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Health workers' perceptions of access to care for children and pregnant women with precarious immigration status: Health as a right or a privilege?



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ABSTRACT

The Canadian government's recent cuts to healthcare coverage for refugee claimants has rekindled the debate in Canada about what medical services should be provided to individuals with precarious immigration status, and who should pay for these services. This article further explores this debate, focussing on the perceptions of healthcare workers in Montreal, a large multiethnic Canadian city. In April–June 2010, an online survey was conducted to assess how clinicians, administrators, and support staff in Montreal contend with the ethical and professional dilemmas raised by the issue of access to healthcare services for pregnant women and children who are partially or completely uninsured. Drawing on qualitative analysis of answers ($n = 237$) to three open-ended survey questions, we identify the discursive frameworks that our respondents mobilized when arguing for, or against, universal access to healthcare for uninsured patients. In doing so, we highlight how their positions relate to their self-evaluations of Canada's socioeconomic situation, as well as their ideological representations of, and sense of social connection to, precarious status immigrants. Interestingly, while abstract values lead some healthcare workers to perceive uninsured immigrants as “deserving” of universal access to healthcare, negative perceptions of these migrants, coupled with pragmatic considerations, pushed most workers to view the uninsured as “underserving” of free care. For a majority of our respondents, the right to healthcare of precarious status immigrants has become a “privilege”, that as taxpayers, they are increasingly less willing to contribute to. We conclude by arguing for a reconsideration of access to healthcare as a right, and offer recommendations to move in this direction.

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Introduction

The Canadian government's recent cuts to healthcare coverage for refugee claimants has rekindled the debate in Canada about what medical services should be provided to individuals with precarious immigration status, and who should pay for these services. Citizenship and Immigration Minister Jason Kenney justified the cuts in a news release, claiming that Canadians should not fund benefits for refugees that “are more generous than [what] they are entitled to themselves” (Fitzpatrick, 2012). In recent decades,

public funding for healthcare in Canada has been curbed as a result of policies aimed at reducing national and provincial deficits. These reforms in universal health coverage have resulted in increasingly limited medical services for Canadian citizens and immigrants, as well as growing out-of-pocket expenses for related services (Lewis, Donaldson, Mitton, & Currie, 2001).

Since membership is associated with full access to public services, the central dilemma of advanced welfare states experiencing rising immigration is drawing the line between those who should become members and those who should not (Faist, 1995). Stricter and more complex regimes of naturalization or regularization of immigration statuses have nonetheless not discouraged migration to these countries. Rather, these changes have contributed to rising numbers of immigrants with precarious status, as incomers have responded to the new regulations by going deeper underground to escape detection (De Genova, 2004; Ferré, 1997). In this context,

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Van der Luen (2006) notes that the responsibility to limit access to public services to full members or members-to-be of these states has increasingly shifted down from gatekeepers at external borders, such as customs officers, to gatekeepers inside these borders, such as healthcare workers.

Of course, like their clients with precarious immigration status, social services employees are not passive recipients of such measures. Together, these groups create and exploit loopholes that arise out of the inevitable ambivalence of policies that attempt to curtail unauthorised immigration (Miklavcic, 2011). Certainly, when approached by pregnant women without medical insurance in hospitals, clinicians are challenged with a significant ethical dilemma as they are forced to decide if, and to what extent, they will allow access to resources that have been officially reserved for citizens and legal immigrants by either state or institutional policy (Rousseau et al., 2008). How are healthcare workers coping with these situations? If a dilemma arises between what their professional mandates, or personal values and commitments, suggest they do (such as providing universal access), and what their state or institution requires of them (such as limiting access), how do they respond?

Research conducted with support staff and clinicians to ascertain how care is rationed when patients are uninsured and unable to pay up front, have all concluded that this process is especially conflicted given that it always involves particular moral worlds (Castañeda, 2012; Gottlieb, Filc, & Davidovitch, 2012; Horton, 2004; Rosenthal, 2007; Willen, 2011, 2012). Whereas ethical discourse about the right to medical care emphasizes rational choice over affect, and coherence over the sense of unknowability and uncontrollability of daily life, the moral experience of realizing that right still involves “a view from somewhere and an action that becomes partisan” (Kleinman, 1998, p. 365). In contexts that are nowadays globally characterised by drastic cuts to public spending and an overwhelming sense of highly limited resources, the enactment of the right to health tends to involve a process of defining who is considered a member of one’s moral community, and as such, “deserving” of one’s care (Fassin, 2012).

