

Disqualify, Disincentivize, and Dissonate

Immigration Law as a Barrier to Migrants' Healthcare Access

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10.1 INTRODUCTION

Being able to access healthcare is crucial to migrants' integration into receiving communities. To the extent that healthcare access promotes good health, it facilitates migrants' active engagement in society (Ager and Strang 2008). Healthcare institutions can also function as a gateway that connects migrants with other resources and opportunities important for settlement (Martone et al. 2014). In countries where healthcare is purported to be universally available, having equal access thereto symbolizes migrants' inclusion, which may encourage their further integration (Peninx 2005).

However, studies from around the world reveal that migrants face a combination of barriers when seeking healthcare in receiving countries. Many migrants lack the financial means or health insurance to obtain the treatment they need (Gil-Gozález et al. 2015). Such impediments are exacerbated by other expenses that migrants often must incur in order to access services, including those relating to transportation, child care, and time off from work (Hill et al. 2021; Tsai and Ghahari 2023). Even when affordability is not an issue, migrants' use of healthcare is frequently hampered by such obstacles as language barriers, health illiteracy, discrimination, and a lack of culturally appropriate services (Kacker et al. 2015; Dougherty et al. 2020; Galanis et al. 2022).

Law, “[b]y establishing the rules and frameworks that shape social and economic interactions” (Gostin et al. 2019, 1857), contributes to and reinforces these healthcare access barriers. Among other things, law defines migrants’ entitlement to government benefits, structures migrants’ encounters with healthcare providers, and dictates the extent to which migrants can avail themselves of socioeconomic resources like income and education (Chen 2017). Particularly immigration law, which governs one’s ability to enter and remain in a country as well as the conditions of such entry and stay, acts as a significant determinant of migrants’ access to healthcare. Research has repeatedly confirmed that “immigration policy is healthcare policy” (Pedraza et al. 2017, 926).

A scan of literature uncovers at least three ways that immigration law can modulate migrants’ healthcare access. First, legal statuses and categories created by immigration law are regularly relied on to demarcate migrants’ eligibility to publicly funded healthcare (Parmet 2020; Castellanos González 2022). Second, immigration law can deter or outright block migrants’ healthcare use by subjecting them to screening and surveillance and by tying service access to adverse immigration consequences (Heyman et al. 2009; Pedraza et al. 2017). Third, restrictive immigration law stigmatizes migrants and can influence the extent to which providers see them as deserving (Grove and Zwi 2006). This in turn sours migrants’ health-seeking experience and their perception of the healthcare system (Larchanché 2012; Castellanos González 2022).

In this chapter, I refer to these three permutations of the link between immigration law and migrants’ healthcare access as disqualification, disincentivization, and dissonance, respectively. Using Canada as an example, this chapter aims to elaborate on these immigration law–related healthcare barriers in turn. In section 10.2, I explain how Canadian immigration law works in tandem with healthcare law to disqualify migrants from healthcare benefits both *de jure* and *de facto*. Next, in section 10.3, I identify several ways that immigration law discourages migrants from utilizing healthcare goods and services, including those that they are in principle entitled to receive. Section 10.4 shifts attention to immigration law’s ability to generate dissonance between service providers’ duty of care toward migrants and their other concerns, such as their views on migrants’ healthcare deservingness and their role as immigration gatekeepers. Examples are provided to show how this dissonance can subsequently turn migrants away from the healthcare system. The chapter concludes with some reflections on the relationship between migrant health and justice, as well as the direction of necessary law reform to improve migrants’ access to healthcare.

For the purpose of this chapter, “law” is broadly defined to encompass not only legislation and court decisions but also rules and practices adopted, both officially and informally, by such decision-makers as civil servants, hospital administrators, and healthcare practitioners when exercising their legally provided discretion. This broader conception of law reflects the reality of neoliberal governance that prevails in countries like Canada, where “authority for immigration control [is divested] from the state to a variety of non-state actors, transforming them into calculable and auditable sites” (Lehman et al. 2016, 45).

