Borderzones and the politics of irregularisation: the Interim Federal Health Program and Toronto’s everyday places of healthcare

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Abstract: Engaging with the concept of borderzones, this article critically analyses the irregularisation of refugee claimants residing in Toronto, Ontario, Canada. Specifically, attention is placed on the Interim Federal Health Program (IFHP), a federal health insurance program provided to refugee populations, and how it was experienced in everyday healthcare places. Drawing on semi-structured interviews with doctors, lawyers, social workers, and refugee claimants, this article empirically demonstrates irregularising bordering practices within these everyday places, and how refugee claimants and allies challenged such practices through, what I term, acts of liberating irregularity. Overall, this article sheds new light on the role of borders in the processes and politics of irregularisation within the Canadian asylum context.

Keywords: borderzones; borders; irregularisation; irregularity; irregular; refugee claimants; Interim Federal Health Program; IFHP; healthcare; resistance; acts; Toronto.

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1 Introduction

As a signatory to the 1951 Convention Relating to the Status of Refugees, and its 1967 Protocol (UNHCR, 2015), Canada is obligated to respect and maintain the rights of refugees within the country, however, this is not always the case. From June 2012 to April 2016, refugee claimants – persons who have fled their country and made an asylum
claim in another country – faced restrictions to basic healthcare services across Canada as a result of amendments made to the Interim Federal Health Program (IFHP), a federal health insurance program provided to refugee populations. Implemented by the Conservative Party under the leadership of Stephen Harper, these amendments intended to ‘defend the integrity’ and deter the abuse of Canada’s refugee system [Canadian Doctors for Refugee Care et al. v. Canada, (2014), p.18]; in actuality, they aimed to force those seeking asylum in Canada to leave more quickly, and to deter others from making an asylum claim [Canadian Doctors for Refugee Care et al. v. Canada, (2014), pp.7–8]. Situated within a broader context of restrictive legislative changes introduced in 2012, the IFHP represents one means to control refugee populations within everyday healthcare places, such as doctor’s offices, walk-in clinics, and hospitals. Here, many refugee claimants were denied access to basic healthcare services even though they continued to have some coverage. However, throughout this time numerous protests and campaigns erupted across the country to challenge the IFHP. Also, networks and spaces emerged to offer access to healthcare services to refugee claimants. As a result of the protests, as well as a shift in national discourse surrounding the plight of refugees and a change in federal leadership, the IFHP was reinstated in April 2016 (Government of Canada, 2016a).

In this article, I analyse the IFHP and its impacts within the context of Toronto, Ontario, where the majority of refugee populations coming to Ontario settle (City of Toronto, 2017a). I outline how the amendments to the IFHP can be understood within the broader context of migration management, and how they were experienced and challenged on the ground. I do this by engaging with the concept of irregularisation in relation to everyday bordering practices. The concepts of ‘irregularity’ and ‘irregularisation’ represent an attempt to move away from the problematic notion of ‘illegality’ that criminalises mobile populations, and delegitimises and diminishes their strategies and agency [Squire, (2011), p.4]. Irregularisation moves away from the production of forms of (il)legal status to attend to the production of conditions of irregularity that reflect one’s abnormalised or unwanted presence within the state, regardless of status. In this article I discuss how refugee claimants (who are authorised temporary residents) were irregularised within everyday healthcare places as a result of the IFHP. I view these places as borderzones, sites of homogeneity and consistency that directly affect notions and reify limits of belonging, and contribute to the production of irregularisation. However, I also conceive of irregularisation as consisting of resistance, which can occur in visible and conventional ways, such as through a Federal Court challenge, public protests, or the implementation of various policies, as well as less visible and unconventional ways, such as through system navigation and word of mouth. I define all of these forms of resistance as ‘acts of liberating irregularity’. In this regard, I ask: How can we conceive of the politics of irregularisation within the Canadian asylum context? In responding to this question, this article offers new empirical insight into issues of control and resistance through a critical analysis of the IFHP and Toronto’s everyday healthcare places.

The article is presented in three sections. First, I provide a conceptual overview of my approach to irregularisation and its relation to borders and bordering, as well as acts of liberating irregularity. Second, I detail the practises and experiences of bordering and irregularisation within everyday places of healthcare in Toronto. Third, I discuss how irregularisation is challenged and (re)negotiated by refugee claimants and allies through
‘acts of liberating irregularity’. Methods of data collection and an overview of the IFHP are first detailed below.

1.1 Methods and data

Research for this article comprised of semi-structured qualitative interviews, with 43 participants in Toronto, Ontario, from September 2015 to March 2016. Participants included doctors, lawyers, settlement workers, policy specialists, Executive directors of refugee agencies, Ministry officials, City officials, and refugee claimants. Participants were initially contacted through e-mail and cold-calling, and I also secured participants through referral. Interviews were audio-recorded and lasted an average of 45 minutes. They were conducted in a variety of settings: a public library, refugee agencies, homes, offices, and occasionally by telephone. I relied upon academic and grey literature to identify key actors and organisations, and utilised critical discourse and document analysis of relevant governmental and non-governmental documents and reports.