“Deservingness”, as Willen (2012, p. 813) suggests, can be understood as the flip side of rights. “Whereas rights claims are expressed in a formal juridical discourse that presumes universality and equality before the law, deservingness claims are articulated in a vernacular moral register that is situationally specific and often context-dependent” (Willen, 2012, pp. 813–814). Inscribed in what Watters (2007) calls a “moral economy of care”, conceptions of deservingness and undeservingness, therefore, do not emerge in a vacuum but instead are moulded by political, economic, social and cultural forces, in addition to personal values and commitments. In this article, we will highlight how a mix of health ethics principles, financial considerations, assessments of the moral worth of precarious status immigrants, as well as perceptions of one’s social connection to this group, interact to construct partially or completely uninsured children and pregnant women as either “deserving” or “undeserving” of universal access to healthcare in Canada.

Canada has an estimated population of 100,000 refugee claimants, and between 200,000 (Jiminez, 2006) and 500,000 (Soave Strategy Group, 2006) undocumented immigrants, the majority of which live in large cities such as Toronto, Montreal and Vancouver. In contrast to other countries like the United States, where undocumented migration is associated with clandestine border crossings (Spener, 2009), undocumented immigrants usually enter Canada through legal means but subsequently lose their legal status. Individuals can have their status revoked by: overstaying a work, study or visitor’s visa; having a claim for refugee status or status based on humanitarian and compassionate grounds denied; or experiencing sponsorship breakdown (Magalhaes, Carrasco, & Gastaldo, 2010). Hence our use of the phrase “immigrants with

precarious migratory status”, as proposed by Goldring, Berinstein, and Bernhard (2007) for the Canadian context, to refer to immigrants with different kinds of legal and illegal statuses in Canada, which limit their access to social services. As these authors argue, such a phrase better captures the various pathways to irregular status than the binary conception of migrants as either “legal” or “illegal”. In principle, immigrants with precarious status have no access to public healthcare and any emergency care received is at their own expense. Families with some members who have precarious migratory status (e.g., Canadian children whose parents lack legal status) may also fail to seek care for administrative reasons or for fear that the parents’ immigration status could be exposed (Bernhard, Goldring, Young, Berinstein, & Wilson, 2007).

In April–June 2010, as part of a larger mixed-methods study entitled “The Migratory Status of the Child and Limited Access to Health Care: Equity and Ethical Challenges”, an online survey was conducted in Montreal, a large multiethnic Canadian city. It sought to assess how clinicians, administrators, and support staff contend with the ethical and professional dilemmas raised by the issue of access to healthcare services for pregnant women and children who are partially or completely uninsured. Our study focuses on these two specific groups given the irreversible consequences of depriving precarious status children and pregnant women of medical services, the minimal cost of preventive care (vs. delayed emergency intervention), public health concerns, as well as the fundamental rights of children (Chang, 2005; Ruiz-Casares, Rousseau, Derluyn, Watters, & Crépeau, 2010; Uninsured, 2003). At the time of our survey (before the cuts to healthcare coverage for refugee claimants were instated), partially or completely uninsured pregnant women and children included: partially insured migrants with legal status (refugee claimants), uninsured migrants with legal status (e.g., people with student visas or newly-arrived permanent residents in their three month waiting period), and uninsured migrants without legal status.

An analysis of responses to the close-ended questions ($n = 1048$) of our survey revealed the existence of a wide gap between attitudes towards entitlement to healthcare and the endorsement of principles stemming from human rights and the best interest of the child (Ruiz-Casares, Rousseau, Laurin-Lamothe, Rummens, Zerkowitz, Crépeau, & Steinmetz, 2012). Indeed, one-third of respondents who endorsed health as a human right (33.6%), or child development as a priority (36.8%), also endorsed restricted or no access to healthcare services for uninsured children and pregnant women. It was also found that country of origin, institutional affiliation, and professional role impacted responses. Foreign-born respondents (75.2%), clinicians (61.1%), and those working in primary-care centres (68.5%) were more likely than Canadian-born respondents (51.2%), administrators (53.5%), support staff (42.1%), and those working in hospitals (49.2%), to endorse broad or full access to services.

This article further explores these findings by analysing the responses ($n = 237$) to the open-ended questions of the survey. It asks: what kind of discursive frameworks do clinicians, administrators and support staff mobilise when arguing for, or against, the “deservingness” of pregnant women and children who are partially or completely uninsured to access healthcare? And how do such assessments relate to self-evaluations of one’s nation’s socioeconomic situation, as well as ideological representations of, and one’s sense of social connection to, immigrants with precarious status?

To begin with, we will briefly describe the method used as well as the profile of respondents. Next, we will analyse the moral positioning of respondents with respect to this issue, paying specific attention to the different factors at play in shaping these viewpoints. We will conclude by highlighting how the right to healthcare of precarious status migrants has come to be seen as a privilege in the eyes of our respondents. After having situated this

phenomenon within an increasingly dominant humanitarian conception of the right to health worldwide, we will reflect on why and how we should promote the reconceptualization of health as a human right.