10.2 IMMIGRATION LAW AS DISQUALIFIER

Given the costly nature of many healthcare goods and services, accessing them typically requires government assistance. In Canada, such government support primarily takes the form of social insurance. One of the ways that immigration law obstructs migrants’ healthcare access in Canada, therefore, is by rendering migrants ineligible for publicly funded health insurance.

According to the Canada Health Act (1985), Canadian provinces and territories must entitle all their residents to government health insurance plans. Failure to do so may cause provinces and territories to lose their annual healthcare funding from the federal government. A resident for this purpose, however, is not defined by physical presence alone. Rather, it refers to “a person lawfully entitled to be or to remain in Canada who makes [their] home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province” (Canada Health Act 1985, s. 2). The demand that an insured person be “lawfully entitled to be or to remain in Canada” and not be “a tourist, a transient or a visitor” has prompted corresponding provincial and territorial laws either to explicitly limit health insurance eligibility to those who possess certain citizenship or immigration statuses, or to be interpreted to the same effect (Health Canada 2025). As such, immigration rules around who is permitted to reside in Canada, and with which status, become embedded in healthcare law to deny public insurance coverage to some migrants.

In recent decades, migrants’ healthcare entitlement in Canada has been in lockstep with the logic of neoliberal governance that grabs hold of Canada’s immigration system. It valorizes “autonomous, flexible individuals open to risk-taking and aversion while barring the entry of those perceived as integrative risks or social burdens” (Walsh 2011, 872). Migrant workers, with their perceived entrepreneurialism and labor market

engagement, are often regarded as an example of the former. Consequently they are awarded public health insurance coverage across the country, provided that their work permits are valid for the legislatively stipulated length, which is six months in some parts of Canada and 12 months in others (Chen 2017).

In contrast, asylum seekers—namely, those who have applied for refugee protection in Canada but whose status as a refugee is not yet confirmed—are frequently portrayed in policy discourse as a threat to national security and to the economy (Huot et al. 2016). They are disqualified from all provincial and territorial health insurance plans (Chen 2022). They must instead rely on the Interim Federal Health Program (IFHP) administered by the federal government for healthcare assistance, and their entitlement is not immune from the restrictive effects of immigration law either. Between 2012 and 2016, in the name of limiting government spending and combating fraud within the refugee system, healthcare benefits under the IFHP were stratified in favor of asylum seekers whose claim for protection was deemed more genuine. Asylum seekers from a list of Global North countries considered improbable to produce refugees, as well as people who received a negative first-instance decision on their asylum claim, had their healthcare coverage significantly reduced (Dhand and Diab 2015).

Canadian healthcare law is similarly unsympathetic toward migrants who lack any immigration status in the country. These migrants are excluded from both provincial and territorial health insurance, as well as the IFHP (*Toussaint v. Canada (AG)* 2011). For them, immigration law not only operates at the international borders to block their entry to Canada, but it also follows them even after they somehow find a way in, to impede their social integration by depriving them of healthcare entitlement. Notably some provinces and territories have extended such healthcare disenfranchisement beyond migrants themselves to encompass their Canadian-born children, who are Canadian citizens by birth. For instance, in Nova Scotia a government policy provides that children born in the province to non-citizen parents will not qualify for public health insurance unless their parents are legally deemed residents (Nova Scotia Department of Health and Wellness 2014). Relevant laws in British Columbia, Alberta, and, until recently, Quebec likewise tie the healthcare coverage of children born to migrants to the resident status of their parents (Rahimian 2020).

