy work, and has
partnered with researchers to organize public workshops and symposia. These events have served to
consolidate a shared political agenda and broad understanding of the health-seeking behaviours of
precarious noncitizens.

Narrating membership and deservingness

Over the years, a diversity of narratives of membership and deservingness have been mobilized
to advocate for health care access for precarious noncitizens; claims for access invoke both legal-status
blind and legal-status centred frameworks of entitlement. The primary importance of citizenship as the
basis for health care access is consistently eroded. Narratives overlap, are fluid and situational,
reflecting the multiplicity of individual experiences, different institutional environments, and the tenor
of specific interactions.
Facing an antagonistic work environment, frontline workers have developed a terminology of precarious noncitizen health care access that is “empathetic and compassionate and caring”. One frontline worker explained:

The moment that you say nonstatus you get a response [from other healthcare professionals], “they are not one of us so why should we care about it”. And then you hear people saying, “well we have people that are homeless; we should be taking care of them first before we take care of those people” [without status].

Even within healthcare organizations working with vulnerable populations, access for precarious noncitizens is contentious, and hierarchies of entitlement that distinguish between citizen and noncitizen are readily invoked.

Healthcare workers have also developed an alternative, more combative framework for claiming the rights of precarious noncitizens. Drawing on the politics of the migrant rights and no borders movement emerging in Toronto, healthcare workers challenge all citizens – and in particular healthcare workers who deny migrants care—to justify their right to exclude ‘non-citizen’ others on the basis of their “Canadian origin stories”. One frontline worker said:

I think it bears repeating endlessly because of this sense of entitlement given the number of generations *they* have tallied up in Canada; if you are not First Nations, everybody came from somewhere else, and we forget that. We homogenize our own history and we give credence to some groups and not to others. I think that as long as that kind of …cultural racism [exists]…we are not able to draw that distinction between us and them, and there *is* no divide between ‘us and them’.
By invoking Canada’s settler-colonial history, migrant rights advocates and frontline workers in particular blur the temporally-oriented symbolic boundary between citizen and noncitizen.

Health care professionals draw on a variety of narratives of health care access that offer different understandings of the relationship between precarious legal status and healthcare. Legal-status blind narratives emphasize the similarities across the citizen-noncitizen boundary, where precarious noncitizen health seekers are defined as members of a ‘high-risk’ population with “equal vulnerability and need as the homeless”. Another narrative centers precarious noncitizenship as a legal obstacle to access. One Toronto public health nurse explained why she considered precarious legal status a distinct obstacle to access:

I like precarious [status] because it really implies there is a quality of risk in the person that doesn’t get reflected in ‘the uninsured’. For me, for uninsured, somebody who is Canadian-born and may be street affected or have lost their documentation isn’t somebody who isn’t eligible for health care; that’s just somebody who needs somebody’s help to get some papers, which is different from somebody who can’t access health care.

A third narrative emphasizes the vulnerabilities associated with deportability and positions precarious legal status as a distinct social determinant of health, not simply as a bureaucratic obstacle to health care access. A social worker based in a community health clinic explained, “education, income, all of these things…you need that to be healthy, but you need full immigration status to be healthy…even more so than some of the other things”. In this iteration, legal status overlaps with other dimensions of social location to mark the distinct forms of vulnerability of the precarious noncitizens.

The narratives of membership and health access articulated by clinic managers draws on the notion of compassionate care and reflect their institutional locations. One clinic manager and policy
analyst explained how a 100-year-old narrative of religious compassion enabled select hospitals in the city to extend care:

The Sisters of St. Joseph who started the hospital and also started St. Mike’s in 1892 with a mission to serve the poor and marginalized. And they were very clear about that mission: to promote the healing ministry of Christ. It’s a very difficult thing to argue with…are you going against Christ by not accepting this [nonstatus] client? As a result there is a real buy in…and a fairly high level of compassion.

Compassionate care echoes the legal-status blind emphasis on vulnerable deservingness.

Management workers also prioritized risk management and fiscal efficiency over formal legal status restrictions on access care. They emphasized the efficiencies of preventive healthcare as a cornerstone of the medical system and distinguished their perspective from that of frontline workers. Reflecting on these professional differences, one manager explained:

They [frontline workers] don’t think about the fiscal piece but the reality is that if you are looking at policy change…you are dealing with people who are in a different place right now. It is very fiscal, safety and quality control oriented. I think those are the top priorities at our hospital and anything above and beyond that is lost.