Methods

Participants

The participants in this online survey were all practitioners (e.g., physicians, nurses, and social workers), administrators, researchers, and other support staff, based in 3 hospitals and 2 primary care centres in Montreal. There were 1048 responses to the survey, however, respondents who did not answer the open-ended questions ($n = 823$) were excluded from analysis. As a result, this article utilizes comments provided by 237 respondents (23% of all survey respondents) who provided detailed comments in the open-ended space at the conclusion of the survey or for one of three questions offering “other” as a response choice.

The demographic characteristics of these respondents were as follows: 38 males (16%) and 196 females (84%); 19 people under 30 years of age (8%), 44 people in their 30s (19%), 68 people in their 40s (29%), 82 people in their 50s (35%), and 18 people in their 60s (8%). One hundred and ninety-three people (81%) were born in Canada. A total of 121 (51%) respondents identified themselves as healthcare practitioners, 93 (40%) as support staff, 14 (6%) as managers or administrators, 3 (1%) as academic staff, and 6 (2%) as holding other positions.

Questionnaire

A brief questionnaire was developed to measure the perceived healthcare needs and services of immigrant and refugee children and pregnant women not covered by the *Régime d'assurance maladie du Québec* (RAMQ), the universal health insurance plan in the province of Québec, where Montreal is located. This instrument consisted of 18 Likert-type or multiple-choice questions, plus one open-ended question. The three closed-ended questions that included an open-ended option, and have therefore been included in the analysis reported in this paper, inquired about: (1) the most important problems facing immigrant or refugee children and pregnant women without provincial universal health coverage in accessing healthcare in Montreal, (2) where these groups access health services in Montreal, and (3) the types of health services sought by this population. The final open-ended question asked participants for “any final thoughts or ideas on this subject that [they] would like to share with us.” The instrument was piloted and refined in both English and French.

Procedure and analysis

With the assistance of participating hospitals and health and social services centres, email invitations to complete an online semi-structured questionnaire were sent to staff in all but one sample institution, where invitations were instead included in a weekly email delivered to all staff. The website for the survey (SurveyMonkey) was accessible for two-to-three consecutive weeks between April and June of 2010. As only those who accepted our invitation participated in the survey, the survey was based on a self-selected sample. Participation was informed, voluntary, and anonymous. Aside from professional occupation, responses were not required for any question. The IP addresses for responses were not recorded. Ethical approval was obtained from all participating institutions: the Centre de santé et de services sociaux de la Montagne, and the McGill University Health Centre.

Free text comments were made by 237 respondents, in either English or French. These free text responses were analysed in the language in which they were written, by researchers fully fluent in both language (no translation required). Using a grounded theory approach, they identified the main themes and subthemes. Results were then compared and discussed between the researchers until consensus was reached. Subsequently, coding was performed in NVivo9 by two of the authors and one research assistant, who were also all fully fluent in French and English. Inter-rater reliability was established at 80%. French data was translated into English only for the purposes of publication and only at the final draft stage of publication. Translation was performed by a fully bilingual researcher and edited for accuracy and clarity by another fully bilingual researcher.

Results

Deserving or underserving of universal access to healthcare?

As explained above, from the quantitative analysis of the 1048 responses to the close-ended questions of our survey (Ruiz-Casares, Rousseau, Laurin-Lamothe, Rummens, Zerkowitz, Crépeau, & Steinmetz, 2012), we learnt that a wide gap exists among healthcare workers, between attitudes towards entitlement to universal healthcare access, and the endorsement of principles stemming from human rights and the best interest of the child. We also found that variables such as country of origin, institutional affiliation and profession impact these attitudes. What we then hoped to assess through qualitative analysis of the 237 sets of comments, was how the health workers we surveyed rationalised their positions towards the issue, and what role their country of origin, institutional affiliation and professional role played in shaping their arguments.

However, very few of the 237 sets of comments provided us with a clear window on how these variables concretely frame health workers' attitudes towards entitlement to universal healthcare. In the analysis that follows, we therefore focus solely on answering our first question: how do healthcare workers argue for, or against, providing access to healthcare services for uninsured pregnant women and children? To do so, we will present the various discursive frameworks mobilised in respondents' arguments, paying specific attention to the particular self-evaluations of Québec/Canada's socioeconomic situation, ideological representations of precarious status immigrants, and senses of social connection to them, that appear to be linked to each of these frameworks. Given that respondents who provided answers to the open-ended questions of our survey represent but a small fraction of all respondents (23%), we do not consider the comments analysed here as representative of health workers' attitudes in Quebec overall. As such, we have not enumerated the frequencies of the various arguments exhibited, but instead have reported on the general trends in our data, through the use of terms such as “few”, “some”, or “most”.