Besides manipulating who is considered a resident and who is a “genuine” asylum seeker, immigration law can affect migrants’ healthcare eligibility by making it difficult for them to produce the necessary documents or meet other administrative requirements. This healthcare barrier can manifest either *de facto* or *de jure*. A *de facto* healthcare disqualification of this sort arises when access to healthcare goods and services is conditioned upon

certain requirements not specified in the formal policy on healthcare eligibility, such as a need to present personal identification or proof of residency. As a case in point, when COVID-19 vaccine first became available, the government of Ontario assured that everyone in the province would qualify for it regardless of their citizenship and immigration statuses. Yet for a brief period after the vaccine was rolled out, some migrants could not book a vaccination appointment through the province's website because they had to enter a health insurance card number, which they did not have (Fox 2021). For migrants who were able to secure an appointment, some reported being turned away by service providers because they failed to show a provincial health insurance card when requested (O'Shea 2021). In both instances, as immigration status dictates whether a person is eligible for the requisite documentation, immigration law effectively acts as a healthcare disqualifier, albeit not at the stage of policymaking but at the point of service access.

For an example where immigration law draws on documentation requirements to deprive migrants of publicly funded healthcare *de jure*, consider the above-mentioned Nova Scotia policy. Pursuant to that policy, asylum seekers who have been granted protection in Canada are eligible for the province's health insurance program only if they have a letter from the federal immigration department confirming their application for permanent residence (Nova Scotia Department of Health and Wellness 2014). However, protected persons may be unable to immediately apply for permanent resident status for reasons ranging from unaffordability of the application fees to delay caused by the need to change names and/or gender markers first. Even if protected persons could submit their permanent residence application expeditiously, there is no guarantee that a letter from immigration authorities acknowledging this application will arrive quickly. All the while, asylum seekers will typically lose their IFHP benefits 90 days after being successfully recognized as people in need of protection (Government of Canada 2024). This means that the immigration-related documentation requirement in this case has the potential of leaving protected persons without any publicly funded healthcare, ironically rendering them worse off than before their asylum claim was accepted.

10.3 IMMIGRATION LAW AS DISINCENTIVE

Another way that immigration law hinders migrants' healthcare access is by limiting their ability or desire to seek out healthcare goods and services in the first place. Healthcare law in this situation, when compared with the role it plays when immigration law acts as a disqualifier, is less complicit

in the obstruction of migrants' healthcare access. Rather than actively exploiting immigration categories and processes to circumscribe migrants' health insurance eligibility, when immigration law functions as a disincentive healthcare entitlement of the affected migrants is clearly provided. What immigration law does in such a scenario is cause migrants to refrain from using healthcare that they qualify for by linking healthcare utilization to some negative immigration consequences. As migrants strive against jeopardizing their ability to remain in or return to Canada, any healthcare entitlement they supposedly enjoy turns out to be illusory.

The disincentivizing effect of Canadian immigration law on migrants' healthcare access starts before one's arrival in the country. With a history of discrimination, Canada has long barred the admission of migrants who are suspected of imposing a burden on public resources (Hanes 2009). Today prospective migrants are found inadmissible to Canada if "their health condition . . . might reasonably be expected to cause excessive demand on health or social services" (Immigration and Refugee Protection Act 2001, s. 38(1)). This rule impedes migrants' access to healthcare in at least two ways. It physically keeps certain prospective migrants out of Canada and, by extension, prevents their utilization of Canadian healthcare goods and services. Moreover, insofar as the evaluation of excessive demand takes into account prospective migrants' past medical expenses, it discourages these migrants' healthcare use even before their seeking entry to Canada. For example, up until 2018 a federal policy deemed most HIV-positive immigration applicants who were on antiretroviral treatment inadmissible because of the therapy's high cost (Heywood et al. 2002). The only exception to this policy pertained to refugees and certain immigrants coming to Canada through family sponsorship (Immigration and Refugee Protection Act 2001). This raised concerns that some prospective migrants living with HIV who were aware of the policy might choose to postpone treatment in hope of circumventing a finding of excessive demand (Bisaillon 2022).