Strategic considerations about the political climate for policy change are an important element in the narratives of access mobilized by management workers. They resonate with the approach of some members of the WCH-NUC.

The WCH-NUC and its member organizations have also mobilized narratives of access that hinge on the normative integrity of Canada’s healthcare system. Emphasizing legal and human rights obligations, WCH-NUC members point to Canada’s obligations as a signatory of the International
Covenant on Economic, Social and Cultural Rights, and link these to the values enshrined in the 1984 Canada Health Act and the 1982 Canadian Charter of Rights and Freedoms. Another narrative emphasizes social justice as the basis from which access should be ensured. The OHIP For All Coalition has called for the Ontario government to extend OHIP coverage to all residents of Ontario, regardless of immigration status, stating, “access to health services is a basic human right and a matter of justice…we call for access for all without fear of debt, denial of service, detention or deportation” (OHIP For All Coalition 2018).

The deployment of discretion

Enforcing and extending access to health care requires all network actors to set priorities. These can be understood as forms of discretion because they require navigating formal and substantive criteria of access at the intersections of precarious legal status and the regulations of the public medical insurance system. Some forms of discretion allow for assessment and adjustment—such as setting policy change priorities or clinic budget planning—and others occur on the spot—such as frontline intake procedures.

Over the years, the WCH-NUC has developed an agenda of policy change goals premised on the notion that “the problem of access is so overwhelming that they need to be strategic, opportunistic and focus on winnable issues that align with other drivers of the health care system” (Network on Uninsured Clients 2010, p.18). Policy change focuses have included: the elimination of the three-month wait for OHIP for new permanent residents; the reinstatement of Interim Federal Health Program funding for refugee health care; and ensuring that the newborn children of nonstatus mothers are registered for OHIP, in hospital, at birth. These policy change goals prioritize the temporal extension of health insurance to citizens-in-waiting; those on track to permanent residence and eventual
naturalization. Their policy priorities leave unchallenged the relationship between health care access and formal citizenship.

Healthcare management professionals apply procedural discretion in their interpretation of the bureaucratic category of medically uninsured, creating wiggle room within existing regulations. Clinics stretch eligibility criteria attached to global funding envelopes designated for the uninsured to serve nonstatus migrants. One healthcare professional explained the strategy applied by the CHC where she works:

It really depends on who the funder is and for [each funder] you need to look at their guidelines and see exactly what language they use and that’s the language you use back with them. And you don’t change anything, you just give them back what they find is appropriate.

A midwife explained her clinic’s approach to creating wiggle room, “We looked carefully at the legislation and found that there were loopholes [that]…allowed us to provide care for anyone.” The management of access to health care ‘works’ the system, reading regulations with discretion to extend the category of uninsured to include precarious noncitizens. The legal-status-blind emphasis on ‘uninsured’ focuses on medical need over legal status limitations, either formal or substantive.

Clinic intake procedures blend the discretionary practices of management and frontline workers and generate two-tiered discretion. On the one hand, resource limitations and formal partnerships with hospitals have forced health clinics to establish legal status-based restrictions on access within the precarious noncitizen population. One clinic worker told us:

We do have a couple of policies and one is no visitors or [international] students. And the reason we do that is because the hospitals with which we work are very unhappy with us that we are…bringing them people to the hospital who can’t pay their bill. And so there is an
enormous amount of pressure on us…And the first question comes [from the hospital], “is she a visitor?”

Clinics will not jeopardize good relations with the hospital system to move visitors with a valid tourist visa through the system, regardless of medical need.

The visitor is also a moral trigger for many healthcare workers and the institutions in which they work. One frontline worker referred to the case of pregnant women, questioning the timing of individuals who arrived ‘too pregnant’ and were simply coming to have their baby and go home.

Managers also raised concerns about the optics of advocacy for precarious noncitizen access to health care, given the reality of medical tourism. A policy advocate and clinic manager explained:

…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 they become the typical threat when they are mentioned.