Arguments against universal access to healthcare

According to Portes, Light, and Fernández-Kelly (2009), one way to argue against providing unrestricted access to healthcare services for uninsured immigrants is to claim that a problem does not actually exist. Some of the respondents to our survey sustained this point of view, evident through such claims as “[t]o my knowledge, whether the caregiver agrees or disagrees [with providing care to children or mothers with precarious immigration status], uninsured patients receive the same kind of services everyone else receives, all aspects considered” (psychologist/psychoeducator).

Further, those opposed to more open access for uninsured immigrants reasoned that only “illegal” immigrants encountered this

problem since the federal government's Interim Federal Health Program (IFHP) offered coverage to refugee claimants and landed immigrants during the 3 month period prior to becoming eligible for the RAMQ, as was the case when the survey was conducted. This argument then outlined the following reasons to refuse access to these "illegals": (1) the government had legitimate reasons to deny them legal status in the first place; (2) they had no respect for our immigration laws and procedures, and entered the country fraudulently; or (3) once their legal status had expired, they had voluntarily gone underground, and as a result, not contributed income taxes to the funding of our social services, including healthcare. According to this argument, access to healthcare services for pregnant women and children without full insurance coverage was not an issue, since those without coverage were "illegals", and thus unworthy of our care. From this perspective, the only treatments this group should have been eligible for were those that could prevent or cure diseases that constituted a threat to public health.

Nonetheless, most of those arguing against providing full access to healthcare services for uninsured pregnant women and children believed that there was a problem: abuse of the healthcare system by this population, creating a strain on healthcare resources for Canadians, Québécois, and taxpayers. From this perspective, healthcare in Québec was generally perceived as being in a critical state, with proponents frequently making claims such as "[t]he health system in Québec is in the red". Further, immigrants who were partially or completely uninsured were constructed as primarily malevolent "medical tourists" or "professional fraudsters and thieves" spitefully taking advantage of Québec's weakly protected healthcare and social services systems. As discovered by Villegas (2010) in Toronto, those who perceived precarious status immigrants as "fraudsters", particularly despised pregnant women in these situations, either because they delivered "anchor babies" (i.e., Canadian citizens whose birth could be used to deceitfully facilitate their mothers' status regularisation and, with that, access to health and social services), or because pregnant women without legal immigration status were assumed to be non-contributing "medical tourists".

Sentiments of insecurity, frustration, and exclusion were shared by most of those who argued for restricting access. These respondents included mainly support staff and nurses born in Canada, who had either experienced or heard about critical shortages of medical staff in frontline services or specialised care. They believed that the fraudulent abuse of healthcare resources by immigrants with precarious status was the root cause of these shortages, or, at the very least, one of its main contributing factors. As one nurse reflected:

When I have to plead to get a paediatrician for my children and cannot get my family seen by specialists within a reasonable time frame, then see persons without standing in Canada get health care, I become distressed. Alas, at 50% income tax of my household, my parent's household, my friend's household, we should get readily available care.

Feelings of bearing more than one's share of the tax burden as a result of precarious status immigrants' free access to health services also abounded, especially among respondents who identified as support staff. Some further claimed that in the end, immigrants with precarious status were receiving more care than "honest citizens" and "responsible tax payers", a belief that significantly increased a respondent's feelings of frustration and sense of exclusion.

In the face of what all these respondents perceived as critically scarce healthcare resources, and what some viewed as resources unfairly distributed to the advantage of precarious status immigrants, all those who were against providing free access to

healthcare for this population constructed membership in the community of those deserving such care as follows: they had to be taxpayers, have Canadian citizenship, or be born in Québec. Following this line of argument, solutions offered to address what was perceived as abuse of the healthcare system by immigrants with precarious status included "issuing them their (...) RAMQ card only once they have filed their income tax return" (nurse), "proper [immigration] screening (...) to avoid having persons admitted with existing medical conditions who are trying to gain access to our country to take advantage of services to which they would not be entitled in their own country" (support staff), or "limiting access to certain services to Québécois only (such as surgery or family doctors)" (administrator). This final respondent also added, "Aren't people migrating here because of our social services?" Indeed, many of those who perceived partially or completely uninsured immigrants as illegitimate beneficiaries of free healthcare or spiteful fraudsters, also believed that universal access to healthcare in Québec or Canada had the effect of attracting unwarranted numbers of "clandestine migrants". Some also accused Canada and Québec of "criminal benevolence", arguing that the government was aware of the fraud, but neglected to do anything about it.

