



Immigration Status as the Foundational Determinant of Health for People Without Status in Canada: A Scoping Review

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Abstract

Migration is increasing at unprecedented rates worldwide, but inadequate mechanisms for granting citizenship or permanent residence have rendered many immigrants without legal status. We study the health of people without immigration status in Canada, building on a 2010 review on being without status and health. We employ an expanded definition of health, guided by the WHO Social Determinants of Health (SDoH) framework. Using a scoping review methodology, we reviewed literature from 2008 to 2018 on the SDoH of people without legal immigration status in Canada, selecting 33 articles for analysis. We found that structural determinants of health, such as stigmatization and criminalization, and intermediary determinants, such as fear of deportation and healthcare avoidance, produce ill health. We show how different social positions are produced by SDoH, finding immigration status to be the foundational determinant of health for people without status in Canada. We argue that lack of immigration status as a SDoH is missing from the WHO framework.

Keywords Immigration · Canada · Undocumented · Illegal · Social determinants of health · Access to health care

Introduction

Irregular migration, or the movement of people outside of regular migration channels [1], is the fastest growing form of international migration across the globe. In high-income countries, this type of migration is associated with neoliberal market demands for a readily available, cheap and flexible workforce [2]. In the case of Canada, people without legal immigration status usually enter the country with some form of status such as a temporary work permit, student visa, or tourist visa, which later expires, or a refugee claim which fails or is withdrawn, leaving the person without status [3]. The Canadian immigration system is complex to navigate, with people frequently shifting in and out of status,

often dependent on third parties like employers or partners to secure legal immigration status [4]. They have limited options for obtaining permanent immigration status, and live under the threats of arrest, detention, and deportation [5]. People without status are denied most health, social, and legal services [5], with direct and wide-ranging implications for their health and wellbeing. Because of this varied and shifting state of belonging, not having citizenship or permanent residency in Canada has been referred to as having “precarious” legal status, defined by the conditionality of one’s presence and access to services [3]. In this paper, we focus in particular on the population of people with precarious status who have no legal immigration status in Canada, using the terms “without status,” or “non-status.”

This paper builds on Magalhães, Carrasco, and Gastaldo’s 2010 review [5], which focused on how being without status in Canada affects people’s health, service access, and working conditions, covering the 1999–2008 period. We reviewed the literature published over the following ten years, expanding on the previous review in order to include other social determinants of health (SDoH) affecting people without status in Canada. We use a broad definition of health that incorporates social, spiritual, emotional, and physical health and wellbeing. Our study is unique in bringing together the health and social sciences literatures to provide a more

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comprehensive understanding of the health and social position of immigrants without status in Canada. We provide an update on the state of the literature and present a new representation for conceptualizing immigration status as the foundational determinant of health for immigrants without status in Canada.

Conceptual Framework

Migration has traditionally been conceptualized in the health sciences either as an individual or family undertaking with the goal of economic improvement, or as an epidemiological issue, where morbidity and mortality reveal trends in human movement within and across national borders [6, 7]. However, these views neglect to consider that at the core of irregular international migratory processes are millions of people searching for decent living and working conditions. In this paper, we bring a postcolonial perspective to the study of migration and health. We believe that studies about immigration must take into account the principles of destruction and violence that operate in modern democracies, where imperialist, neoliberal capitalist competition among nation-states, aiming at wealth concentration, simultaneously promotes irregular migration and leads to criminalization of unauthorized immigrants [2]. Nevertheless, irregular migration continues, and many immigrants are not entitled to rights in the nations where they reside [8]. Our analysis of the SDoH affecting people without status takes into account the ways in which the lives of people without legal immigration status are shaped by discourses of “illegal human existence” accompanied by exploitative relations and unjust suffering [7, 9].

The World Health Organization (WHO)’s SDoH framework examines how structural and intermediary SDoH shape people’s living circumstances, resulting in particular social positions that can promote or impede their health [10]. Structural determinants encompass political and socioeconomic contexts, which include social policies and social positions (e.g. race/ethnicity and income level). Intermediary determinants include specific material circumstances (e.g. food availability, working conditions), biological, behavioural and psychosocial factors (e.g. fear of deportation, capacity for social mobilization) [10]. These structural and intermediary determinants create the conditions for differential health consequences. For example, in Canada, where neocolonial and neoliberal political-economic logics for social stratification are dominant, racialized individuals and immigrant groups have limited access to social and material resources and bear a greater burden of health damaging conditions as a result [2, 7]. Poverty and material deprivation alone do not produce low social positions; at the core of the production of inequity

is social injustice [11]. The result is a social hierarchy that varies along a gradient from extreme privilege to profound disadvantage, and immigrants without status are at the bottom of this hierarchy [7].

With a postcolonial perspective, we believe the SDoH can help health scholars think about how political and socioeconomic practices lead to physical, mental, and social health consequences for individuals and groups, particularly those without status. While migration has been noted as a social and public health issue, seldom has a SDoH approach been used to understand the inequities produced in the migratory process [6]. In summary, we use the WHO SDoH framework as a tool to study the mechanisms of health inequity, exposing the importance of structural and social circumstances for health. Thinking about immigration through the lens of structural and intermediary SDoH offers an opportunity to better understand the health consequences that manifest in unnecessary suffering, disease, and reduced life expectancy among immigrants without status in Canada, and to denounce, mitigate, or transform oppressive social discourses and practices.

