

POLITICIZING THE WHITE COAT

POLITICIZING THE WHITE COAT:
PHYSICIAN ACTIVISM AND ASYLUM SEEKER HEALTHCARE
IN CANADA, GERMANY AND ENGLAND

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Abstract

The Canadian identity narrative typically centres on two features: universal healthcare and a longstanding tradition of welcoming newcomers – in particular, refugees. In 2012, this mythology was troubled when, without warning, asylum seekers' healthcare access was dramatically limited. In an equally dramatic fashion, physicians and the greater healthcare community took to the streets, occupied offices, and interrupted politicians in an effort to restore refugee claimants' access to healthcare. While this physician-led response was unprecedented in Canada, physicians had previously rallied in a similar fashion in two other universal healthcare countries: England and Germany. Across all three cases, formidable physician responses emerged following efforts to remove or restrict asylum seekers' healthcare access.

In Canada, asylum seeker health restrictions, and the successful social movement they spurred were unexpected entirely. In England, attempts to restrict access are expected, but the government's failure to implement wide-scale reforms are not. Finally, in Germany, restrictions are potentially expected, but one also expects the decades-long advocacy movement to have had greater impact at the national level; instead, ripples of impact are seen unevenly across the country. This prompts two central questions: what conditions are necessary for a national government to successfully restrict asylum seeker healthcare? And, what conditions will support physician-led social movements' efforts to reverse these legislative changes?

This thesis examines these two questions in a three-case comparison of Canada, England and Germany. Drawing on over 60 qualitative interviews with physicians, policymakers, and politicians, this study takes an ecological approach to understanding what factors facilitate reform, and what factors shape successful advocacy movements. In doing so, this study identifies factors at each of the macro, meso, and micro-levels of analysis to map advocacy movements against their institutional contexts and political climates. These findings are of use to scholars of social movements but also everyday advocates and those who drive change within asylum seeker social policies.

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1. Introduction

There's nothing more impressive
than a doctor in a white coat,
haranguing a politician.

(Lorne Waldman, President, Canadian Association of Refugee Lawyers¹)

White coat-clad doctors occupying the Toronto office of Member of Parliament Joe Oliver. Physicians leading protests outside of the offices of Citizenship and Immigration Canada. Tenured medical professors interrupting cabinet ministers' speeches in Vancouver and Ottawa. These images of Canadian doctors advocating for asylum seeker healthcare following cuts to the Interim Federal Health Program (IFHP) in 2012 were certainly not 'politics as usual' for Canadian health providers. Photographs of these physician protests were splashed across newspapers in Canada and around the world, prompting everyday citizens to question what universal healthcare and 'inclusion' really meant in the Canadian context (e.g., Keung, 2013). However, these atypical physician actions were not contained to Canadian borders. In 2003, physicians in England began to rally against proposed asylum seeker healthcare cuts by creating a network of providers who were committed to universal health access. Similarly, in 1993, German policy reform dramatically reduced asylum seekers' coverage, and this too was met with resistance from radical and mainstream physicians, alike, who sought to include asylum seekers in German healthcare.

This thesis examines physician-led asylum seeker healthcare movements in Canada, England and Germany. To understand why movements were met with success in some instances and prolonged struggle in others, I compare the strategies undertaken by physicians against the institutional foundations that shaped their actions, constrained their choices and created opportunities for these social movements to make impact. Canada, England and Germany's empirical stories are woven together using an ecological model that identifies intersections and divergences in each country's approach, while also taking note of the unique national dynamics that shaped each movement's trajectory.

First, the Canadian case serves as the backbone of the analysis. Across the three countries considered in this study, Canada's provision of full healthcare to asylum seekers via the IFHP is

¹ Interview by author, June 7, 2017.

historically the least contentious. Yet, the 2012 Conservative government's IFHP cutbacks were also the most severe. While the previous IFHP framework offered uniform care to all asylum seekers, the new policy provided coverage in emergencies only for some claimants, and no coverage for others. In response to the cuts, physicians launched Canadian Doctors for Refugee Care (CDRC) with the sole aim of reinstating asylum seeker healthcare access to pre-2012 levels. The nature of physicians' response to the cuts was unprecedented and unexpected. While physicians are often associated with advocacy, their efforts are most often localized, particular to community-oriented providers, led by individual doctors on behalf of specific patients, or channeled through international organizations, such as *Médecins sans Frontières* (Newman, 2008)². Moreover, while many physicians in Canada are well-versed in issues of immigrant and refugee health, many have limited engagement with these populations. However, the pro-asylum seeker health access movement ("pro-access") spanned physician specialities, had a strong cross-national presence, and involved a diverse set of major institutional supporters that are historically apolitical, including the Canadian Medical Association. Four years after the cuts were announced, and following years of physician-led lobbying, a successful physician-led court challenge, and a change in government, the IFHP was fully reinstated in 2016.

