ACCESS TO HEALTH CARE FOR PRECARIOUS AND NON-STATUS MIGRANTS DURING COVID-19: ONTARIO AND QUÉBEC

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The COVID-19 crisis is testing principles of universal healthcare like never before. Interpreted politically and legally, the term is a misnomer, as publicly insured healthcare in Canada is only available to citizens, permanent residents and prescribed immigrant categories. A literal and moral reading would require that all residents have equal access to healthcare, whether or not they are citizens or permanent residents. The COVID-19 crisis has rendered more clearly the underlying reality that truly universal healthcare is a collective good and not just an individual right. Since March 2020, Ontario, Québec, British Columbia, and other provinces have recognized this fact, temporarily removing barriers to, at minimum, COVID-19 assessment and treatment.

Although the removal of formal legal barriers is a good first step, precarious and non-status migrants still face institutional, linguistic, ideological, and structural barriers – factors that we already know impede the implementation of local, Access Without Fear Policies (Hudson et al. 2017). So-called *sanctuary cities* have been hit especially hard by COVID-19, and they are likely home to the majority of non-status and precarious status migrants. Confirmed cases are concentrated in major urban centres, especially Toronto and Montréal. Montréal has roughly 30,000 cases, out of some 62,000 across Québec. There have been around 14,000 reported cases in Toronto, of Ontario's case total of 35, 000.[1] While disaggregated data is incomplete, the distribution of cases speaks volumes about the intersections of race, migration, and labour.

The purpose of this short article is to review how immigration status and the lack thereof affect access to healthcare for non-status and precarious status migrants in Ontario and Québec. We focus on Toronto and Montréal, but we also refer to some rural issues and examine provincial and, to a lesser extent, federal policy. We survey barriers to implementation, which include lack of clarity in policy, inconsistent practices in hospitals and walk-in clinics, continued exclusion from social assistance and rights regimes, and the looming threat of being reported to the Canada Border Services Agency.

HEALTHCARE AND IMMIGRATION STATUS

While there are statistics and demographics pertaining to migrants with precarious status (CCR, 2016; Goldring, Berinstein & Bernhard, 2009), there is no data on the number of non-status migrants in Canada. There are a couple of studies

1 The number rises to approx. 29,000 if we include the GTA (Toronto and Peel, Durham, Halton, and York regions): www.toronto.com/news-story/9964297-map-tracking-COVID-19-cases-across-ontario-by-region.

that provide clues regarding the numbers of non-status persons who access particular services in local settings, including health, education, and those provided by labour organizations (Hynie, 2016; Goldring et al. 2009; Bou-Zeid 2007; Khandor, MacDonald and Nyers 2004). A report by Soave Strategy Group found in 2006 that in the Greater Toronto Area, there were up to 40,000 non-status workers (Soave, 2006). A more recent study on emergency room consultations suggest that there are at least 58,000 non-status migrants in Ontario (Hynie et al, 2016). Interestingly, the use of emergency room services by non-status migrants is highest in areas where migrants live (e.g. Toronto, Ottawa) and prevalent in counties with a strong agricultural industry (e.g. Windsor-Essex, Niagara). More recently an analysis by the SHERPA Institute estimated that there could be between 40,000 and 70,000 people living without a health insurance because of their immigration status in Québec.[2]

The human rights implications of living without status or with a precarious status are profound. The degradation of mental and physical health is a primary concern, which is attributable in large part to fear of detection and deportation, social isolation, poor working and living conditions, vulnerability to abuse and exploitation, and a host of institutional barriers (Barnes, 2011; Ruiz-Casarez et al. 2010; Bernhardt et al, 2007). One report noted:

> "Migrants without status also face unique and serious health needs and access challenges… (r)esearch found that non-status migrants in Toronto present signs of trauma, chronic stress and depression from family separation, and physical illnesses associated with stress…It is important to recognize that the challenges facing residents without status are often persistent; they are not unique to those who have recently arrived in Canada" (Toronto Public Health and Access Alliance, 2001, p. 117)