2 The IFHP

Introduced in 1957 through Order-in-Council PC 157-11/848, the IFHP is a federally administered program managed since 1995 by Immigration, Refugees and Citizenship Canada (IRCC), previously Citizenship and Immigration Canada (CIC), that provides limited, temporary coverage of healthcare benefits to resettled refugees, refugee claimants, and other protected persons who are not eligible for provincial or territorial health insurance, or private health insurance [Government of Canada, 2016b]. The IFHP pays for basic healthcare, preventative/supplementary care, and coverage for most medications; basic healthcare coverage is equivalent to provincial coverage offered to citizens and permanent residents, and supplementary and medication coverage is equivalent to that provided to citizens or permanent residents on social assistance. The stated goal of the program is to “contribute to optimal health outcomes in a fair, equitable and cost effective manner” [Government of Canada, (2006), p.5]. However, in 2012 the program was drastically amended.

On April 25, 2012, Minister of Immigration Jason Kenney announced that changes would be made to the IFHP, which took effect on June 30, 2012. On this date, the 1957 Order-in-Council was replaced by a 2012 Order-in-Council, Order Respecting the Interim Federal Health Program, 2012, that restricted basic healthcare coverage to urgent and/or essential services, and cut coverage for supplemental benefits and medications (Government of Canada, 2012a). These cuts were presented as a means to protect Canada’s refugee protection system from ‘bogus’ refugees, and as a cost saving measure that would save $100 million over the next five years (Government of Canada, 2012a, 2012b).

Since 1957, the IFHP provided the same basket of services for all refugee populations. The newly revised IFHP hierarchically ranked and organised refugee populations into different categories of healthcare coverage: expanded healthcare coverage, healthcare coverage, and public health and public safety (PHPS) coverage. Refugee claimants not from a designated country of origin (DCO), also known as a ‘safe’ country, received ‘healthcare coverage’ which includes most services received from a doctor or nurse, limited access to diagnostic tests and hospital services, and no
medication except to prevent or treat a disease or condition that poses a public health and safety threat. Refugee claimants from a DCO received PHPS coverage, which only provides coverage for medications or services that prevent or treat a public health and safety threat (Government of Canada, 2012c). This meant that life sustaining medications, like insulin, were no longer covered.

The IFHP categories constructed legitimate and illegitimate healthcare needs and lives based upon status and country of origin. But, the amendment also distinguished between those refugee claimants who made a claim at a port of entry and those who claimed inland. Prior to the cuts, port of entry claimants received their IFHP coverage almost immediately while inland claimants would receive a temporary IFH certificate until the date of their eligibility hearing. After 2012, inland claimants were no longer issued this temporary coverage, meaning they did not have coverage until their eligibility hearing [Canadian Doctors for Refugee Care, et al. v. Canada, (2014), p.41], which could take up to two months. If a refugee claimant required healthcare services within this time, it must be paid out of pocket. According to one refugee claimant:

“I have a friend who got sick before he got the [certificate] and he had to pay for the medication. Yeah he was very sick [...] He was turned down from all the places he went. But he got a doctor at some clinic that offered to treat him but he had to pay, but he had no option, he paid for the treatment. Probably around one hundred and thirty dollars.” (Interview with Refugee Claimant, Toronto, 11 March, 2016)

Pregnant refugee claimants who claim asylum inland were particularly affected by this change. As one doctor states, “we’ve seen women who have arrived in the country […], claim [inland], but then had to wait until they meet an eligibility officer six weeks later, but they’re pregnant and due in the next six weeks” (Interview with Doctor, Toronto, 20 October, 2015). While the differentiation between inland and port of entry claimants reflects the criminalised presence of those refugee claimants who do not claim at the border, the overall healthcare cuts speak to how the government was ‘getting out the message’ that a refugee claimant who arrives on their own volition, “is somehow doing it wrong, is jumping a queue, is illegal, is bogus, etcetera” (Interview with Lawyer, Toronto, 7 October, 2015). This attempt to control migration through healthcare is not specific to Canada nor is it new; foreign nationals are deemed medically inadmissible to Canada if their health condition is likely to be a danger to public health or public safety, or if it might cause “excessive demand on health or social services”\(^5\), the latter of which may include common health conditions like diabetes (Desloges and Ling, 2013; see http://ccrweb.ca/en/res/medical-inadmissibility). However, organisations and refugee populations contested the IFHP changes and their negative impacts. By far the most visible came in the form of a Federal Court challenge.