Even when migrants manage to enter Canada, the influence of immigration law as a disincentive to healthcare access proves inescapable. In particular, when migrants without legal status in the country are exceptionally made eligible for certain publicly funded healthcare, the risk of their being discovered by immigration authorities during the health-seeking process and subsequently removed from Canada poses a serious roadblock to healthcare access (Magalhaes et al. 2010). More than empty threats, detection and deportation of non-status migrants following healthcare use has been reported in the media (Britten 2016). In some Canadian jurisdictions, such as Ontario, the possibility of such immigration surveillance is aided by privacy legislation that authorizes immigration status collected in healthcare settings to be shared with law enforcement without the need

for a warrant if the disclosure aims to assist with an investigation (Macnab 2021).

Outside the context of irregular migration, another well-documented example of Canadian immigration law acting as a healthcare deterrent concerns migrant agricultural workers. Each year the Seasonal Agricultural Worker Program (SAWP) brings in tens of thousands of migrants from Mexico and the Caribbean, who are desperate to earn a better living, to work in Canada's agri-food sector (Hennebry and Preibisch 2012). On paper, these migrant workers either enjoy provincial or territorial health insurance coverage or have private health insurance that employers are obligated to purchase on their behalf. They are also covered by provincial or territorial workplace safety and insurance regimes (MacIntosh 2018). In reality, however, many seasonal migrant workers do not seek healthcare or report work-related illnesses and injuries (Hennebry et al. 2016).

Although multiple factors contribute to seasonal migrant workers' underutilization of healthcare, a significant culprit is the extreme power imbalance created and reinforced by law between these migrants and their Canadian employers, which in turn places these migrants under constant fear of losing the ability to continue working in Canada, thus losing their income (MacIntosh 2018). Pursuant to the agreements reached between Canada and SAWP-participating countries, early cessation of seasonal migrant workers' employment contract is permitted in cases of workers' noncompliance, refusal to work, or for "any other sufficient reason" (Employment and Social Development Canada 2025a, s. 12.1; Employment and Social Development Canada 2025b, s. 10.2). In the absence of a clear definition of what constitutes "sufficient reason," Canadian employers have for years repatriated migrant workers prematurely with impunity when workers become sick, injured, or pregnant (Orkin et al. 2014). What is more, employers have the ability to request specific migrant workers' return in subsequent years, which ensures the named workers' continued participation in the SAWP (MacIntosh 2018). This naming system, coupled with the threat of early repatriation, exerts a coercive pressure on seasonal migrant workers to appear fit and to avoid healthcare use. Indeed, studies show that up to half of the seasonal migrant workers surveyed either have at one point decided to keep working while being ill or know a colleague who did so (Brem 2006; Hennebry et al. 2016).

Just as in circumstances where immigration law precipitates migrants' disqualification from public healthcare, when immigration law operates as a disincentive, its impact on healthcare access extends to migrants' Canadian-born children as well. The healthcare gap facing some newborns in Ontario offers an illustration of this spillover effect. Legally, any child born in Ontario, regardless of their parents' immigration status, is covered by the

provincial health insurance so long as Ontario is their intended primary place of residence (R.R.O. 1990, Reg. 552). The health insurance registration process for newborns usually entails parents completing a simple mail-in registration form provided by either birthing hospitals or midwives. However, occasionally, hospital staff who have doubts about a newborn's residency in Ontario have opted to provide the parents with a "proof of birth" letter instead. The parents must then bring the letter to a government office to register their child for the provincial health insurance in person (Bates and Cheff 2018). This extra step imposes a burden on migrants, particularly those without legal status, who may have good reasons, as explained, to want to minimize direct interactions with government bureaucrats. And as a result of this hesitation, their Canadian-born children may end up with no public health insurance despite being eligible to register for it (Cheff and Bates 2018).

10.4 IMMIGRATION LAW AS DISSONANCE

In addition to disqualifying migrants from publicly funded healthcare and disincentivizing them from healthcare use, immigration law can come between migrants and their healthcare access by fueling stigma and discrimination toward migrants, thus pitting healthcare providers' patient-care responsibilities against certain other concerns. These other considerations may include, for example, healthcare practitioners' negative appraisal of migrants' healthcare deservingness and the immigration control function that healthcare providers are sometimes asked to assume. When these other considerations overshadow healthcare providers' duty of care toward migrants, the health-seeking experience of migrants often suffers. Sometimes migrants are denied healthcare by service providers outright, while at other times the health-seeking encounter proves so distressing that migrants end up choosing to disengage from the healthcare system.