Non-status and precarious-status migrants are not eligible for any federal health coverage, such as the Interim Federal Health Program, which is mainly reserved to asylum seekers only. Similarly, non-status and most precarious-status migrants do not have access to a provincial healthcare plan. Ontario's *People's Health Care Act* and Québec's *Health Insurance Act* require citizenship or certain classes of immigration status (plus three months residency in the province) to access provincial health insurance coverage (respectively the Ontario Health Insurance Program (OHIP) and Québec Health Insurance Plan (the Régime d'Assurance Maladie du Québec (RAMQ)). Public insurance is only available to temporary workers if they satisfy rigid legal criteria. Even if one is formally eligible for provincial coverage, delays in the receipt of OHIP cards, language barriers, and remoteness impede access to healthcare (MWAC, 2020; Cole et al, 2019; Hennebry, McLaughlin and Preibisch 2016).). The government may also choose to deport migrants if healthcare is too expensive. The most common reasons for deportation of seasonal agricultural workers seem to be medically related, accounting for over 41% of deportations according to a 2015 Ontario study (Orkin et al. 2015).

Prior to COVID-19, someone without public or private insurance could access medical services, including emergency medical services, but would have to pay non-OHIP or non-RAMQ (which is 200% of the RAMQ fees in Québec) rates. If one cannot pay up front, they will in most cases be ineligible to receive medical services, except in a case of emergency (especially if a situation is deemed immediately life-threatening) even though the patient would be billed afterwards. There are some reports of non-status persons being detained and/or reported to the CBSA while seeking healthcare (Toronto, 2015; Gatsaldo et al. 2012). There are a handful of walk-in clinics in Toronto and, even fewer in Montreal, that provide free primary care to uninsured migrants, but these count as a small fraction of clinics, and care does not include specialist care or diagnostics. As members of Doctors of the World, two authors of this paper notice that these issues, among others, can cause a delay in consultation which can lead to complications and deterioration of the global health of a person.

THE IMPACT OF COVID-19 ON NON-STATUS AND PRECARIOUS-STATUS MIGRANTS

Due to a combination of racism, economic suppression, lack of democratic and legal rights, geography, and poor health, non-status and precarious migrants are exceptionally vulnerable to COVID-19. This is supported by aggregated data outlining the spatial concentrations of cases in low-income, racialized, and migrant-heavy neighborhoods in both Toronto and Montréal. Non-status and most precarious-status persons are highly likely to continue working regardless of the risk to exposure, as they cannot reliably access federal and provincial supports. Most of the time, they are excluded from provincial support programs, including both Québec and Ontario.[3] And, in the current context, most of them are also not eligible for the CERB. In this context, losing a job with no governmental social safety net represents a huge deterioration

2 Hanley, J. and Clevland, J, Population sans aucune couverture d'assurance-santé publique – Québec 2020 (Estimé), Institut universitaire Sherpa, CIUSSS Centre-Ouest de l'Ile-de-Montréal, available on request.

3 There is some disagreement among lawyers in Ontario on this point, but most agree that front-line workers generally do not think non-status migrants are eligible to receive Ontario Works (OW).

of their socioeconomic situation (which is often already precarious) and they can only turn to community organizations, food banks, peers, etc. to seek support.

The conditions in which non-status and precarious-status migrants work is also an important factor of risk to COVID-19. The best documented example at this point are seasonal agricultural workers. Migrant Workers Alliance for Change and Justice for Migrant Workers have reported systemic violations of workers' rights and COVID-19 emergency legislation relating to physical distancing and sanitation. Run by major corporations, farms crowd workers in small, shared dwellings without adequate physical distancing measures, face masks, or sanitizer., requiring shared bathrooms, showers, and eating utensils (MWAC, 2020; Hennebry, et al. 2020). Disregard for basic rights and health protocols have been linked to several outbreaks in Ontario farms. Hundreds have tested positive for COVID-19, three have died (Bonifacio Eugenio-Romero, Rogelio Muñoz Santos, and Juan López Chaparro) and several others are in intensive care units.