A different outcome is observed in Germany. In 1993, the German federal government implemented the *Asylbewerberleistungsgesetz (AsylbLG)*. The *AsylbLG* replaced the federally-funded, uniform coverage that was previously offered to claimants through the same program that provided healthcare for unemployed German residents. Under the *AsylbLG*, claimants' coverage was reduced to care in 'emergencies only'. Since the reform, physicians' have responded through public protest, petitions, direct lobbying of policymakers and politicians at all levels, and press releases that call for reinstatement of full asylum seeker healthcare. Yet, the 1993 *AsylbLG* reforms remain unchanged at the federal level. This is unexpected given that asylum seekers in Germany receive a full complement of other social supports, including housing, food provisions, financial and integration support services during their asylum claim. Moreover, Germany now projects a relatively welcoming image to refugee claimants following its open-door policy to Syrian and

² Canadian physician protest history is limited in its frequency and scope. It includes the Saskatchewan strike in 1962 and a sporadic national strike in 1984, both of which were in reaction to changes to physicians' fees and not in reaction to political policy changes that affect physicians' patients. This suggests a sectoral unfamiliarity with coordinated protest action.

Central Asian asylum claimants in 2015. Yet, while several German *Länder* and municipalities have implemented administrative reforms that improve claimants' ease of access, there has been no change to the *AsylbLG*'s healthcare provisions since 1993.

Finally, England presents a third policy variation. Interestingly, England's trajectory sits between that of Canada and Germany – while some refugee claimants' health care is restricted, others maintain full access to the National Health Service. In 2003, England curtailed asylum seeker healthcare, but the reforms pertained to only *rejected* asylum seekers' (i.e., persons whose refugee claims had been refused) access to *secondary* care (i.e., blood tests, x-rays). An attempt to also limit *primary* care for both current and rejected claimants was also initiated, but ultimately failed. Each of these efforts started first with formal stakeholder consultations, led by the Department of Health (DH). Since 2003, the DH has routinely consulted on issues of refugee claimant health access, and launched multiple proposals to implement charging requirements. While some proposals are not successful, these consultations lead misinformation and confusion amongst physicians regarding current levels of entitlement. In response to these cutbacks and consultations, physicians have grown their networks of politicized healthcare providers, launched protests and public support campaigns, and initiated an unsuccessful 2008 court challenge. Still, rejected asylum seekers remain chargeable for secondary healthcare in England, and the DH continues to probe for interest on charging all claimants for primary care. Importantly however, while England has experienced asylum seeker healthcare cutbacks, the most interesting story in England is that of its *continued* provision of care for most asylum seekers. These higher levels of asylum seeker healthcare are unexpected. Previously, strong anti-immigrant sentiment has supported reforms that reduced asylum seekers' access to public housing, financial support, and food vouchers (Sales, 2002). Yet, most asylum seekers remain formally entitled to the same healthcare as British citizens. It is not clear if the physician movement is relatively unexpected. As a schema of medical practice (e.g., including culturally competent care), asylum seeker healthcare and awareness of common refugee ailments is not as prevalent as in Canada, but at the same time, physicians are not unknown to protest in response to a variety of professional concerns.

Canada, England, and Germany present three examples of a rare social movement - one that leverages an elite group's social power in an attempt to extend and guarantee rights for non-citizens. Across geography and time, physicians in these three countries exhibited remarkable similarities, but also perplexing differences, in their choices around strategy, goals, and approach.

Documenting these movements and analyzing why each took their respective shapes and reached their respective outcomes is of theoretical and practical importance. Three cases, three comparable movements and three varied outcomes prompt two research questions: under what conditions do countries liberalize or retrench health care services for asylum seekers? And, under what conditions do physician-led groups succeed in broadening asylum seeker healthcare access?