Because its impact on migrants' healthcare access is mediated by migrants' unpleasant encounter with the healthcare system, immigration law, when acting as a source of dissonance, need not explicitly aim to inhibit migrants' healthcare use. In fact, immigration law in this situation may even have a stated purpose of bettering migrants' health. This distinguishes it from the two varieties of healthcare access challenges explored above, where immigration law is more openly hostile toward health-seeking migrants. Incidentally, this also gives rise to dissonance of another sort, between the law's supposedly health-promoting purpose and its health-impairing effects in actuality.

In particular, the dissonance generated and exacerbated by immigration law has had a profound impact on asylum seekers' healthcare access in Canada. Canadian immigration law has long contributed to the othering of asylum seekers (Olsen et al 2016). It does so, for example, by allowing asylum seekers who arrive in groups to be designated as irregular arrivals, who are subject to potentially lengthy detention as well as restrictions on their legal rights (Protecting Canada's Immigration System Act 2012). For a period of time, Canadian immigration law also targeted asylum seekers from certain countries that were considered "safe" by limiting their rights to appeal negative refugee determination decisions and to apply for alternative immigration pathways that may allow them to stay (Protecting Canada's Immigration System Act 2012). These immigration measures perpetuate the stereotype of asylum seekers as fraudsters who take advantage of the refugee system to bypass the usual immigration mechanisms (Huot et al. 2016). They cast suspicion on asylum seekers in the public discourse and paint asylum seekers as undeserving of social benefits (Jackson and Bauder 2014).

In the healthcare context, the influence of Canadian immigration law's othering effect on asylum seekers' deservingness is amplified by the setup of asylum seekers' healthcare in Canada. As described, asylum seekers receive publicly funded healthcare in Canada through the IFHP instead of provincial and territorial health insurance programs. The establishment of the IFHP circa 1995 was the federal government's response to successive decisions made by some provinces in preceding years to withdraw asylum seekers' coverage from their respective health insurance plans (Chen 2022). As such, the origin of the IFHP in itself exhibits the trappings of asylum seekers' othering, and the program stands as a constant reminder of asylum seekers' separation from the general populace.

Added to that, the IFHP operates on the basis of charity, and this opens asylum seekers' healthcare deservingness to greater scrutiny. On more than one occasion, coverage under the IFHP is characterized by the government as *ex gratia*, namely "a benevolent payment . . . made in the public interest . . . where the [government] has no obligation of any kind or has no legal liability or where the claimant has no right of payment or is not entitled to relief in any form" (*Canadian Doctors For Refugee Care v. Canada (AG)* 2014, para. 356). This representation contrasts with the typical characterization of provincial and territorial health insurance as an entitlement enjoyed equally by all residents. Seeing as charity is grounded in generosity as opposed to obligation, healthcare under a charitable approach "is always discretionary," where "the question of who should receive what kind of care is continuously negotiated and defined" (Huschke 2014, 353).

Given the logic of charity, asylum seekers' healthcare access under the IFHP hinges significantly on their perceived healthcare deservingness (Olsen et al. 2016). As the specter of "bogus refugees" conjured up by immigration law chips away at the socially constructed image of asylum seekers as vulnerable and in need of society's assistance, uncertainty about asylum seekers' deservingness grows (Vanthuyne et al. 2013). Research into patient experience under the IFHP has consistently identified access problems stemming from healthcare providers' hesitation to treat asylum seekers. Many healthcare practitioners never sign up to become service providers under the IFHP, and even when they do, some are known to have turned asylum seekers away either because they have not familiarized themselves with the program or because they find maneuvering the program too complex to be worth their effort (Chen et al. 2018; Leps et al. 2022). At times healthcare providers have charged asylum seekers for services or goods that are supposedly covered by the government, because they felt the government reimbursement process was too slow (Miedema et al. 2008). In short, asylum seekers' healthcare access under the IFHP is partly at the mercy of service providers' whim. Whereas immigration law shapes healthcare providers' calculus by raising doubts about asylum seekers' deservingness, the workings of the IFHP as charity normalizes providers' subsequent decision to refrain from caring for asylum seekers. After all, benefactors have no duty to keep giving if they no longer feel generous.