Methodology

Search Strategy

We utilized the scoping review method of literature review [12]. In order to understand the landscape of recent literature and not duplicate work done by Magalhães et al. [5], we limited our search to articles published between 2008 and 2018. Searches were conducted in Medline, PsycInfo, CINAHL, Web of Science, and Sociological Abstracts in order to establish a broad view of the issue from both the social and health sciences literatures. In addition to searching peer-reviewed databases, we searched Google Scholar for studies citing Magalhães et al. [5]. Our exclusion criteria were: articles not focusing on the Canadian context, articles published in a language other than English or French, literature reviews, books, book reviews, theses, and gray literature. We also excluded articles that primarily discussed populations with forms of precarious immigration status other than being without status, such as refugee claimants and temporary foreign workers. The search resulted in 9419 titles which were reviewed by one author (NK) who selected 475 for abstract review. Two authors (MG, NK) conducted the abstract review, selecting 55 articles for full-text screening. These articles were divided among all authors, with two authors reviewing the full text of each article to determine the final dataset. Thirty-three articles were ultimately included in our analysis based on the above inclusion and exclusion criteria. See Table 1 for profiles of selected articles.

Table 1 Article profiles

Citation	Journal	Geographic focus	Type of article and methodology	Key aims of article
Bennett and Burton [33]	Canadian Journal of Midwifery Research & Practice	Ontario	Qualitative research: interviews	To examine the experiences of midwives providing care to uninsured women
Bhuyan [25]	Law & Policy	Canada	Qualitative research: policy analysis	To examine how service providers can influence access to state rights
Bhuyan, Osborne, and Cruz [26]	Journal of Immigrant & Refugee Studies	Toronto, Ontario	Qualitative research: feminist and participatory methodology	To illustrate how immigration policies in Canada that deny women legal channels for seeking protection from gender-based violence experienced in their home country, produce forms of gendered "illegality" that increase women's exposure to interpersonal and structural violence
Brabant and Raynault [18]	Social Work in Public Health	Montreal, Quebec	Qualitative research: interviews	To explore the living conditions and health of migrants with precarious status in Montreal, Canada as compared to other countries
Bunn et al. [44]	Canadian Family Physician	Toronto, Ontario	Qualitative research: medical chart review	To determine demographic and diagnostic information about the medically uninsured patient population and compare it with that of the medically insured patient population
Campbell et al. [37]	Journal of Immigrant & Minority Health	Toronto, Ontario	Qualitative research: community-based participatory research	To explore the immigrant experience accessing healthcare
Caulford and D'Andrade [13]	Canadian Family Physician	Scarborough, Ontario	Discussion paper	To discuss health and healthcare access for medically uninsured immigrants and refugees
Chen [17]	Alberta Law Review	Canada	Discussion paper	To better understand the design of Canada's contemporary immigration system that has pushed migrants into a state of perpetual precariousness
Chen et al. [39]	Journal of Health Care for the Poor and Underserved	Toronto, Ontario	Qualitative research: community-based research	To shed light on the encounters of people living with HIV/AIDS who are immigrants, refugees, or non-status, with the mental healthcare system
Da Lomba [24]	Netherlands Quarterly of Human Rights	France, UK and Canada	Qualitative research: comparative analysis	To explore the right to access to healthcare for irregular migrants as an example of realization of basic social human rights
Ellis and Stam [21]	Migration Studies	Toronto & Mississauga, Ontario	Qualitative research: ethnography	To explore Polish irregular migrants' agency

Table 1 (continued)

Citation	Journal	Geographic focus	Type of article and methodology	Key aims of article
Goldring and Landoit [27]	Globalizations	Canada	Discussion paper	To create a framework describing how precarious work and precarious legal status intersect, and the impact of migratory status on work outcomes over time. To understand employment experiences of immigrant workers with precarious legal status in Toronto
Goldring et al. [4]	Citizenship Studies	Canada	Discussion paper	To develop a conceptual approach to precarious legal status, broadly understanding who is captured within the non-binary concept of precarious legal status, in comparison to binary conceptions such as legal/illegal. To analyze how precarious status is produced in Canada. To explore the implications of precarious legal status for differential inclusion in social rights and entitlements
Hanley et al. [15]	Pistes: Perspectives Interdisciplinaires Sur le Travail Et la Sante	Quebec	Mixed methods research: survey and follow-up interviews	To examine pathways to healthcare for precarious status migrants
Hari and Liew [30]	International Migration	Canada	Discussion paper	To introduce a series on precarity, illegality, and temporariness in Canada's immigration system, in order to understand the current state and future of migration management in Canada
Hynie et al. [38]	Journal of Immigrant & Minority Health	Ontario	Quantitative research: analysis of National Ambulatory Care Reporting System data	To examine health outcomes among the uninsured
Jarvis et al. [40]	Journal of Obstetrics And Gynaecology Canada	Montreal, Quebec	Quantitative research: retrospective chart review	To look at prenatal care and perinatal outcomes for uninsured pregnant women
Marks [34]	The Hastings Center Report	Ontario, Canada	Discussion paper	To discuss the case of Nell Toussaint, a migrant without legal status in Canada who was denied healthcare coverage, resulting in serious negative health consequences
Mattatall [31]	Journal of Obstetrics And Gynaecology Canada	Calgary, Alberta	Quantitative research: chart and survey data	To look into care for uninsured non-Canadian maternity patients

Table 1 (continued)