The Canadian Doctors for Refugee Care (CDRC), the Canadian Association of Refugee Lawyers (CARL), and Justice for Children and Youth (JFCY), along with two refugee claimants, Daniel Garcia Rodriguez and Hanif Ayubi, brought the Canadian Government to Federal Court to challenge the legality of the IFHP changes. They argued the cuts were unconstitutional and inconsistent with Canada’s international obligations to refugees, as stated in the 1951 Refugee Convention and the Convention on the Rights of the Child. They also argued the cuts were in violation of Section 7 (the right to life and security of the person), Section 12 (cruel and unusual treatment), and Section 15 (discrimination) of the Canadian Charter of Rights and Freedoms (Canadian Doctors for
Refugee Care, et al. v. Canada, 2014; CARL, 2013). On July 4, 2014, the Court ruled the
cuts were in violation of Sections 12 and 15 of the Charter, with the Section 12 ruling of
‘cruel and unusual treatment’ constituting a first in a non-criminal case. This ruling is
particularly important for those challenging cuts to social programming, considering
there had previously been little success in this realm. It also shows that government
actions that subject human beings to forms of suffering will not go unchallenged in the
country (Voices-Voix, 2014; CARL, 2014a). The Court ordered the government to draft a
new Charter-compliant policy within a four-month timeline. The government appealed
the ruling and requested to suspend the decision until the appeal was heard, which the
Federal Court of Appeal denied, ruling “the harm of continuing to deny refugees health
care pending the resolution of the government’s lengthy appeal was greater than the
inconvenience of requiring the government to reinstate the IFHP” (CARL, 2014b). As a
result, on November 4, 2014, the government introduced the ‘temporary IFHP’ that
restored full benefits to pregnant women and children, and gave all refugee claimants
regardless of country of origin coverage for laboratory and diagnostics, doctor and
hospital services, and medications to treat public health and safety risks (Government of
Canada, 2014). The victory was short-lived however because the revisions maintained
complexity and confusion within the program through the introduction of six types of
healthcare coverage. As one refugee doctor explains:

“now there’s different coverage if you’re a child, versus if you’re a pregnant
woman versus if you’re an active refugee claimant versus if you’re from a
moratorium country versus if you’re rejected before your date of deportation, if
you’re [...] port of entry claim, inland claim, and that’s just refugee claimants.”
(Interview with Doctor, Toronto, 20 October, 2015).

In addition to the complexity and confusion, the negative political discourse that
surrounded the process had a considerable impact on the situation of refugee claimants
within everyday healthcare places, such as doctor’s offices, clinics, and hospitals. As
some interview participants note, “people who continued to have IFH coverage could be
refused care, and it was partly because [...] there was so much political rhetoric around
bogus refugees who were being made ineligible for care” (Interview with Policy Analyst,
Toronto, 21 October, 2015) or because health professionals were uncertain if providing
care to refugee claimants was legal (Interview with Doctor, Toronto, 20 October, 2015).
These issues persisted within everyday healthcare places until spring of 2016.

In August 2015, Stephen Harper dissolved Parliament for a general election to be held
on October 19, 2015. His main opponents, Justin Trudeau of the Liberal Party and Tom
Mulcair of the New Democratic Party (NDP) ran on a platform of enhanced refugee
rights, including the reinstatement of the IFHP, and increasing the numbers of resettled
19, Justin Trudeau and the Liberals won a majority government. They dropped the court
appeal of the IFHP and officially reinstated the program to its pre-2012 coverage in April
2016. Now refugee claimants receive: basic coverage (hospital services, services from a
healthcare professional, pre- and post-natal care, laboratory, diagnostic, and ambulance
services), supplemental coverage (limited vision and urgent dental, home and long-term
care, assistive devices, and services from allied healthcare practitioners such as
psychologists or therapists) and prescription drug coverage.

In the next sections, I map out the concepts of irregularisation and irregularity and
explain how the framework of ‘borderzones’ enhances our understanding of the
irregularisation of refugee claimants. I then apply this framework to explore the effects of the IFHP within the context of Toronto’s everyday healthcare places from June 2012 to April 2016.

3 Irregularisation, borderzones, and acts of liberating irregularity

The concept of irregularity is used to define mobility or residency that is unregulated or unauthorised. Those migrants who move or reside in irregular ways are labelled irregular migrants (Bloch and Chimienti, 2011; Johnson, 2014). For example, McNevin [(2009), p.165] defines irregular migrants as “having crossed state borders or remaining in state territory without the explicit and ongoing sanction of the host state. They may be stateless persons, asylum seekers, refugees, or labour migrants who have overstayed their visas or evaded immigration clearance”. Similarly, Düvell [(2011), p.288] argues that the main paths into irregularity are “legal entry and overstaying or legal entry and stay whilst working in breach of immigration regulations”. However, for scholars like Hepworth (2014) and Squire (2011), irregularity does not always correspond with unauthorised movements, actions, or legal status. Rather, it can be conceived of as an experiential condition that “migrants and citizens move in and out of depending on whether their movements and activities are targeted for control” [Squire, (2011), p.8]. The production of irregularity is termed ‘irregularisation’ which entails processes of securitisation and abnormalisation that inform various practices, policies, and discourses of control. The interpretation of these policies, practices, and discourses by actors works to question – and render irregular – the legitimacy of one’s presence or activities within a space [see Squire, (2011), pp.6–14; see Hepworth (2014), p.4]. In this sense, irregularity is not the stripping of one’s status nor is it the granting of a particular status. Rather, irregularity is an exposure to, or embodiment of, control that is individual, contextual, and inconsistent, and entails experiences of insecurity, abnormality, and reduced rights. According to Squire [(2011), pp.6], (re)bordering practices that deny or reduce rights determine irregular movements and activities. In order to better understand irregularity and how it is produced, I engage with the concept of ‘borders’.