Arguments for universal access to healthcare

Complex combinations of dominant "health ethics" and "preventive fiscal" frameworks were mobilised when arguing for providing universal access to healthcare to partially or completely uninsured pregnant women and children. As found elsewhere (Gottlieb et al., 2012; Marrow, 2012; Willen, 2011, 2012), arguments that drew on health ethics frameworks usually involved humanitarian, human rights, social justice, or public health principles, while those drawing on the preventive fiscal framework generally made use of arguments emphasizing the higher end cost of restricting or banning access to healthcare services for the host society. Some respondents referred to only one of these principles in their comments, while most combined several or all of them when arguing for universal access to healthcare.

Responses that mobilised the humanitarian framework to argue for universal access prioritised healthcare over "lower financial considerations", and typically constructed precarious status immigrants as "vulnerable subjects" that should be treated, unconditionally, when in need. Insisting on compassion as a fundamental value of Canadian society, and on Canada's duty as a host country to care for all immigrants, one support staff, for example, claimed that "protecting the have-nots is what makes our society a moral and humane one". From this point of view, children with precarious immigration status were conceptualised as the most helpless and therefore the most deserving of healthcare services. For respondents employing humanitarian language, shortages of medical resources were not real issues: "We certainly have the funds, they are just often mismanaged" (support staff). Moreover, if abuse existed, it did not stem from fraudulent "illegal" migrants, but rather from healthcare workers, as argued by a support staff who referred to the existence of a clandestine network of doctors willing to deliver uninsured pregnant women's babies in exchange for a fee. After sharing the story of a pregnant undocumented woman whose baby had died in utero after she was denied healthcare access, a nurse asserted that workers should have compassion and "believe that the person is not always acting in bad faith, wanting to take advantage of the system".

Responses in favour of unrestricted access that drew on the human rights framework viewed medical care as a fundamental human right. From this perspective, uninsured immigrants were perceived as "subjects of rights" that Canadian officials were obligated to provide health services for upon admittance into the country. As a result, medical care should be accessible to all,

irrespective of client status and associated costs: “Anyone needing medical attention should be given that right no matter what status he or she has”, asserted an academic staff; “Healthcare is a human right, not a financial issue”, further argued a support staff. While some respondents using this framework stressed Canada’s obligation to provide care, as “a civilised country”, others quoted international human rights conventions to more specifically proclaim the right to healthcare of undocumented children.

Social justice arguments for providing healthcare access to all, with or without full insurance coverage, considered healthcare an economic resource to be shared unconditionally. Conceptualising migrants as aspirants to full membership in Canadian society, respondents who employed this framework warned us of the dangers of discriminating against immigrants with precarious status. For instance, as one social worker argued “It is through refusals that refugees [whose claims have been denied] come to see themselves as different from the other members of our society, as excluded persons”. A common sentiment among the respondents with this perspective was a feeling of being privileged, from an international point of view, and therefore indebted to those less so.

Responses that were couched in the public health discourse valued both individual and societal wellbeing as priorities, and saw such wellbeing as dependent on unrestricted access to social and health services. Indeed, as one practitioner stated, “Healthy individuals make up a healthy society”. From this perspective, healthiness was usually conceptualised based on a social determinants approach to wellbeing (Public Health Agency of Canada 2012), which considers the numerous social factors that influence a person’s ability to become healthy. For instance, another practitioner argued that “[a]ccess to schools and daycares is also an issue”, further claiming:

Parents must work to provide for their families’ basic needs, and children who do not go to school experience academic delay, social exclusion, and unwarranted stress, [which in turn has] important repercussions on the whole society.

From this point of view, uninsured children and pregnant women were thus seen to be particularly vulnerable to physical and mental health problems, and as potential vectors of individual and societal disorders, their access to healthcare would be to the benefit of all.

Finally, respondents employing the “preventive fiscal” framework for claiming full access to healthcare services for uninsured immigrants perceived such care as an economic resource that ultimately, could not be denied to anyone. For those with this perspective, healthcare had to be offered without restriction, as the cost of not providing care, or of providing emergency care only, would be higher than the cost of preventive care itself. Moreover, uninsured immigrants were perceived by these respondents as legitimate consumers of free healthcare services, and thus, people who should be encouraged to access services as soon as they fell ill or required follow-up (as in the case of pregnancies). Furthermore, since this viewpoint may have been frequently challenged in their working environments, respondents taking this position oftentimes underlined the need for “education”, or for thinking creatively and with a broader perspective, in order to effectively address the issue. Frequently, they also stressed Québec’s labour market need for immigrants, and the fiscal advantage that could be gained if such immigrants were well integrated and healthy.