Citation	Journal	Geographic focus	Type of article and methodology	Key aims of article
Meloni et al. [20]	International Journal of Migration Health and Social Care	Canada	Qualitative research: action research	To examine trajectories and discourses of invisibility in the context of access to education
Miklavcic [35]	Medical Anthropology	Montreal, Quebec	Qualitative research: ethnography	To discuss the context of immigration, citizenship, and healthcare in Canada, and explore what it means to live a non-status life, and the associated health hazards
Munro et al. [28]	Journal of Obstetrics And Gynaecology Canada	Montreal, Quebec	Qualitative research: interviews	To examine prenatal care for uninsured women
Pashang [19]	International Journal of Mental Health and Addiction	Canada	Mixed methods research: survey questionnaires, individual interviews, and focus group interviews	To explore the mental health impact of sex trafficking on foreign-born trafficked youth in Canada without legal status
Rousseau et al. [29]	Paediatrics & Child Health	Montreal, Quebec & Toronto, Ontario	Quantitative research: review of emergency department medical files	To examine access to care for uninsured immigrant and refugee children
Ruiz-Casares et al. [16]	Social Science & Medicine	North America & Europe	Discussion paper	To discuss access to care for undocumented children
Ruiz-Casares et al. [32]	Maternal & Child Health Journal	Montreal, Quebec	Quantitative research: survey	To understand healthcare personnel's attitudes about access to care for undocumented migrant children and pregnant women
Tenenbaum and Singer [41]	Alternative—An International Journal of Indigenous Peoples	Toronto, Ontario	Mixed methods research: narrative inquiry	To understand specific barriers to accessing mental health services for undocumented Indigenous Latinx border-youth
Tungohan [43]	International Migration	Edmonton, Alberta	Qualitative research: critical ethnography	To assess irregular migrants' experiences in Alberta and demonstrate how the cognitive processes of "imagining," "strategizing," and "developing inter-provincial legal consciousness" are crucial in allowing migrants to exercise agency despite living amid uncertainty
Vanhuynne et al. [14]	Social Science & Medicine	Montreal, Quebec	Mixed methods research: survey	To explore healthcare personnel's attitudes about access to care for children and pregnant women with precarious immigration status

Table 1 (continued)

Citation	Journal	Geographic focus	Type of article and methodology	Key aims of article
Villegas [23]	British Journal of Sociology of Education	Toronto, Ontario	Qualitative research: semi-structured interviews, textual data, and experiential knowledge	To analyze barriers to schooling for children without migratory status despite the “Don’t ask, don’t tell” policy
Villegas [42]	Citizenship Studies	Toronto, Ontario	Qualitative research: interviews	To understand how precarious status migrants experience illegalization through the framework of time, and how status affects perceptions of belonging, security, stability, and ultimately physical and mental wellbeing
Villegas [22]	Women’s Studies International Forum	Toronto, Ontario	Qualitative research: case study	To explore migrant exclusion from benefits of membership in a nation-state
Wilson-Mitchell and Rummens [36]	International Journal of Environmental Research and Public Health	Greater Toronto Area, Ontario	Quantitative research: retrospective chart review	To examine perinatal health outcomes for uninsured vs insured women

Analytical Strategy

Analysis was conducted in two phases, with the participation of all authors in the inductive phase and three authors (MG, NK, DG) in the deductive phase. In the inductive phase, we identified the theoretical frameworks that guided the studies and grouped articles as either social sciences or health sciences to compare their contributions, using the journals and the authors’ academic degrees and institutions to establish their disciplines. We also identified research, practice and policy recommendations made by the articles’ authors. In our inductive analysis, we identified multiple themes and subthemes reflecting the articles’ main findings about the health and wellbeing of immigrants without status in Canada. Next, we conducted a deductive analysis, using the WHO SDoH framework as a guide. We organized the themes from the inductive analysis under the three main WHO SDoH categories: structural determinants of health, intermediary determinants of health, and impact on equity in health and wellbeing, or health consequences. Once the inductive and deductive analyses were complete, we revisited our original themes to ensure the final analysis remained grounded in the articles’ content. This process led to the inclusion of a few additional themes. The final list of analytical themes and subthemes is presented in Table 2.

Results

Profile of the Literature

In the decade since Magalhães et al. [5] published their paper, there has been a small but steady stream of research about the health implications of living without immigration status in Canada. Articles have been published in a wide range of journals including health and medical journals, immigration and citizenship journals, sociology, anthropology and legal journals (see Table 1 for article profiles). While some articles discuss Canadian trends broadly, or Canada in relation to other countries, most focus on particular metropolitan regions in Canada. The majority of studies are either from Toronto or Montreal, perhaps due to those cities having large immigrant populations. Methodologically, there is a dominance of qualitative studies.

While the fields of health and social sciences are both influenced by principles of human rights and equity, we identified distinct differences between the ways in which authors in the health and social sciences conceptualize the impact of being without status on health. Authors in the health sciences either implicitly or explicitly use frameworks pertaining to the SDoH, health as a human right [13–17] or health equity [18], while social scientists approach the issue through conceptual frameworks such as deportability

Table 2 Analytical themes and sub-themes

Structural determinants of health	Intermediary determinants of health	Health consequences
<i>Political views and practices in Canada</i> Institutionalization of temporariness - Complexity of migratory system - Politically produced precarious immigration status Stigmatization/illegalization/criminalization - Considered morally inferior - Considered taking advantage of the system/costly - Threat to national security (Un)deservingness Invisibilization - Limited data - Unofficial healthcare provision - “Don’t ask, don’t tell” policy Rights - Health as human right - Health as a human right vs. right of citizens Myth of universal healthcare - Universal versus selective healthcare system <i>Intersectional social position</i> - Nationality/immigration status - Social class/occupation - Gender/sexuality - ‘Race’/ethnicity	Living conditions - Poor housing conditions - Food insecurity Working conditions - Financial insecurity/low wages - Precarious working conditions - Deportability Social practices - Social isolation - Social network mobilization - Health care avoidance Psychosocial conditions - Lack of social support - (In)visibility - Fear of deportation - Fear of debt - Powerlessness/hopelessness - Autonomy and resilience Healthcare - Lack of coverage - Access does not ensure utilization - Barriers and facilitators: gatekeeping/administrative, sustainability, provider ideology - Limited access to healthcare - Fear of using services (deportation risk) - Differential utilization according to social position/intersectionality - Debt due to healthcare Social services - Lack of access to education - Barriers and facilitators: gatekeeping/administrative, sustainability, provider ideology - Limited access to social services - Fear of using services (deportation risk) - Differential utilization according to social position/intersectionality	<i>Broad impact on health and wellbeing</i> Physical health - Increased risk of complications - Poorer health outcomes - Accidents - Domestic violence - Pregnancy and obstetric issues - Increased rate of HIV Mental health and wellbeing - Inability to plan for future - Stress/Fatigue - Anxiety - Depression - PTSD - Addictions Lower quality care - Limited or lack of continuity of care - Seeking care only for emergencies