Moving away from situated, territorial understandings, scholars now analyse borders as divisive multiscalar and multidimensional processes that consist of various (dis)connecting elements and social constructions (produced by actors, organisations, objects, practices, representations, discourses, symbolic expressions of territorial identity, and policies) in (un)expected places within and beyond the state to regulate movement (Sohn, 2016; DeGenova, 2013; Mezzadra and Neilson, 2013). As a result, borders are now commonly understood in their multiplicity, or in other words, the multiple ways in which borders are articulated and enacted in various contexts. Bordering (re)configures everyday spaces in ways that deny or reduce rights, and exclude and filter out ‘others’ by determining certain movements and activities as irregular [Squire, (2011), p.6; Laine (2016), pp.469–470, p.474]. This is achieved through various border technologies and techniques of identification [Monforte, (2016), p.415], such as databanks and identification documents that are utilised by employers, landlords, or healthcare providers to identify and regulate mobile populations, such as refugees, and exclude them from accessing services [Weber and Bowling, (2004), p.201; Weber, (2012), p.38, p.40]. Within everyday sites such as healthcare centres, the functions, forms, and effects of
borders depend on documentation and data that allow some to move through these sites with ease, but stop others and marks them as irregular or out of place. This is seen with the IFHP, which limited refugee claimants’ ability to access healthcare services. In order to grasp how borders transform spaces of everyday life into strategic sites of regulation and irregularisation, scholars are using with the concept of ‘borderzones’.

The concept borderzones highlights how the nature and function of borders are changing in delocalised and diffuse ways that directly affect conceptions, and reify limits, of belonging [Monforte, (2016), p.415]. They can be thought of as strategic sites of regulation and policing located in everyday life [Inda, (2011), p.79]. Here, individuals are identified, classified, categorised, and monitored against standards and norms. Any presence or action that does not reflect the standard or the norm is deemed abnormal or irregular and subject to restrictions that may circumvent rights; the contrast between the abnormally IFHP document and the standardised provincial health insurance card, which I discuss below, illustrates this. The restriction of rights and experiences of marginality and insecurity that occur as a result of identity verification in everyday places can be termed the ‘irregularising effect’ of borderzones [Rygiel, (2011), p.149; Nyers, (2010, 2008), p.132, p.129]. For example, in Toronto’s everyday healthcare places, refugee claimants experience fear and insecurity because of perceived risks of persecution due to their status. As one doctor explains,

“I’ve even had patients that have asked me if the government will know that they’re seeking healthcare services and whether they should not seek them because maybe the government will then think that they’re costing the system too much and then they will not approve their refugee claim. So there’s a lot of fear, there’s a lot of uncertainty.” (Interview with Doctor, Toronto, 20 October, 2015)

This experiential condition of irregularity is reminiscent of DeGenova’s [(2013), p.1188] concept of deportability, a disciplinary bordering mechanism that is a ‘defining and enduring feature’ of non-citizens, such as refugee claimants. It exemplifies the lived experience of borders through the realisation of one’s vulnerability to borders and of one’s irregularised condition. However, it is important to be aware of how borderzones are, as Squire (2011, p.4) states, “marked by the intensification of political struggles over the condition of irregularity”. In this article, such struggles are referred to as acts of liberating irregularity.

Drawing from Isin’s (2008) theorisation of acts of citizenship, I define acts of liberating irregularity as deeds that seek to liberate, however momentarily, irregularised populations from experiential conditions of irregularity. These acts prioritise justice and equity, and aim to make a difference in the lives of refugee claimants by changing existing relations and practises and/or altering existing knowledges and understandings. These are disruptive moments of solidarity that are expressed in visible and less visible ways, ranging from major protests and campaigns, to letter writing and sharing stories, and they yield a potential to incite other actions or effects that can lead to other transformations. In the section below, I discuss the irregularising effects of borderzones within everyday healthcare places in Toronto. I follow this discussion with an analysis of the various forms of acts of liberating irregularity enacted by both refugee claimants and allies.
3.1 Irregularising refugee claimants in Toronto’s everyday healthcare places

Various factors and marginalising techniques that enact borderzones determine how refugee claimants experience Toronto’s everyday healthcare places. Actors, discourses, regulations, standards, knowledge’s, data, and documentation all work to restrict, and sometimes exclude, refugee claimants from accessing healthcare services. Such forms of restriction exemplify irregularisation [Nyers, (2011), p.195].