Tensions and dilemmas

While approximately two thirds of responses to the open-ended survey questions consisted of rationale either against or for providing full access to healthcare for women and children with

precarious immigration status (around one third for each position), the other third incorporated reasons to support both positions, in this way evoking the tensions at play between abstract conceptualizations of a universal right to healthcare and practical engagements with its implementation.

Typically, these responses began with a preface such as “this is a complicated issue” (psychologist/psychoeducator) or “it’s difficult to resolve [this dilemma]” (support staff), before addressing reasons both for and against providing access. For some respondents, the conflict was so intense that they shared how completing our survey had been an emotionally taxing experience for them.

Most of our respondents who expressed division over this issue opposed humanitarian or professional principles based on their perception that healthcare resources in Québec and/or Canada were critically scarce. Abuse of the system was another important preoccupation for this group. Oftentimes, respondents asserted that while they did not support restricting access to healthcare for truly vulnerable subjects, including “children”, “poor and destitute women”, “real refugees” and “emergency cases”, they did adamantly condemn the exploitation of a severely limited healthcare system by “illegals”, “false refugees”, “medical tourists” or “wealthy pregnant women”, believing it further deprived taxpayers, Québécois and Canadians of proper care.

Ultimately, the fundamental question in this dilemma appeared to be about the extent to which Québécois and/or Canadian taxpayers were willing to assume the cost of caring for others. As a physiotherapist/occupational therapist phrased it:

I know by experience that uninsured foreigners become heavily indebted when their children are medically treated, and that hospitals (and therefore taxpayers) do not succeed in receiving full reimbursement for these expenses. It is a very challenging debate for our society. (...) Are we willing to share some of our relative wealth? In some ways, it’s a form of indirect charity.

Instead of referring to humanitarian or professional values, a few respondents opposed the human right to healthcare of some individuals (including those who are undocumented), to the belief that limited health resources in Québec and Canada were being abused by “medical tourists”. Others cited public health concerns as reasons for providing access when articulating their dilemmas. Another position, albeit one that only a small number of survey respondents reflected upon, opposed the humanitarian principle of emergency care due to concerns about respect for the rule of law. As one support staff claimed:

I don’t have any problems with providing emergency medical service but I do believe that illegal immigrants should be deported after [they have been treated]. (...) If they are illegal that means that they don’t respect our justice system.

Discussion

When the right to health for immigrants with precarious status becomes a privilege

Practical engagements with the implementation of rules of access to universal healthcare services in Québec, as elsewhere (Castañeda, 2012; Gottlieb et al., 2012; Horton, 2004; Willen, 2011, 2012), are fraught with tensions. In a socioeconomic context marked by increasing cuts to universal healthcare coverage, drawing boundaries between who “deserves” free medical care and who does not involves conflicting ideas about the costs and affordability of medical treatments, in addition to contrasting perceptions of host societies’ moral obligations, and the perceived worth of precarious status immigrants.

In Canada, administrators, support staff and clinicians in hospitals and community health centres are confronted with major legal limitations surrounding the provision of services to uninsured individuals, most notably, lack of reimbursement by the State. Although a few of the health workers who answered the survey's open-ended questions did not believe that such restrictions were problematic (since they assumed that individuals with precarious immigration status received care no matter what), most did express some concerns. Interestingly though, these concerns were grounded in two very contrasting, yet often intertwined, interpretations of the impact of the current legislation, highlighting the social divisiveness of this issue. While some believed that the rules of access and their implementation were not strict enough, leading to abuse of the system by "illegal" immigrants, others argued that on the contrary, these measures and their enactment were too severe, and that critical medical care was being denied as a consequence.

Divergent assessments of Canada's and Québec's financial capacity to offer universal health coverage to all residing within the state and province, contrasting perceptions of precarious status immigrants, as well as different senses of one's moral obligation towards this group play crucial roles in shaping these two positions. On the one hand, our respondents who argued against providing access to universal coverage for not fully insured pregnant women and children, generally tended to perceive the governments of Canada and Québec as unable to offer health coverage to all residents within their borders. For them, medical resources were too scarce and taxpayers could not contribute any more to their funding. These respondents were also inclined to construct all partially or completely uninsured immigrants as "fraudsters", and therefore, as people "undeserving" of free medical care. From their point of view, those they were morally bound to care for only comprised fellow citizens and taxpayers. On the other hand, respondents who argued for providing universal access to healthcare tended to view the governments of Canada and Québec as fully capable of offering health coverage to everyone living within their boundaries. For them, resources had become scarce as a result of their mismanagement, not because a veritable shortage existed. Those who were in favour of universal access also tended to perceive precarious status immigrants as either "vulnerable subjects" (humanitarian and public health framework), "subjects of rights" (human rights and social justice framework), or "legitimate consumers of healthcare services" (preventive fiscal framework), and therefore, as people fully "deserving" of free medical care.