Although a conception of healthcare as charity rather than entitlement can help mobilize the dissonating effect of immigration law, it is not a precondition for this type of healthcare access barriers. To illustrate this point, I now turn to the impact of Canada's immigration medical exams on the healthcare access of some migrants living with HIV.

Besides the deterrence of fraud, another long-standing objective of the Canadian immigration system has been to mitigate the ostensible public health risk posed by migrants, which has its roots in another stereotype that views migrants as diseased bodies (Reitmanova et al. 2015). To that end, Canada's Immigration and Refugee Protection Act (2001) requires a large number of migrants to undergo medical exams as a part of their application for a visa, refugee protection, or permanent residency. Since 2002 these immigration medical exams have included mandatory HIV testing for all individuals age 15 and above (Bisaillon 2010). Migrants who test HIV-positive during this process are not automatically denied admission to Canada. However, as mentioned earlier, they may be found inadmissible on the ground that they are expected to pose excessive demands on Canada's healthcare system.

Studies reveal that “panel physicians,” who are contracted by the government to perform the immigration medical exams, often conduct the HIV tests in a manner that falls short of professional ethics and internationally accepted medical standards (Bisaillon 2011). According to relevant guidelines published by the World Health Organization (2021), provision of pre-test information and post-test counseling is key to improving people’s knowledge about HIV, reducing HIV-related stigma, and facilitating HIV-positive persons’ linkage to care. Despite this, migrants who test positive for HIV during the Canadian immigration process have complained about panel physicians not adequately preparing them for the receipt of positive results, not offering them sufficient support to cope with the diagnosis, as well as not properly referring them to treatment and other resources (dela Cruz et al. 2022). Migrants have also raised concerns about potential breaches of confidentiality by panel physicians and their staff during and after the HIV testing process (Bisaillon and Ells 2014).

These troubling doctor-patient interactions have led commentators to conclude that the work of panel physicians when carrying out the immigration medical exams is “primarily focused on disease detecting and reporting[, thus] blurring the role of the doctor whose work in this setting is not about care as conventionally understood” (Bisaillon and Ells 2014, 294). In other words, panel physicians effectively function as immigration gatekeepers, and in that capacity their administrative responsibilities take precedence over their duty toward migrants as patients. To the extent that this dissonance between panel physicians’ dual roles tarnishes migrants’ perception of the Canadian healthcare system at large, it risks alienating migrants from the system and causing them to refrain from seeking care in the future (dela Cruz et al. 2022). In the HIV context, such a barrier to healthcare access is all the more problematic in light of the government’s public health objective, given how important HIV treatment is to curbing the risk of HIV transmission (Cohen 2011).

10.5 CONCLUSION

In this chapter, I have used examples from Canada to illustrate how immigration law hampers migrants’ access to healthcare through disqualification, disincentivization, and dissonance. Each of these healthcare access barriers results from a unique form of interplay between immigration and healthcare laws, whose respective intent to discourage migrants’ healthcare use varies. First, immigration law and the various legal statuses it creates can feed into exclusionary healthcare law and serve as the bases

for migrants to be disqualified from public healthcare programs. Second, in situations where healthcare law does furnish migrants with entitlement to publicly funded healthcare, immigration law can still disincentivize migrants' healthcare use by threatening them with adverse immigration consequences. Third, even when both immigration and healthcare laws do not outwardly aim to block migrants' healthcare access, immigration law can nevertheless achieve the same effect by causing healthcare providers to interact with migrants in ways that are dissonant from their patient-care responsibilities. As such, these three mechanisms together provide somewhat of a typology of immigration law-related impediments to migrants' healthcare access.