[19], invisibility [20], illegalization or institutionalized precarious status [4, 21, 22], bordering [23], human rights [24] or theories of citizenship [25, 26]. Social scientists tend to interrogate how social processes like illegalization and invisibilization hinder social justice for groups without status, but they seldom relate these processes to health consequences. Conversely, health scientists tend to emphasize access to healthcare, overlooking broader political and social influences and material circumstances that impact health.

Structural Determinants of Health

According to the WHO framework [10], structural determinants refer to the “interplay between the socioeconomic-political context, structural mechanisms generating social stratification and the resulting socioeconomic position of individuals” (p. 28). Our review reveals that the socioeconomic and political contexts are characterized by discourses and practices that support or thwart the ability of people

without status to participate in social life in Canada, live with dignity, and achieve optimal health and wellbeing. Below, we present those themes described in the literature that relate to dominant ideas about nation-state, status temporariness, stigmatization, invisibilization, and the right to health and healthcare.

Temporariness and its Institutionalization

There are almost no pathways to citizenship or legal residency for people who are in Canada without status, marriage and humanitarian cases being exceptions. According to the articles reviewed, legal status is a politically produced and complex phenomenon [14, 21, 24, 27–29]. Canada’s fragmented immigration system produces illegality, with temporary residency much easier to obtain than permanent status [4]. Chen [17] argues that growing numbers of immigrants are granted only temporary legal status in order to ensure a flexible labor force while minimizing government

expenditure on benefits like healthcare. Goldring and Landolt [27] argue that limited opportunities for obtaining legal status are part of a “global citizenship and migration management regime,” (p. 338) that furthers illegalization and exclusion in order to produce a cheap, exploitable workforce. Despite limited opportunities to secure permanent immigration status, the dominant view in Canada is that the responsibility to obtain status lies with the individual [17]. However, many of the authors of the articles in our review disagree. Hari and Liew [30] call for the implementation of clear pathways to residency in Canada, and according to Goldring, Berinstein, and Bernhard [4], the discourse needs to shift from an onus on individual responsibility to a demand for changes in immigration policy that would foster permanence rather than temporariness.

Stigmatization of People Living Without Status: Illegalization and Criminalization

The literature establishes that people without immigration status in Canada are popularly portrayed as morally inferior [14, 16, 17], as taking advantage of Canada’s generosity [24, 28, 31], or as threats to national security [24, 30]. According to the articles we reviewed, the idea that people without status do not deserve access to healthcare and social services because they do not contribute to the system is prevalent in Canada [16, 32]. For example, a problematic view noted by Vanthuyne et al. [14] is that only taxpayers and Canadian citizens are deserving of care, while those without status are undeserving because they do not contribute to the tax base, thereby straining the system for Canadians. The argument that people without status do not contribute has been challenged as incorrect, as these individuals do pay sales tax, effectively supporting a system from which they do not derive any benefit [13]. Still, our review highlights that irregular migration has come to be associated with criminality [21, 24, 33], and that people without status, particularly those who are racialized, are popularly perceived in Canada as abusive of Canadian institutions, having not arrived through “regular” channels [14, 16, 32]. Problematically, such views are prevalent among healthcare professionals [14, 16]. This stigmatization and criminalization can lead to migrant illegalization, or what Villegas [22] calls a “process of excluding immigrants from the benefits associated with being members of a nation-state” (p. 192). The illegalization of people without status in Canada serves as justification for governments not fulfilling their right to health [17, 34]. Provincial governments justify denial of most subsidized health services to non-status immigrants as a necessary result of limited resource allocation [17]. Some authors of the reviewed articles argue that such restrictions are rooted in racism and xenophobia [30, 33].

Invisibilization of People Living Without Status

According to our review, the lack of visibility of people without status in mainstream Canadian society compounds their marginalization [4]. Miklavic [35] describes invisibility as “ascribed to the illegal immigrant by the host country via exclusionary practices resembling social death” (p. 501). As a clear sign of their invisibility in research and policy, there are limited data on the numbers of people without status in Canada [16, 30, 31, 36], as well as limited data on their specific healthcare needs and usage [24]. Villegas [22] calls for more options for people without status to be able to safely document their presence in Canada in order to improve wellbeing and community participation. We discuss the particular issue of invisibility in the context of health and social services below.

Health as a Human Right

In some of the articles reviewed, the discourse of health as a human right is drawn on to support the promotion of health for all people in Canada. The right to health has been used as a justification for supporting expanded access to care for people without status [17, 34]. Some authors assert that withholding healthcare in Canada is a violation of human rights [17, 27]. Others call on Canada to uphold its commitment to the International Covenant on Economic, Social, and Cultural Rights, which recognizes the international right to health [16, 24, 34]. Ruiz-Casares et al. [16] describe the tension in Canada between the view that healthcare is a human right and the view that it is a right reserved for people with legal immigration status (citizens, permanent residents, or refugees with documents). Despite the presence of these human rights discourses, citizenship remains the dominant rationale for entitlement to healthcare and other services in Canada [27].