Between the two ends of this spectrum were those who felt divided over the issue of universal access to healthcare for not fully insured pregnant women and children. Most of this camp believed, like some who argued for universal access, that as "vulnerable subjects" or "subjects of rights", immigrants with precarious status deserved healthcare. Nonetheless, like all of those who argued against universal access, they also thought that scarce healthcare resources in Québec and Canada were the result of their abuse by "illegal" immigrants, and that healthcare services should therefore be limited to rightful beneficiaries, such as citizens and taxpayers. Among those expressing this predicament, some held a more nuanced view of not fully insured immigrants, and felt conflicted over the idea of barring access to services for this group, recognising that amongst them were "children" or "poor and destitute women". Others though, held more negative views of uninsured immigrants, or expressed concern for respecting the rule of law, allowing them to rationalise their support for reserving free medical care for citizens and taxpayers only.

As outlined in the introduction, the quantitative analysis of responses to the close-ended questions of our survey revealed the existence of a wide gap between attitudes towards entitlement to healthcare, and the endorsement of principles stemming from

human rights and the best interest of the child (Ruiz-Casares et al., 2012). Indeed, while more than half of our respondents were in favour of extending services to not fully insured pregnant women and children based on child development considerations (68.6%), or human rights principles (61.1%), a greater number were in favour of restricting access given abuse of the system by the uninsured (82.8%). Hence our conclusion, drawing on the qualitative analysis of the survey's comments, that while abstract values may lead some healthcare workers to perceive uninsured immigrants (and more specifically pregnant women and children) as "deserving" of universal access to healthcare, pragmatic considerations push most of them to consider these immigrants as "underserving" of free care. This conflicted process, in which theoretical appraisals of these immigrants' right to universal healthcare are opposed by grounded moral evaluations of the group's actual "deservingness" of healthcare, is important. Not only does it illustrate the gap between ethical discourse and moral positioning (Kleinman, 1998), but it also highlights the growing divide between entitlement and implementation in the domain of access to healthcare for precarious status immigrants, and points to the erosion of legal and political rights of access (Ruiz-Casares, Rousseau, Derluyn, Watters, & Crépeau, 2010). What seems to bear most influence in shaping healthcare workers' attitudes towards this issue are pragmatic considerations of their government's capacity to afford care for this population. These concerns are themselves grounded in personal experiences of difficulties accessing care, as well as dominant representations of the root cause of such difficulties: the abuse of Québec's universal health system by "fraudsters".

According to Holmes (2012), medical training, clinical experiences and narratives on migrant patients all contribute to clinicians' attitudes towards this migrant group. Beyond the scope of our study is an analysis of the role played by larger political, economic, social, and cultural forces in shaping the particular local worlds through which healthcare workers in Canada assess the "deservingness" of immigrants without legal status to universal healthcare. Some open-ended answers to our survey nonetheless suggested that media coverage of undocumented immigrants may play a significant role in their portrayal as "fraudsters". For instance, a few of our respondents referred to an alarmist story depicting illegal networks of "medical tourism" that had been broadcasted several months prior to the questionnaire on Radio-Canada, Canada's francophone public broadcasting corporation. The story featured a non-resident Lebanese woman seeking and gaining access to Québec's public services (Gagné, 2009), and described how although public authorities had been alerted to the scheme, they were either slow or ineffective at putting an end to it. In the meantime, so the story went, Québec taxpayers had been subsidizing rich medical tourists and crooked migration entrepreneurs.

The reality though, as elsewhere (Chavez, 2012), is that most immigrants with precarious status who attempt to access healthcare services in Québec are not "medical tourists" shamelessly seeking ways to take advantage of services subsidised with the income tax collected from honest residents of Québec. Indeed, also part of our larger study was a review of 1552 emergency files of uninsured children in three paediatric hospitals in Montreal and Toronto (Rousseau et al., in press), which revealed that the proportion of "visitors" (i.e., children not residing in Canada) was in fact very small (from 1.1% to 11.5% of uninsured children). Thus, as many scholars have suggested, we should instead look at how precarious status and illegality have been institutionalised and created by immigration policies in recent decades to produce multiple and potentially variable ideas about "undeservingness", and restrict social services (Crépeau & Nakache, 2006; De Genova, 2002, 2004). For many individuals who live in Canada and become "illegal", this condition of "illegality" is a risk factor for

their own health, their children's health, social vulnerability and abuse, in many different contexts (Castañeda, 2009; Larchanché, 2012; Simich, 2007). Moreover, while most immigrants without legal status do not pay income tax, it should be noted that they do nonetheless contribute to the public funding of education, health, and social services through provincial and federal sales taxes (Soave Strategy Group, 2006). Many undocumented workers also subsidize life and disability insurance funds, as well as health and pension plans, through false social insurance numbers, but without the privilege of being able to access these services (Parkdale Community Legal Services, 2005).