One of the most important elements of irregularisation is the IFHP certificate. In Ontario, citizens and permanent residents receive healthcare coverage through the Ontario Health Insurance Program (OHIP), which is verified through an OHIP card. This card should be presented to frontline staff at every visit to a healthcare centre to demonstrate that the holder is insured through the province. As long as the card is valid that is the extent of the process. The IFHP operates differently since it is a federal program. In order to provide healthcare services to IFHP beneficiaries, doctors must register as an IFHP service provider with Medavie BlueCross (hereafter BlueCross), the insurance company that administers the program. Upon entering a healthcare facility that provides care to IFHP holders, refugee claimants present their Refugee Protection Claimant Document to medical staff. Key to this document is an eight-digit client identification number that verifies whether or not the person is eligible for services. Providers verify this number by contacting BlueCross, either by phone or online at every visit prior to receiving services [Medavie Blue Cross, (2014), p.6]. Confirming an identification number may take time if the system is being updated, which can create backlogs in the waiting room. A Director of Policy elaborates: “you need to have your medical receptionist calling up BlueCross and checking eligibility and sometimes there were problems at the BlueCross end and it took three days for the system to be updated” [Interview with Director of Policy, Toronto, 21 October, 2015]. Cases also exist of BlueCross denying valid requests as a result of communication and administrative problems [Barnes, (2013), p.6]. In addition to contacting BlueCross, the provider must also confirm the identity of the patient either by the photograph on the document or through another government issued photo ID [Medavie Blue Cross, (2014), p.9]. Once the patient is confirmed as having coverage, services may be provided; if a service requires prior approval, such as prosthetics, or some forms of dental care or therapy [Government of Canada, 2011], providers must consult the IFHP Benefits Grid and then submit a prior approval request to BlueCross [Medavie Blue Cross, (2014), p.15]. After the doctor or nurse treats the patient, they must submit a claim that includes client information, the ID number, the medical professional’s information, and claim information. The provider must also fill out the appropriate claim form that applies to that particular health benefit, agree with the Terms and Conditions and confirm that the claim is true and accurate, sign the form, and have the client sign the form (if submitting a paper claim form) [Medavie Blue Cross, (2014), p.15]. Although healthcare professionals also need client information to submit an OHIP claim [MOHLTC, (2015), pp.4-5], the main issue is that the IFHP is a separate process, entailing different forms, types of coverage, procedures, documentation, and funding bodies. What results is the irregularisation of refugee claimants within those places because the abnormality of the process, in addition to the bureaucratic and administrative complexity, stops some doctors from providing care to IFH holders even though they may have coverage. The abnormality of the IFHP claim process is intensified by the appearance of the document.
The IFHP document is visibly different in contrast to the OHIP card. As a result, IFHP holders are constructed as out of place. In comparison to OHIP, which is a piece of identification similar in look and size to an Ontario driver’s licence, the IFHP document is a large piece of paper that consists of various details and information in fine print, including the document’s one-year expiration date that reminds IFHP document holders of the temporariness and precariousness of their status. The sight of this abnormal document differentiates and problematises holders in ways that can lead to denied services. Many participants noted how front line medical staff was confused when presented with the IFHP document, which often led to denied services. This is reminiscent of Bennett’s (2004, pp.354–355) discussion of the ‘thing power’ of documents which “does something, [...] perform[s] actions, produce[s] effects, and alter[s] situations”. The manner in which the IFHP document divides groups of people and restricts services demonstrates how it may be conceived of as a ‘paper border’ [Rajkumar et al., (2012), p.486]. The personal, numerical, and categorical data that constitute the IFHP – presented through codes, charts, grids and documents – represent an attempt to make patients knowable, so as to be made governable. IFHP data and documentation identifies and differentiates people in ways that render some as eligible to move within healthcare centres in order to gain access to healthcare services while others are deemed ineligible and denied services. But the data does not operate alone; rather, the manner in which it is interpreted by healthcare professionals also plays a key role in the production of borderzones that irregularise refugee claimants.

Medical professionals shape access to services based upon knowledge and understandings of policy, procedure, and discourses, which can have very real affects on the health and wellbeing of refugee claimants. According to participants, pregnant women suffered greatly as a result of the IFHP cuts, in that these women were constructed as a group that could not and/or should not be served. As one Program Manager expresses,

“we’ve had doctors say well, this person’s a refugee claimant, they’re going to have their claim heard while she’s pregnant, I can’t fire her as a patient once she’s my patient, so if she ceases to be eligible for healthcare, I’m on the hook, so I won’t take her to begin with.” (Interview with Program Manager, Toronto, 8 October, 2015)

This example yields powerful insight into the ways in which the medical realm operates as a site of power and inequality where professionals “judge which bodies are worthy of being called human” [Ticktin, (2011), p.127]. Such forms of judgement are based upon assessments of worthiness and deservingness that are conditional on presumed or actual features of the patient, grounded in social and political context, and liable to shift in response to new knowledge’s, circumstances, or experiences [Willen and Cook, (2016), p.97]. To deny care to a refugee claimant based upon these judgements and assessments demonstrates how medical professionals can become gatekeepers of boundaries and conditions of entry [Villegas, (2013), p.221, p.224] that enact irregularising borderzones. For Tyler (2013, p.217), the experiences of pregnant refugee claimants highlights how women’s bodies constitute biopolitical sites of policing, management, and control – or ‘corporeal borderzones’ – that should not be separated from the sovereign desire to manage ‘the undesirable reproduction of non-citizens’.