Pushed to explain how they distinguish among healthcare seekers in light of concerns about visitor visas and medical tourists, frontline workers explained the kinds of on-the-spot evaluations they apply. They all said they made exceptions for visitors if the person planned to stay in Canada. One clinic social worker explained:

If somebody says to us that they are going to stay in the country and they are going to find a lawyer and figure out whatever immigration stream they are going to do, I think we would make an exception for that…They have to be in the process of trying, they have to have a plan to have some permanent residency.

Similarly, a nurse with Toronto Public Health explained her own approach to assessing the intentions of noncitizen healthcare seekers, and thus their substantive eligibility to access services:
There are a lot of people that come on a visitor visa and who really want to stay. But those on a visitor visa when they come for a health care reason, they are often going to go back home again. They don’t want to be Canadian. But that is different for me. But I am also pretty good. I have been doing this for a long time, I can read bullshit a mile away.

Thus, criteria for eligibility are blended as frontline workers consider both the formal protocols established by the clinic where they work and their own on-the-spot evaluations. The latter hinge on frames of deservingness tied to temporality and intentionality.

Overall, hierarchies are established based on the intersections of precarious legal status, medical capacity, and medical need. Orders of priority are not simply based on a logical outcome of the most reasonable decision. Some hierarchies may be considered temporally relative (first this then that); others may be justified as strategic or intrinsic on the basis of resource limitations – they are often a combination. Discretion is sometimes guided by health needs, or by the regulations of the healthcare system, i.e., stretching the intent of budgets for the uninsured to include nonstatus healthcare seekers who are not really the intended target. In some cases, legal status is relevant to distinguish between different categories of precarious legal status: international students and visitors are excluded from the clinic on the grounds that a) they have money and coverage and b) just got here … leading to the slippery slope of medical tourism. In other cases, substantive understandings of precarious legal status enter into the equation where perhaps a visitor is eligible and passes the gate because she ‘intends to stay’ and is making some kind of effort or claim. Immigration status is interpreted as more than a legal category, not all timelines and trajectories are considered acceptable as indicators of intentions and deservingness.

Discussion
In Toronto access to healthcare for precarious noncitizens has been assembled through the confluence of four analytically distinct components. The intersecting regulations of the medical insurance and the federal immigration systems lay the groundwork for a ‘chutes and ladders’ landscape of formal incongruities and substantive ambiguities in health care access for precarious noncitizens (Goldring and Landolt 2013). Changes in one regulatory arena intersect with and trigger changes in the other (Könönen 2018). The legal transition to the more secure immigration status of permanent residence, for instance, imposes a three-month denial of health care access. Rules governing closed work permits ensure access to health care, but accessing the medical insurance system can easily trigger the removal procedure of the immigration system as established in Temporary Foreign Worker programs. The administration of healthcare for the uninsured produces a regulatory context of health care access with procedural wiggle room and regulatory windows of opportunity for precarious noncitizen access to health care and to ongoing presence on the territory. Temporary or more permanent adjustments towards more or less health care access and more or less secure immigration status are conjointly assembled.

Social network actors navigate the regulatory chutes and ladders of the immigration system and the medical insurance framework. In so doing they negotiate the formal and substantive possibilities of healthcare access that are in place; the work of these individual and collective actors produces the boundaries of social citizenship. The social network that seeks to enforce and extend precarious noncitizen healthcare access has multiple modalities of action. A resource-thin patchwork, held together through professional and personal reputation advocates for precarious noncitizens. It ensures individuals are seen by doctors, receive proper follow up. It can even connect noncitizens to other social supports related to work, housing, food insecurity and schooling. Network members also share
knowledge to produce best practices for clinic-level procedural guidelines that ensure precarious noncitizen access; and they work for policy change across different sites of the medical system including professional groups and relevant government ministries. Consolidated through the WCH-NUC, the network has considerable analytical reach and creative vision. The diversity of the membership also poses a challenge to the functionality and agenda setting processes given the diversity of political positions and institutional contexts connected through the network.

The network produces a discursively complex and fluid amalgamation of narratives of membership and frames of deservingness. Legal status circulates as a symbolic category to be invisibilized on the frontlines of care and, alternatively, to be invoked as an administrative obstacle to access. Precarious legal status is also positioned as a source of vulnerability, like poverty, racialization and other social determinants of health; it is also framed as a social injustice that generates fear of debt and deportation among precarious noncitizen health seekers. One narrative of membership demands unconditional and intrinsic compassion for the vulnerable health seeker, and another invokes an instrumental concern for the fiscal integrity of the health care system. Narratives link the normative integrity of Canada’s medical insurance system with a commitment to ensure equitable access to health care for everyone as a core “Canadian value”.