The Myth of Universal Healthcare

Authors of the reviewed articles acknowledge a prevailing view among Canadians that the healthcare system is universal, while noting that in practice, care is provided selectively [14, 16, 29, 35]. This results in a tiered system, where care for those without public health coverage, including people without status, can be prohibitively expensive [37]. Even if individual physicians provide services for no compensation [35], most hospitals charge high fees for non-insured clients, who may not be able to pay, and therefore go without needed care [38]. While certain institutions like volunteer clinics serve people without status, they do not provide a sustainable or comprehensive solution [13]. Despite the indisputable fact that not everyone in Canada has access to healthcare, the dominant discourse maintains that healthcare is universal.

Social Position

As noted above, the structural determinants of health illuminate the ways in which socioeconomic and political contexts create and interact with individuals' social and economic positions [10]. In the literature we reviewed, immigration status is one of many social positions that result in social and political exclusion in Canada, along with others such as race, class, and gender. Not having legal immigration status is a core element of low social position in Canada [21, 22, 24, 37]. Authors of the reviewed articles note that such low social positions are characterized by socioeconomic precarity [4, 29], vulnerability to abuse and precarious working conditions [28, 33], and experiences of stigmatization [39].

Intermediary Determinants of Health

According to the WHO framework, intermediary determinants of health are the everyday practices and processes that affect health, influenced by the operationalization of the structural determinants described above [10]. We identified three main themes in the literature, as well as subthemes, that we categorized under intermediary determinants of health: social practices and psychosocial conditions, living and working conditions, and healthcare and social services (see Table 2).

Social Practices and Psychosocial Conditions

While the WHO framework separates social or behavioral practices from psychosocial conditions or circumstances, we found the two to be intertwined in the literature, as people's psychosocial conditions are often revealed through their social practices. We present our findings, organized by sub-theme, here.

Fear of Deportation and Social Isolation Fear of deportation among people without status is cited in the reviewed literature as a major impediment to accessing healthcare and social services [15, 16, 20–22, 25, 37, 39–41]. There is a prevalent fear of government authorities in the non-status population [18] and an awareness of the perpetual threat of deportation [26, 42]. Service delivery organizations often ask for identification in order to establish entitlement, leading to avoidance of these organizations [4, 19]. Fear that healthcare information will be shared with immigration authorities can discourage utilization [15, 20, 21, 35]. Even if they are not afraid of being deported outright, people who have immigration or refugee applications in process may worry that service utilization could jeopardize application outcomes [17]. One strategy employed by people without status to avoid deportation is social isolation [18, 39, 41]. They make themselves invisible [22, 35], decreasing com-

munity participation [42]. While isolation in these cases is a strategic practice, it can also be a result of a lack of social support and not knowing where to go for help [22, 41]. Studies show a lack of family psychological support [18] and limited feelings of belonging [22].

Healthcare Avoidance A highly cited behaviour among immigrants without status in Canada is healthcare avoidance [18, 24, 35, 40]. As noted above, such avoidance is cited in connection with fear of deportation [15, 20, 21, 35], but cost is another significant reason for healthcare avoidance [15, 21, 28, 38], given that hospitals charge people without status for services. In addition, in order to seek care, many people have to give up work hours, increasing the total cost of care [22]. People may delay seeking care until conditions worsen [9, 19, 26], presenting to the emergency department for critical conditions [25, 31]. Care may also be avoided because services do not meet specific needs [39]. Mental health services in particular lack culturally-informed and language-appropriate options, leading to underuse [41].

Multiple Responses: From Creative Strategizing to Powerlessness According to the literature, people without status may fall along an emotional spectrum that ranges from resilience to defeatism [26, 43]. The purposeful isolation described above is just one of many examples of what Ellis and Stam [21] call “creative strategizing” (p. 11) among people without status [15, 35, 42]. They may find other ways to act within oppressive power structures to improve their situations [43], such as mobilizing resources and networks in order to fulfill their present and future needs [15, 20, 42]. Some people without status feel that working in Canada fulfills a long-held ambition and feel a sense of increased autonomy and decision-making power, seeing challenges as opportunities [43]. Many engage with their communities in Canada and consider themselves deserving of entitlements and services [26]. However, people also report feeling powerless, helpless, hopeless, stuck, or unable to plan for the future [18, 19, 21]. They may experience a loss of motivation associated with waiting to acquire status [18] or knowing that they have no possibility for obtaining permanent status. They may feel suspended in a state of limbo knowing that they could be deported at any time [42].

Living and Working Conditions

The WHO framework identifies living and working conditions as material circumstances that are intermediary determinants of health [10]. The reviewed literature discusses differential access to decent living and working conditions as being tied to health and wellbeing for non-status immigrants in Canada. Many have poor living conditions [18, 26], experience food insecurity [26], and have limited work

opportunities [35]. They may earn low wages [15, 35] and have poor working conditions [15, 18, 24, 42, 43]. Without legal status, they are often only able to access precarious work [21] which keeps them vulnerable to deportation, and they may be forced to accept low pay and poor conditions due to fear of their lack of status being exposed [18]. They may experience wage theft, gendered wage disparities, higher risk of injury [22], and sexual exploitation [19]. Furthermore, it can be difficult to shift out of a precarious work pathway, even if secure legal immigration status is eventually obtained [18, 43]. Thus, there is a strong relationship between precarious immigration status and long-term unemployment [27].

Healthcare and Social Services

In the WHO framework, the healthcare system is characterized as an intermediary determinant of health [10]. Here we describe health system-related determinants discussed in the literature: lack of coverage, limited access, and other barriers and facilitators to utilization. While these themes overlap with the section on social practices and psychosocial conditions, we have kept them separate in our analysis because we view the themes here as specifically system-related determinants rather than social or psychosocial determinants.