Borderzones are not only experienced in one place by irregularised refugee claimants, but can rather follow their everyday lives of refugee claimants. For example, there are
cases where female refugee claimants have been threatened with collection agencies after being unable to pay the cost of giving birth (Interview with Program Director, Toronto, 22 October, 2015). If refugee claimants cannot pay a hospital service bill, which can range from a few hundred to a few thousand dollars, then the hospital will stop providing services until the person pays, or they “send collections agencies after people” (Interview with Doctor, Toronto, 20 October, 2015). Other hospitals will continue to notify patients of the bill or engage in repayment plans, sometimes of a minimum of $5 per month. Although the latter option may appear accommodating, what is important to acknowledge is how long it may take to pay off the bill and the stress and anxiety that constant reminders and outstanding payments create for refugee claimants. Some refugee claimants may avoid seeking care services altogether in order to avoid the cost, or will self-treat (Interview with refugee claimant, Toronto, 18 October 2015). For others, the inability to pay for healthcare services, such as vision and eye care, impact other areas of life, such as schooling (Interview with refugee claimant, Toronto, 11 March 2016), which can further contribute to insecurity and marginality.

In order to rectify the issues produced through the IFHP cuts, the Ontario Ministry of Health and Long-Term Care (MOHLTC) introduced the Ontario Temporary Health Program (OTHP) on January 1, 2014. OTHP was designed to ‘top-up’ the healthcare coverage of IFHP holders back to pre-2012 levels (Ministry of Health, 2016). Members from the Canadian Doctors for Refugee Care, who were the key actors in the above-stated Charter challenge, participated in the development of the program (Interview with Ministry Officials, Toronto, 25 November 2015). Although discussed as a very ‘slick’ program, OTHP suffered from administrative problems (Interview with Doctor, Toronto, 19 October 2015). In order to make a claim, doctors first submit their IFHP claims to BlueCross. Upon receiving notification that a service is not covered, doctors then resubmit their entire claim for OTHP. Like the IFHP, providers have to be registered and clients must also sign a consent form (Interview with Ministry officials, Toronto, 25 November, 2015). According to a doctor, the complexity of the program is a result of the unwillingness of the federal government to allow this program to work effectively:

“[OTHP] hasn’t worked very well for one simple reason. It’s because, I would suggest, the federal government has completely sabotaged the program, and how did they do that? They did that by not sharing information with the province. So now that information that goes to the Federal person [at] that BlueCross office in New Brunswick, instead of them passing it down the hall if they can’t deal with it, they send it back to the clinician. The clinician has to then gather all the paperwork together and send it back to that same office at BlueCross in New Brunswick. And for many clinicians, [...] it’s time consuming, it’s bureaucratically very cumbersome to keep all that paper work around [...] and so OTHP hasn’t really caught on as much as it should have.”
(Interview with Doctor, Toronto, 19 October, 2015)

For some research participants, OTHP represented yet another layer of complexity to the existing IFH program, making it an unattractive alternative. For others, they simply were not aware of OTHP and therefore could not inform, or offer it to, clients. Although it represents an important piece of policy that challenged the state’s attempt to exclude refugee claimants from healthcare, OTHP also worked to irregularise refugee claimants by incorporating this group into another separate complex and non-standardised program.
With the re-instatement of the IFHP on April 1, 2016, OTHP was discontinued March 31, 2016.

### 3.2 Acts of liberating irregularity

In this article, I also explore how the IFHP was challenged and resisted in visible and less visible ways and places to demonstrate how borderzones and irregularisation also consist of struggle, (re)negotiation, and resistance (Inda, 2011; Squire, 2011; Johnson, 2014). As I discuss below, the protests that surrounded the IFHP, and the continued provision of healthcare to refugee claimants, in addition to other acts, aimed to free refugee claimants from experiential conditions of irregularity (however temporarily). I define these important acts of resistance as acts of liberating irregularity.

Public protests, campaigns, press conferences, occupations of government spaces, and interruptions of government officials occurred throughout Toronto (and across the country) between 2012 and 2016 to challenge, and draw public attention to, the IFHP cuts. For example, on June 15, 2015, protestors in Toronto participated in the largest National Day of Action that called on the federal government to rescind the IFHP amendment; here healthcare professionals and refugee claimants shared information with the public through stories and flyers that detailed the effects of the cuts. On May 11, 2012, 90 physicians occupied then Minister of Natural Resources Joe Oliver’s Toronto office and presented a signed letter by the medical community detailing their concerns and their call to end the cuts (Docs4refugeehc, 2012). Numerous campaigns also erupted such as the Non-Cooperation Campaign, launched by the grassroots organisations of Health for All and No One Is Illega on July 15, 2012, where healthcare professionals declared their commitment to continue to provide healthcare services to refugee populations (Keung, 2012). The Fill the IFH Gap campaign launched in January 2013 that urged the Ontario Government to fill in the gap created by the cuts (http://www.ocasi.org/fill-ifh-gap-campaign), which led to the development of OTHP. These acts by the medical community, that involved refugee populations, interrupted designated government spaces and portrayed government actions as irresponsible and uninformed. Finally, while not directly linked to the IFHP, the City of Toronto declared itself a Sanctuary City in February 2013. The policy aims to guarantee all Toronto residents, regardless of status, access to City services without fear, including Toronto Public Health services (dental, immunisation, sexual health clinics, etc.) (City of Toronto, 2017b). This is a form of resistance that challenges irregularisation through the assertion of rightful presence in and access to the city to facilitate pathways to rights. The City of Toronto also produced some important staff reports on medically uninsured residents in Toronto (City of Toronto, 2013) and the impacts of the IFHP cuts on city residents (City of Toronto, 2012). Other notable examples include OHIP for All, a multidisciplinary grassroots collective of concerned healthcare professionals, students, activists, and allies who, after launching in Spring 2016, are fighting to attain provincial healthcare coverage for all residents of Ontario, regardless of status (http://ohipforall.ca/why-ohip-for-all/).