ACCESS TO HEALTHCARE DURING COVID-19

The pandemic has highlighted the need for more comprehensive health care coverage amid the interdependency of all individuals. The pandemic has tested the capacity of all three levels of government to coordinate their responses, to draw from and support the valuable work of the medical profession and community organizations. Some progress has been made, but measures are limited in effectiveness, scope, and scale.

On March 20, 2020, the Ontario Ministry of Health announced through a press release that it would "cover the cost of COVID-19 services for uninsured people who do not meet the criteria for OHIP coverage" (OMH 2020a). The same day, the Assistant Deputy Minister of Health sent a letter to Ontario hospitals requesting the providing of *all medically necessary* services to any patient present at a hospital, including those who do "not have health insurance under OHIP or another provincial health insurance plan", and promising to reimburse physicians and hospitals using designated fee codes (OMH 2020b).

Implementation of expanded coverage has been a challenge. First, the province has been unclear about the scope of available health services. Its media release referenced access to COVID-19 healthcare, but its letter to hospitals extends to "all medically necessary" services. This mixed message has led to front-line staff in hospitals denying care. Second, the province has not clearly communicated the policy to walk-in clinics. In its May 5 OHIP Bulletin 4756, the Ministry of Health issued fee codes for services "provided in the community".[4] The Ontario Medical Association (OMA) has disseminated a FAQ sheet to its members and, on June 5, the President of the OMA reiterated to all members that all healthcare will be covered for those who are uninsured during the COVID-19 pandemic. The collective OHIP for All compiled a list of clinics that provide health care to uninsured persons, as well as languages spoken in these clinics; just over 100 of the 800 clinics contacted confirmed access to non-status and precarious-status migrants at no cost.[5] The team created a Healthcare Access Ontario website that allows migrants to identify clinics in their neighborhood.[6]

In Québec, Médecins du Monde, other advocates, and community groups offering services to migrants with a precarious status, have immediately conveyed concerns regarding the coverage for diagnosis and treatment of COVID-19. At the end of March, the Québec Ministry of health and social services announced that COVID-19-related testing and care would be covered by the provincial health plan. However, it quickly became apparent that this change was insufficient to achieve its initial objective, which was to remove remaining barriers to testing and treatment of COVID-19. First, there was insufficient communication to health professionals and institutions, which led to people being billed for COVID-19 related care or needing an ID card for testing, which had the effect of discouraging people who did not have needed documents. Second, coverage only for COVID-19-related care has dissuaded people from seeking health care out of a fear of being billed for care related to other illnesses. As a consequence, these issues were quickly brought to the Québec Ministry of Health and calling for all services to be covered in the context of the pandemic for people without insurance, on the same model as Ontario. However, in contrast with the Ontario government, Québec has refused to budge from its usual practice, leaving an important blind spot in its response, despite being the province with the most cases in Canada.

On May 21, 2020, due to the lack of action of certain provinces and inadequate action in others, the Healthcare for All National Coalition (a group made of migrants right defenders and healthcare organizations) sent an open letter signed by more than 200 organizations to the federal and provincial governments. The letter demanded that all people living in Canada be able to access health care for free and without fear of being reported to the CBSA. It called on the CBSA to officially pledge that accessing healthcare will not result in

4 www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4756.aspx

5 Data on file with authors.

6 http://healthcareaccessontario.herokuapp.com/

detention or deportation. On May 21, 2020, due to the lack of action of certain provinces and inadequate action in others, the Healthcare for All National Coalition (a group made of migrants right defenders and healthcare organizations) sent an open letter signed by more than 200 organizations to the federal and provincial governments. The letter demanded that all people living in Canada be able to access health care for free and without fear of being reported to the CBSA. It called on the CBSA to officially pledge that accessing healthcare will not result in detention or deportation.