Lack of Coverage Lack of health insurance coverage among people without status in Canada is highly cited in the literature [4, 15–18, 24, 28, 29, 33, 36, 40, 44]. This is because access to Canadian provincial and federal health insurance is directly linked to immigration status [38]. Therefore, as noted above, many people without status have to pay for care [22, 39]. Though uninsured people do have the option of purchasing private health insurance, this is usually not feasible due to pre-existing conditions, high costs, and age-related exclusions [13].

Limited Access to Health and Social Services Lack of coverage is directly associated with limited access to healthcare [18, 21, 22, 24, 29, 33, 38]. People without status in Canada are less likely than those with permanent status to be able to access emergency care, primary care, medications [37], and prenatal care [15, 28, 36, 40]. They also have limited access to education [20, 21, 23] and to official accreditation if they do complete schooling [18]. People without status have limited or no access to workers' compensation, employment insurance, or welfare [18]. They are also prevented from accessing settlement services and social assistance, and from participation in federally-funded language instruction classes [4].

Barriers and Facilitators to Utilization Even when people without status do have access to healthcare or social ser-

vices, the literature indicates that access does not ensure utilization [16]. Barriers to utilization can be financial, logistical, or cultural [28]. As we have noted, cost is a major barrier to accessing healthcare, due to having to pay if one is without status [15, 28, 40]. As a result, people may experience debt resulting from healthcare costs [15, 18, 22, 28, 33, 40]. Although people without status can access some healthcare through community clinics, such clinics may have inadequate capacity that limits access [4, 13]. People may lack familiarity with the healthcare system, be unaware of available services, or be unable to find providers who will care for them in a culturally or linguistically appropriate manner [17, 39–41]. Those who are technically eligible for certain services may not know their rights [24].

Provider ideology can be either a barrier or a facilitator to accessing services. Some authors argue that healthcare providers in Canada have a moral obligation to protect those without status [14, 18]. However, Ruiz-Casares et al. [32] point out that even healthcare providers and staff who value human rights do not necessarily support expanding access to care for people without status. While some frontline workers may be able to exercise discretion as to who they agree to serve [4], in many cases, access to care depends on staff and providers' willingness to bend the rules [24]. Some providers feel ethically obligated to offer uninsured patients emergency care, but not non-emergency care [31]. Munro et al. [28] note that procedures for caring for those without status often have to be "arranged outside the regular pathway of care" (p. 602). By avoiding recording what services are provided and to whom, providers may be able to offer services [32]. However, lack of systematic documentation obfuscates the need for these services [25]. Caring for people without status in most healthcare settings is taken on as additional, unpaid work [4, 28, 33], and people may be turned away.

Health Consequences

While it is clear in the literature that structural and intermediary determinants impact the health and wellbeing of people without status in Canada, available evidence on specific health consequences is limited. Those articles that do cite specifics usually reference a particular group of people (e.g. pregnant women). Here we present the health consequences documented in the current literature in order to show what is known about the specific impact on health and wellbeing for people without status in Canada, as well as to reveal the outstanding knowledge gaps.

Broad Impact on Health and Wellbeing

Many of the articles we reviewed reference a general negative impact on the health and wellbeing of people without status in Canada without discussing specific health

outcomes. Authors identify poor health outcomes for pregnant women [40] and poor outcomes in general due to care-seeking delays [24]. Villegas [42] reports that not being able to plan for the future can have a negative impact on both physical and mental wellbeing.

Physical Health Consequences

Some articles identify specific physical health consequences of being without status, though the outcomes are most often for the entire uninsured patient population, as data to allow stratification based on type of immigration status are not usually available [38, 44]. Uninsured people have higher rates of emergency department presentation for injuries and obstetrics issues than the general population [38]. Uninsured children have higher rates of emergency department presentation with musculoskeletal injuries and lacerations, and report higher rates of family violence than insured refugee claimant children [29]. There are higher rates of HIV-positive patients in the uninsured population [44]. People without status report higher rates of accidents, pregnancy, and childbirth compared to other groups of migrant workers [15].

Mental Health Consequences

Decreased mental wellbeing is cited in the literature as a consequence of being without status [18, 41]. Specific mental health consequences include stress, weakness and fatigue [21], depression, anxiety [15], suicidal thoughts, post-traumatic stress disorder, and substance abuse [29]. Uninsured people have higher rates of emergency department presentation for mental and behavioral health issues [38]. Chen et al. [39] report that some people have frequent anxiety attacks due to worries about HIV, legal status, underemployment, and financial insecurity.

Lower Quality Care

Many studies cite lower quality care for people without status than for the general population in Canada [16, 22, 33, 36, 38]. There is limited continuity of care for this population [37], which is especially problematic for those with chronic diseases [16]. There are fewer referrals, lack of tests, lack of follow up, and delays in consultation [18, 28]. Studies report inadequate prenatal care due to delays and missed screening opportunities [26, 36, 40].

Recommendations for Research, Policy and Practice

The authors of the reviewed articles recommend actions that could advance the achievement of health equity for people without status in Canada (see Table 3). More research is recommended on the complexity of migrants' experiences

[21], the health situations and consequences for people without status [18, 36, 40], and the impact of lack of access to services and lack of opportunities to obtain permanent status for people with precarious status [14, 27, 29]. Authors also recommend research into how different forms of marginalization are compounded to produce exploitation [22]. Collaborative research is recommended beyond academia [20]. Policy recommendations include providing pathways for acquiring permanent legal status [17, 19, 42]; upholding the right to health and other human rights protections in Canada's health, work and immigration policies [24, 27, 34], addressing disparities in access to care [33, 36], and ensuring providers are compensated to provide care to populations without status [13]. Recommendations are made for practice include: education and training for healthcare providers on access to care and health and human rights [15, 16, 28, 31, 32]; improving access to services [17, 19]; and including documentation of immigration status in medical records [29].