In addition to coalitions, campaigns, and protests, the provision of medical aid to refugee claimants represents another important act of liberating irregularity. Some of the more visible players are Crossroads Refugee Clinic, Community Health Centres (CHCs), and Midwife Clinics. Created in 2011, Crossroads Clinic is Toronto’s first hospital-based refugee health clinic that provides primary care to refugee populations for their first two years in Toronto; afterwards they are connected with a family physician
Borderzones and the politics of irregularisation

CHCs are community governed not-for-profit organisations that deliver primary care services in combination with other wraparound services, such as community development, health promotion, and illness prevention, through health and social service agency partners. These supports are offered to those who reside within specific catchment areas and specifically to those populations who face barriers to healthcare. Midwives, who are funded through the MOHLTC, offer pre- and post-partum services to pregnant residents of Ontario regardless of status and assist patients in making connections in the community, mostly with CHCs. However, the costs of additional services, including lab tests and ultrasounds, are not included. In the case of a hospital birth, the patient is responsible for paying the associated fees, which can range from $500 to over $3,000 per day. To address this issue, a birth centre was opened in Toronto in 2013 that enables uninsured women to give birth without having to pay a fee. CHCs and midwives have also developed agreements with hospitals that allow clients to access specialists or delivery rooms within the hospital without the risk of high fees or bills. These all represent ‘common’ spaces of solidarity where the categorisations that inform irregularisation are rendered obsolete and where the healthcare rights of all residents are prioritised. Providing care services to un(der)insured populations within these places challenge traditional notions of citizenship and exclusionary bordering logics, leading to define them as ‘acts against citizenship’. Similar services are also offered in less visible/apparent yet no less political spaces, such as homeless shelters and refugee shelters, and uninsured clinics. In homeless shelters like Seaton House and Sistering, and refugee shelters like FCJ Refugee Centre and Christie Refugee Centre, health professionals from the Inner City Health Associates (ICHA) provide primary care and/or psychiatric services. Working closely with case managers and social workers, ICHA also assists in connecting clients with permanent support services. According to one refugee claimant: 

“because I was from [Seaton House], first started, they provide me service from a family doctor. They are giving me service now, until now. But if I directly came here [to this refugee shelter], then it was a problem for me. There is no service. I have to pay from my pocket.” (Interview with Refugee Claimant, Toronto, 11 March, 2015) 

Because of this person’s connection with Seaton House, they were able to receive primary care services, including medication for diabetes. Finally, uninsured clinics operate throughout the Greater Toronto Area to offer free healthcare services to uninsured populations. For example, the Canadian Centre for Refugee and Immigrant Healthcare (CCRIH) consists of an inter-disciplinary team of healthcare professionals that offer free primary care, paediatric, dental, and chiropractic health services. Because many of the patients are women and children, CCRIH opened the SWAN (Scarborough Women Assessments and Needs) Clinic, a dedicated medical and dental space for uninsured immigrant and refugee women. Although issues of quality may arise as a result of providing services in shelters or uninsured clinics rather than designated healthcare centres, they are nevertheless important spaces in the overall struggle against irregularisation.
Less visible acts also played an important role in liberating refugee claimants from conditions of irregularity. The IFHP amendments made it difficult for refugee claimants to access healthcare services; through ‘word of mouth’ these difficulties were (re)negotiated. ‘Word of mouth’ is a subtle act of information sharing among allies and refugee populations to assist in navigating the healthcare system without direct attention from governing/immigration authorities. According to one doctor,

“There’s a lot of advocating on behalf of the individual that’s involved. There’s often a lot of finding back channels of who is willing to see somebody and not bill or who’s willing to see somebody and bill less and finding ways [...] for us to pay for things for people.” (Interview with Doctor, Toronto, 20 October, 2015)

Word of mouth includes speaking with allies, or attending meetings and seminars, where information is shared on policy or practices and then relayed to refugee claimants or colleagues (Interview with Program Manager, Toronto, 22 October, 2015). It can also include having social workers, lawyers, and program managers “go to the places where newcomers go” such as schools and apartment buildings, to “knock on doors and hand out flyers” (Interview with Program Manager, Toronto, 8 October, 2015). When refugee claimants share their experiences with friends and family members, they are also engaging in word of mouth in that they are sharing, and making known, important information on people, places, and practises in the city. One social worker elaborates, “it’s really just people in the community saying I had a very good experience at this agency or I had a really good experience with this worker, go see them, or that agency has a worker that speaks our language” (Interview with Social Worker, Toronto, 26 November, 2015). These examples of word of mouth reflects Ilcan’s [(2013a), p.4] argument that while knowledge can work to classify and differentiate people and places in ways that may create injustices, the exchange of knowledge and information yields the potential to challenge injustices and make possible new spaces for politics and acts of resistance, or what she terms, ‘acts of social justice’ [Ilcan, (2013b), p.199]. For example, many participants in the healthcare field noted how they were made aware through their colleagues of a small group of hospitals in Toronto that provide care to IFHP recipients with as few barriers as possible and how this benefited their patients/clients; these hospitals may have clear policies or simply ‘unspoken understandings’ [Villegas, (2013), p.229] on how to provide care to IFHP holders and other un(der)insured populations.