Conclusion

Drawing on her ethnographic study of a human rights organization offering primary healthcare services to unauthorised immigrants in Tel Aviv, Israel, Willen (2011) convincingly demonstrates how the meaning of the “right [to health] broadens, contracts, shifts, and evolves as it cycles through divergent spheres of discourse, policy and practice” (Willen, 2011, p. 309). If some clinicians who worked in the facility she studied viewed the right to health as but one among many rights on their agenda for a more inclusive state, others adopted a distinctly humanitarian interpretation. They focused on immediate health concerns while averting larger questions of unauthorised migrants' rights. Hence, what for the first group constituted a *political* right, more narrowly involved for the second group the *moral* recognition of their patients' “bio-legitimacy” (Fassin, 2009): the legitimacy of their *suffering* bodies.

According to various scholars (Castañeda, 2011; Viladrich, 2012; Willen, 2011), this humanitarian conception of the right to health, which stems not from the realm of citizenship, but from the realm of compassion, and therefore, moral sentiments, has become dominant in scholarly and public discourses concerning undocumented immigrants' rights to healthcare. The arguments deployed by our respondents to debate for or against providing access to not fully insured pregnant women and children further illustrate this. In their comments, very few constructed the uninsured as “subjects of rights”; rather, they highlighted these migrants' moral (un)worthiness to care. This humanitarian conception of the right to health is deeply problematic. “Humanitarianism”, warns Ticktin, “is about the exception rather than the rule, about generosity rather than entitlement” (Ticktin, 2006, p. 45). As a result, it has the detrimental effect of producing unequal humanities, or in other words, creating hierarchies of “deservingness”: humanities “always reckoned in relative terms” (Willen, 2012, p. 814). We can clearly see how this is taking place among the healthcare workers we surveyed. In a context characterised by ongoing cuts to public spending, the right to health of precarious status immigrants has become for a majority of them a “privilege”, that as taxpayers, they are less and less willing to contribute to. Having experienced challenges in accessing healthcare services for themselves or their loved ones, most of our survey's respondents tended to perceive uninsured immigrants as a “threat” to their own well-being, and therefore, as people “undeserving” of their care.

This widespread erosion of the right to health for immigrants with precarious status needs to be situated within our increasingly globalized world, where frontiers are seen as either more and more porous or progressively impenetrable, depending on one's position in the global chessboard (Sassen, 1999). On the one hand, the desire for most of our respondents to limit uninsured immigrants' access to health services reflects heightened feelings of threat by what the “others” may represent in a context of shifting power relations (Jamil & Rousseau, 2011), and the associated fear of losing privileges in times of perceived economic fragility. On the other hand, the aspiration of some of our respondents, and ourselves, to improve

uninsured immigrants' access to health services, echoes the perception that such privileges can be unfair, and that we should therefore move towards transnational forms of solidarity (Flynn, 2009).

We argue that universal access to healthcare for immigrants with precarious status should indeed be reconsidered as constituting a right, not a privilege. Even if health, as a human right, is often not justiciable because it is rarely constitutionally entrenched (Cole, 2009), and understanding health as a human right may detract attention from underlying structural issues by reducing human health to an individual concern (Castañeda, 2011), still we believe that this conceptualisation of health has the symbolic power to challenge the increasingly dominant view of healthcare as a “privilege” only “deserving”, i.e. law-abiding, taxpaying, responsibly consuming national subjects, are entitled to access. Certainly, from a human rights perspective, the obligation upon states to respect the right to health means not just refraining from denying or limiting equal access to healthcare for *all* persons. Indeed, as argued by Schaap (2011), who draws on Rancière, it also involves recognizing such persons as full political subjects with the inherent right to rights. “[T]he human' in human rights does not refer to a life deprived of politics [as Arendt argues], ... [but to a] litigious name that politicises the distinctions between those who are qualified to participate in politics and those who are not” (Schaap, 2011, p. 22).

To move in this direction, open discussions about the issue are required. As conversations take place within medical institutions and between stakeholders at all levels, they will help challenge misconceptions about the nature of precarious status migrants' “illegality”, their socioeconomic circumstances, and their contributions to the host society. As suggested by Willen, Mulligan and Castañeda (2011), the provision of accurate, factual information about the rights of migrants with precarious status, their genuine position in the global marketplace, and the vulnerability of their health on the one hand, and the creation of safe spaces for discussion on the other, are necessary at the societal and institutional levels to ensure access to healthcare is recognised as a right, and no longer seen as a privilege.

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