ACCESS WITH(OUT) FEAR: HEALTH, POLICE, AND THE BORDER ENFORCEMENT

The threat of arrest, detention, and deportation is even greater in the context where the federal government being hostile to asylum seekers and where provinces and cities expand surveillance and restrictions on mobility. Under emergency law in Ontario and in Québec, all persons must identify themselves to officers if issued a ticket for breaching emergency orders. While the CBSA has reduced its inland enforcement operations, it still receives online reporting and has an open line of communication with local law enforcement and other government agencies. Making matters worse, Ontario has given police access to *critical information* about persons who have tested positive for COVID-19, including names, addresses, and date of birth (Ontario reg. 120/20). This effectively forces non-status migrants to weigh the right to be tested with the risk of being deported.

Patient privacy is another unresolved issue. Formal health privacy laws protect most data from being disclosed to law-enforcement agencies. But documents released by the CBSA through ATIP requests show that hospitals report patients several hundreds of times a year. In the case of British Columbia, calls were made to the CBSA as 243 times, ostensibly to check migrant status for the purposes of fee codes e.g. international student, temporary foreign worker.[7]

It is unclear why these calls needed to be made or why the CBSA was called, rather than the proper authority.

The CBSA has yet to issue an official statement on the status of its inland enforcement operations or specifically its use of health data or its partnerships with local authorities. In the absence of federal assurances, one solution would be for municipalities to move forward with Municipal ID Card policies. Used in San Francisco, New York, and other US cities, Municipal ID cards can be used to verify one's identity to police or by-law officers.

Toronto has chosen not to issue ID cards. Its concern rests with privacy. To issue cards, the city would have to collect the name and address of those who use them, and then store the data for one year. During this time, the CBSA could attempt to compel disclosure though a judicial order. There is no Canadian case law on whether a judge can compel cities to turn over data to the CBSA. Montréal has worked around the problem by subsidizing community organizations (Doctors of the World Canada and 3 participating partners) to issue ID cards to residents, which vouch for the identity and residence of applicants. In this way, the city never collects personal data.

The Montréal ID card program is a pilot project and is coordinated by Médecins du Monde. At present, the card is only issued to non-status and precarious-status migrants, and not all Montréal residents. The City of Montréal confirmed its intention to work towards a card for all its residents however, since it is not yet launched, subsidizing MdM to coordinate the pilot project will help to protect personal data of non-status and precarious status migrant.

Unfortunately, this pilot project is limited to city services and since the pandemic situation forced most city services to close, the ID card project was put on hold because people who would get the card could not use it. We believe it is very important to work towards a Montréal ID card for all, more so since the Montréal Police Service has not pledged to support sanctuary initiatives. Right now, since the ID card is being issued to non-status and precarious-status migrants only, this ID cannot be used to confirm your identity with the police and/or anywhere outside of city services.

CONCLUSION

Québec and Ontario have the dual distinction of being the provinces with the highest migrant populations and the most COVID-19 cases. Each has expanded access to healthcare, but neither has communicated clearly with health professionals or migrant rights organizations. The largest cities in each province – Toronto and Montréal – have experience with AWF policies, but municipal policies and services are of limited value today. To the contrary, restrictive by-laws and expanded roles for local police and by-law officers in managing this public health crisis render the city less safe. Precarious-status migrants in rural settings are also at considerably higher risk of contracting COVID-19 than the general population. While the lifting of formal legal barriers to (some) health services is valuable, and should become a national model, non-status and precarious-status migrants continue to face prohibitive structural, linguistic, ideological, and legal impediments that governments can, should, and must do away with.

7 Documents on file with the authors Request No. A-2018-21430 and A 203-17666.

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