Although an in-depth comparative analysis is beyond the scope of this chapter, a cursory scan of literature suggests that the three-prong typology that I have advanced here also finds resonance in countries other than Canada. For instance, in the United States the disqualifying effect of immigration law is on display when migrants without legal status are excluded from an array of federally funded healthcare programs and are barred from purchasing affordable health insurance on the exchanges (Parmet 2020). Likewise, instances of American immigration law acting as a disincentive abound. Under a now-repealed rule introduced by the first Trump administration, access to certain healthcare benefits risked rendering migrants a "public charge" and inadmissible to the United States, and as a result it caused many migrants to forgo these benefits despite eligibility (Parmet 2020). Furthermore, insofar as medical screening is a mandatory component of migrants' application for permanent residency in the United States (Aptekar 2020), as in Canada, it seems reasonable to expect similar unpleasantness to arise when migrants encounter healthcare practitioners who place their role as immigration gatekeepers ahead of their patient-care responsibilities, thus causing migrants to become disengaged from the healthcare system. Indeed research from France corroborates such a possibility. It observes that physicians' involvement in the immigration process, such as being requested to provide a medical certificate attesting their migrant patients' need to remain in the country, could undermine the trust between them and these migrants (Cailhol et al. 2020).

At the same time, this typology does not purport to be exhaustive. To name but one example, immigration law is also known to interfere with migrants' access to healthcare by placing them in vulnerable socioeconomic circumstances, including financial hardship, precarious employment, social and/or geographical isolation, and more (Ahmed et al. 2016). However, seeing as migrants' health-seeking challenges in this case are mediated by

other socioeconomic determinants of healthcare access (e.g., income, work conditions, social isolation), their link with immigration law is arguably less direct than when immigration law acts as a disqualifier, a disincentive, or a source of dissonance.

Imperfections notwithstanding, the typology developed in this chapter still offers important lessons on the obstacles that migrants face when accessing healthcare and what should be done to remedy them. For one, by identifying different ways that immigration law can thwart migrants' access to healthcare, the typology challenges the inevitability of the status quo and underscores the fact that migrant health is a matter of social justice (Vissandjée et al. 2017). That is, at least some aspects of migrants' health, relative to that of the general population, represent "avoidable health differences on which excluded or marginalized groups fare worse than socially better-off groups" (Paula Braveman et al. 2018, 4). Or, to quote Alicia Ely Yamin (2008, 47), the various legal dynamics unearthed and encapsulated by the typology "[force] us to see the suffering that is not the result of 'natural' biological causes but rather stems from human choices about policies, priorities, and cultural norms, about how we treat each other and what we owe each other." It follows that the betterment of migrant health will necessitate collective interventions to refashion sociolegal structures which prejudice and ostracize migrants (Wiley 2014).

Specifically, the typology draws attention to three areas of immigration law where a different collective choice needs to be made: Should immigration status inform one's eligibility for publicly funded healthcare? Should migrants' utilization of healthcare be shielded from border surveillance and delinked from immigration processes? And should immigration law continue to be organized around principles that stereotype migrants, including those depicting them as fraudulent and a public health threat? A complete strategy for improving migrants' healthcare access must involve legal reform on all these fronts. At minimum, this entails the establishment of firewalls between systems of immigration enforcement and healthcare provision, such that decisions about healthcare can be made without the undue influence of immigration controls. Beyond that, changes must also be made to immigration law more generally, even facets of it that do not appear to immediately concern healthcare. Among others, laws that provide for the differential treatment of migrants based on perceived self-sufficiency and contribution, as well as asylum seekers based on presumed genuineness, should be eliminated. The aim of this reform is to eradicate immigration law's stigmatization of migrants, which will have a positive signaling effect on migrants' healthcare deservingness. Migrants' well-being, as well as justice, demands nothing less.

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