Discussion

Our review of the literature illustrates how the health of people without status in Canada is shaped by structural and intermediary determinants. Applying a postcolonial perspective to the WHO SDoH framework, we examine the SDoH not as passively existing entities, but as factors produced by a global neocolonial and neoliberal regime, operating both in Canada and internationally to create stark social and health inequity [7]. It is our position, supported by the literature, that the structural determinants of health shape the opportunities available to people without status in Canada and how they are viewed by the Canadian public and service providers in particular [16, 18, 25, 36]. People without status are held responsible for their lack of status, are not offered pathways for regularization, and are kept in precarious positions of deportability [17, 34]. The symbolic and material consequences of the structural determinants of health are evident in our analysis of the intermediary determinants, a confluence of factors that result in poor living and working conditions and limited access to healthcare and social services [15, 18, 24, 26, 35, 42, 43]. These intermediary determinants are direct effects of the precarity institutionalized by structural determinants [4, 14, 16, 17, 24, 30], and they lead to the health consequences described above.

In this review, we have challenged traditional biomedical interpretations of health by including studies that explore experiences of stress, weakness, and fatigue, among other broad health consequences. While not specific medical diagnoses, these issues constitute an undeniable burden on the health of people without status in Canada. Still, while there is a clearly documented negative impact of being without

Table 3 Recommendations

Research	Policy	Practice
Understand the impact of limited opportunities for regulation of status [27]	Establish an interdisciplinary national working group to provide evidence-based recommendations to address uninsured issues for at the provincial and federal levels [13]	Physicians have a duty to provide care [13]
Research the health situations of people without status and the impact on the community and the healthcare system [18]	Policy makers must ensure providers are compensated to provide care rather than reliance on volunteer clinics [13]	There must be routine usage of interpreters, improved clinical cultural competence, employment of people to assist with navigation of the healthcare system, and accessible information on healthcare eligibility and available services [17]
Research into the complexity of migrants' experiences [21]	Create more inclusive immigration policies and more flexibility around migrants' ability to document their presence [42]	Health professionals must advocate for the right to healthcare and ethicists can speak to the question of justice of denying access to care [34]
Examine how precarious status has been institutionalized to restrict social services [14]	Provided a pathway for everyone to acquire permanent legal status [17]	Healthcare personnel should be educated so that they can critically engage with the myth of universality, and trained in health and human rights [16, 32]
Understand how interlocking forms of marginalization produce exploitation and oppression [22]	Canada must uphold its commitment to the International Covenant on Economic, Social and Cultural Rights, recognizing the "the right of everyone to the highest attainable standard of physical and mental health" [34]	Healthcare workers must understand the overlapping vulnerabilities of precarious status migrants [15]
Better understand the health consequences and costs of uninsured [36, 40]	Provide opportunities for less expensive care [33]	Providers should be guided and educated to ensure appropriate maternity care for uninsured [28, 31]
Research is needed the impact of insurance status and migratory status on access to care in order to inform policy [29]	The state must use 'personhood rights' rather than 'membership rights' as the basis for healthcare [24]	Include health insurance status and migratory status in medical records [29]
Collaborative research beyond the university [20]	Address disparities in access to perinatal care [36]	Adopt "don't ask, don't tell" policies to improve access to services [19]
	Work protection must cover all workers, shifting from a citizenship approach to a human rights approach [27]	
	Make the six month temporary residency permit permanent under the immigration and refugee protection act [19]	

status in Canada on overall health and wellbeing, we found a dearth of research on specific health consequences for this population. We hypothesize that this is due in part to the difficulty inherent in studying a population that is not identifiable through standard demographic methods, as well as to the limited conceptualization of health currently used by clinicians and researchers in the health sciences. The lack of data is a sign of the invisibilization of people without status in Canada.

Our analysis reveals that immigration status is the foundational determinant of health for people without status in Canada. The intersection of the structural determinants of health with socially entrenched occupational prestige, patriarchy, heteronormativity, racialization, and xenophobia, among others, can lead to multiple social positions. For instance, being a white, heterosexual European immigrant with permanent status produces a starkly different social position than being a Black, transgender Latina immigrant without status. Non-status immigrants tend to occupy a very low social position in Canadian society. In Fig. 1 we synthesize the structural determinants (socioeconomic and political contexts), social positions, and intermediary determinants

affecting the health of people without status in Canada to show how health inequity is produced. The elements found in this literature review are represented (e.g. temporariness and invisibilization), along with other features of Canadian society (e.g. racism and shadism) that contribute to inequity, particularly in terms of health consequences. Depending on how the SDoH are manifested in everyday life, health consequences may vary considerably. Therefore, Fig. 1 does not represent a singular experience for all people without status in Canada. The synthesis is a visual representation of potential intersections that could lead to differential forms of health inequity. Our goal is to offer a reminder to policy-makers, service providers, and researchers that while people without status live in the same society, their unique political, social and economic circumstances, which are produced both internationally and in Canada, determine their health differently from those with secure immigration status.