The deployments of discretion traverse this discursive complexity in ways that variably expand and contract the social and symbolic boundaries between and content within citizenship and noncitizenship. Collaborative and hostile encounters and political planning across health care sites and in the network demonstrate how the grey zones of citizenship and noncitizenship are produced and negotiated. Network members struggle to balance political ideals and the procedural and resource constraints of their work roles, with what experience has taught them is an effective way of enforcing
and extending healthcare access for precarious noncitizens. Central to this juggling act is the politics of pivoting, often strategically, between legal-status centred or legal-status blind discourses. Age-old tropes of membership – compassion for the weak and vulnerable, tied to the normative integrity of the system – also have powerful resonance across a wide spectrum of network members and beyond; among frontline workers, clinic managers and hospital CEOs. Finally, hierarchies of deservingness – based on legal status categories and trajectories, on time in Canada and in time-lapses between arrival and seeking medical care – emerge in routine, frontline decision-making, procedural planning and the establishment of policy change priorities. Discretionary practice reveals how difficult it is to relinquish the power of citizenship.

Assembling healthcare access for precarious noncitizens embodies an ambiguous scalar contestation of the dominant understanding that citizenship is granted and practiced first and foremost at the national-level. Through the work to enforce and extend healthcare access to precarious noncitizens community health clinic, doctors’ offices and birthing centres are claimed as social-spatial scales where social citizenship is chalimed. Bureaucratic rules and procedures are realigned to extend the framework of the medically uninsured to include the precarious noncitizen. Yet in the development of a policy agenda and when faced with challenging resource limitations the framework of national sovereignty and the federal immigration system’s harsh limits on the rights of the visitor are applied. Scalar contestation and regulation are interconnected and unstable mechanisms mediating the boundaries between citizenship and noncitizenship.

**Conclusion**

The framework of noncitizenship assemblages is a methodologically and theoretically robust starting point for understanding the contemporary politics of global migration. The assemblages
framework urges analysis of political contestation over the social and symbolic boundaries between citizenship and noncitizenship that engages with and draws connections across the diversity and complexity of sites and forms of struggle; from routine and mundane to large scale and structured. It also inspires consideration of the ways in which contestation occurs within and across different socio-spatial scales and can lead to changes in taken-for-granted scalar hierarchies that regulate the boundaries between – and content of – citizenship and noncitizenship.

The framework expands how we conceptualize political contestation. The case study shows how local struggles over rights and entitlements borrow and rewrite the legal, procedural and cultural boundaries and content of noncitizenship. It also demonstrates that the alignments between the symbolic and social boundaries of citizenship are temporally variable and uncertain; there may be stable alignments through which momentarily expansions build to procedural and policy change, for instance, or not. Uncertainty is a given. Securing points of connection and contact that can shift the boundaries of membership takes constant work and negotiation on many fronts, both social and symbolic. The work of contestation—of expanding the boundaries of social citizenship in this case—includes a multitude of small acts, often woven into mundane routines and heightened encounters that embody social learning and discretion. These elements are an important dimension of contestation, how and when they gel into a more systemic shift in the social and symbolic boundaries of noncitizenship are not easily determined.

References


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The Parent and Grandparent Super Visa was introduced in 2013 as an alternative to sponsorship to permanent residency. It is a 2-year visa that can be renewed for up to 10 years, requires the sponsorship applicant to demonstrate a minimum maintenance income for the visitor for three years and denies the visa-holder access to health care, basic income security programs and the right to employment.
This includes the stock and flow population, where stock is the total population of migrants in a country at a particular point in time and flow is the count of migrants entering (or leaving) a country over the course of a given time period, typically a calendar year.

The count includes individual study, work, and resident permit holders.

Only estimates are available because Canada does not collect exit data.

The Interim Federal Health Program was suspended by the Conservative Party in 2012 and reinstated by the Liberal Party government elected in 2016.

Refers to an individual with a valid visitor visa who has been in Canada less than six months.