Word of mouth constitutes a politics of solidarity and trust that challenges existing irregularising practises and prioritises rights and access.

Word of mouth is an element of system navigation work, which entails the careful traversing of various pathways to seek out and gain access to services. A refugee claimant explains how they navigated healthcare services in the city:

“in my case, the first place I went [...] they told me they don’t like deal with those piece of papers [for the IFHP]. I have to have, they were calling it OHIP or something, and I didn’t have that, so at least they directed me to another place where they accepted it. [...] so they sent me to another walk-in clinic who treated me but they never took me as their patient. So then I went into the internet and got the [information for a clinic that serves IFHP and uninsured individuals] and then went there and they took me as their patient.” (Interview with Refugee Claimant, Toronto, 11 March, 2016)
Another example includes a pregnant woman who, after being denied care by an obstetrician unless she paid $3000, navigated the system until she received the care she required:

“she went to the hospital, she went to midwives, she went to community health centres, no one would take on her care, finally her lawyer asked her to come and see us. She wasn’t a patient of ours, and although she was quite distraught, it was obvious that she was an incredibly resourceful woman.” (Interview with Doctor, Toronto, 19 October, 2015)

These examples of system navigation demonstrate the agency of refugee claimants, but they also highlight the degree of uncertainty embedded within it. This negotiated quality of healthcare entails knowing the right people and/or information and having the right encounters with medical professionals who structure options for accessing healthcare that can result in complex relationships, practices, and pathways (Villegas, 2013). In this sense, system navigation may work to challenge irregularisation or reaffirm it. However, when it is challenged, it sheds light on how borderzones are also productive of equitable and socially just practices and places that (re)negotiate and re-imagine notions of rights, worthiness, and belonging. Such acts of liberating irregularity alert us to how irregularisation can be a starting place for politics.

4 Conclusions

Through the lens of irregularisation, this article sheds light on the contemporary expression, manifestation, and struggles around bordering practices in Canada’s asylum context. Specifically, this article analyses how amendments to the IFHP worked to irregularise refugee claimants within Toronto’s everyday healthcare places. This was achieved through an engagement with the concept of borderzones. The article also highlighted the disruptions and contestations, referred to as acts of liberating irregularity, that erupted throughout the city to challenge irregularising bordering logics and practices that categorise and differentiate refugee populations in favour of solidarity and social justice.

Even though the IFHP was fully re-instated in April 2016, confusion continues to surround the program and the healthcare coverage guaranteed to refugee claimants due to a lack of government communication to frontline staff and medical professionals (Levizt, 2016; Caulford and Rahunathan, 2017). It is important to acknowledge however that healthcare is not the only sector where refugee claimants are irregularised. Future research will gain new insights by applying the lens of irregularisation to social assistance, work permits, and housing, to demonstrate how these sectors entail elements of control as well as resistance. By expanding our understanding of irregularisation, how and where it operates and is experienced, and who are subjected to it, we may be more able to critically assess the implications of policies that are geared towards refugee claimants, and be more aware of the numerous ways they are challenged.
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References


Notes

1 Orders-in-Council are legislative instruments made by the Governor General on the advice of the federal cabinet and address a wide range of matters from civil service staffing to capital punishment. They are not discussed by Parliament before they are implemented. For more information on Orders-in-Council please see: Government of Canada (2016c).
In the 2010–2011 fiscal year, the cost of the IFHP totalled $84.6 million (Government of Canada, 2012a).

Designated Countries of Origin (DCO) are deemed ‘safe’ by the Canadian government because they “do not normally produce refugees, but do respect human rights and offer state protection”. There are currently 42 countries listed as safe by the Canadian government, with controversial countries such as Mexico and Hungary on the list. This category was introduced in 2012 through the Balanced Refugee Reform Act (BRRA) and the Protecting Canada’s Immigration System Act (PCISA) as a means to control and deter refugee claims in the country. Claimants from a DCO have their claims processed significantly faster than non-DCO claimants, and are not able to appeal a negative decision on their claim. However, claimants from a DCO can ask the Federal Court to review a negative decision but are not given an automatic stay of removal (Government of Canada, 2013, 2017).

See Ticktin (2011) for a discussion of how France enlisted its healthcare system to control migration.

Protected persons, convention refugees, or ‘persons in similar circumstances’ are excluded from the latter category.

Section 7 states “everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice”; Section 12 states “everyone has the right not to be subjected to any cruel and unusual punishment or treatment”; and Section 15 states “every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability” [Government of Canada, 1982].

Other marginalised populations in Toronto, such as homeless or street-involved people, experience these places in a similar manner due to a lack of proper documentation, and/or due to discrimination [Khandor et al., (2011), pp.99–100].