Future Directions

It is our view that understanding the unique social position of people without status, produced by structural and

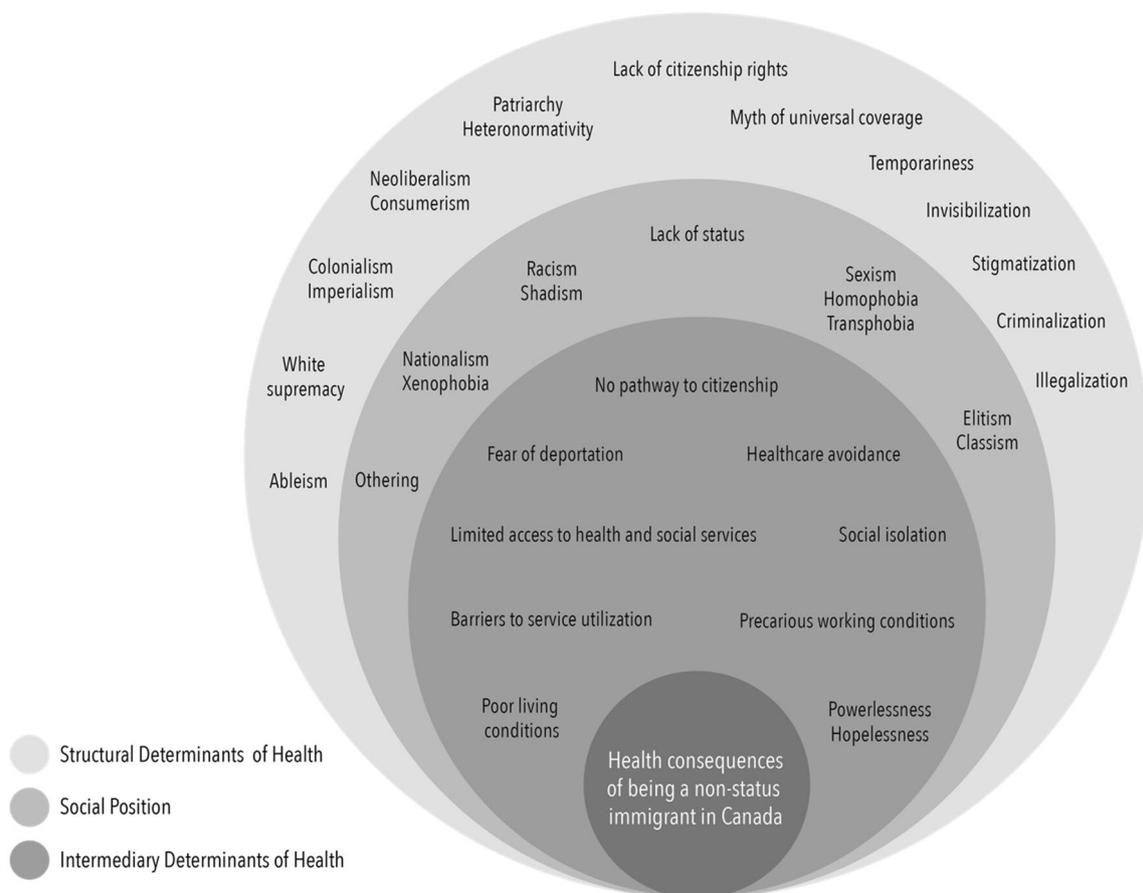


Fig. 1 The production of health inequity for non-status immigrants in Canada

intermediary determinants of health, can help improve social and health services and policies that shape these services, thereby improving health outcomes for people without status in Canada. As our review demonstrates, service providers in Canada tend to work from uninformed and/or prejudicial positions vis-à-vis people without status, perpetuating stigmatizing discourses and enacting exclusionary practices [4, 14, 16, 18, 26]. While some provinces offer limited means of accessing care for people without status, the existence of separate pathways for care perpetuates differential care based on immigration status, contributing to a tiered, rather than universal, healthcare system. A more comprehensive and sustainable solution that does not discriminate based on immigration status is needed.

More well-funded and interdisciplinary research could help to fill some of the persisting knowledge gaps highlighted by our review. Together, social and health scientists and community partners can produce research towards a fuller understanding of the broad health and social consequences of the marginalization and exploitation of people without status in Canada. This visibilization of the impact of lack of status on health could lead to policy changes to decrease inequity. However, it is important to note that visibility may also cause political backlash against existing programs and services for people without status, potentially limiting currently available opportunities to access services. Given that maintaining the confidentiality of people without status is vital to avoid the risk of deportation, research requires time, diligence, and the prioritization of individual and family safety.

Limitations

The major limitation of this study is the exclusion of non-peer reviewed literature, including books, theses, and gray literature. Given the challenges involved in studying the non-status immigrant population in Canada, there may be important insights in gray literature.

Conclusions

Our findings are in agreement with Magalhães et al.'s [5] assertion that “having no-status is a significant form of social exclusion which renders immigrants vulnerable to structural conditions” (p. 148). The SDoH impact everyone's life in Canada, but being without status results in particular forms of deprivation and exploitation that negatively impact health and wellbeing. Problematically, the WHO SDoH framework does not highlight immigration status as a determinant of health, even though lack of status affects millions of people around the globe. The inattention to lack of immigration status is a clear gap in the framework. The grave health impact

of being without status can no longer be denied. Our findings demonstrate that the intersection of other determinants of health with lack of immigration status has compounding effects that lead to diminished health and quality of life.

At the time of writing, we in Canada and around the world are facing the unprecedented threat of COVID-19. During the pandemic, strong activism on access to healthcare in Canada has prompted provincial governments to acknowledge the injustice of immigration status-based prohibitions on access to healthcare. For example, the Ontario government passed a policy to grant all people access to medically necessary health services regardless of immigration and insurance status during the pandemic [45]. Unfortunately, the government maintains that this is a temporary change, set to return to previous restrictions when the pandemic ends. It is our hope that this paper will contribute to a growing body of evidence demonstrating the negative health consequences of restricting access to healthcare on the basis of immigration status, and that access to healthcare and other social services will be expanded into the future.

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Declarations

Conflict of interest The authors have no relevant financial or non-financial interests to disclose.

Human or Animal Participants Ethics board review was not required, as this article is a scoping review and the research did not involve human or animal participants.

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