Overview: Approach and Contributions. This project analyzes two research questions against three different cases with three different outcomes. Predictably, multiple research questions, cases, and interviews with 60 participants evince a rather thorny web of factors to analyze, with factors weighing differently across the three cases. Moreover, fulsomely mapping central government reforms and refugee advocacy movements' strategies necessitates drawing on multiple bodies of complimentary literatures, including most prominently, the social movement and historical institutionalist traditions. Thus, to provide structure to this multi-case, multi-question analysis, this project engages an ecological analytical framework, and organizes literature and empirical findings into four echelons: the macro-systems level (e.g., norms, system of government), the meso-institutional level (e.g., healthcare system, the courts), meso-organizational (e.g., strategies of advocacy coalitions), and the micro-individual level (e.g., issue champions). This approach is used to guide analysis of both research questions.

Through this approach, multiple causal and contextual factors are identified. At the macro level, these include system of government and normative, ideational institutions that shape government retrenchment efforts as well as the shape of advocates' response. At the meso-institutional level, asylum seeker healthcare's constituent ministerial location will create barriers or facilitate a government's ability to exit a policy, while advocates' actions will be shaped by access to judicial remedies. At the micro-level, individual activist ministers and individual issue champions can play key roles in a reform's success.

This dissertation is organized across eight chapters. Chapter 2 expands upon the ecological model alongside a discussion of methodological tools and approaches. Chapter 3 maps each studied country's relevant policy landscapes and asylum seeker healthcare processes. Chapter 4 provides an overview of relevant literature, and is organized according to the study's ecological framework; analyses of each case follow in the subsequent chapters. As the core case under analysis, Canada's asylum seeker healthcare retrenchment is examined as a standalone

issue in Chapter 5, and the experiences of Canada's refugee claimant healthcare movement are unpacked in Chapter 6. Then, Germany and England's retrenchments and physician-led responses are unpacked in Chapters 7 and 8, respectively. Finally, this project's contributions to existing debates and literature are outlined in Chapter 9.

2. Methodology and Approach

Research Questions

This thesis is guided by two research questions:

1. Under what conditions do national governments liberalize or retrench health care services for asylum seekers?
2. Under what conditions do physician-led groups succeed in broadening asylum seeker healthcare access?

This project takes a case-oriented approach to compare the impact of social movements on asylum seeker healthcare policy in Canada, England, and Germany. Methodological design flows from this approach and its ontological underpinnings. This chapter examines these cases' suitability for comparison, including sharing key similarities and differences in defining features. Variation across policy trajectory outcomes is examined as a puzzle, followed by an unpacking of the research questions that drive this research. I then provide information on the methods of data collection and analysis, followed by detailing the limitations of this study. This chapter finishes with a more detailed overview of selected cases, including policy histories to contextualize this research and provide the information needed for a holistic, case-oriented approach.

Examining Policy Change in Three Countries

This analysis focuses on the advocacy, organizations, and institutional arrangements in three universal healthcare countries: Canada, England, and Germany. These cases share important causal and contextual factors, but also exhibit variations in key factors and policy trajectories. This combination of similarity and variance that is made possible by the case-oriented approach's method of conceiving of cases as complex, holistic units replete with history; see *Approach*.

The Canadian case is of particular note because its asylum seeker health reforms were unexpected and unsupported by most Canadians, and internationally. A country willing to eliminate refugee claimant healthcare was in sharp contrast to the narrative Canada had carefully sown. Its extreme divergence from Canada's decades-long commitment to immigration and public

healthcare as two separate but related institutions of nation-building triggered an unprecedented national response that surpassed that seen in England and Germany. Core or peripheral, each case is well-suited for a productive three-case comparison. These cases are similar in their policy reform and social movement trajectories: each country historically provided free healthcare to all asylum seekers that was comparable to that received by citizens. Then, national governments initiated reforms to limit asylum seekers' access to its universal healthcare systems. Physicians responded with considerable advocacy movements led in each country. But, these cases had different outcomes. In Canada, national healthcare was restored and then extended slightly beyond its original offerings. In Germany, healthcare was never restored at the national level, but several states including Berlin introduced administrative reforms that increase asylum seekers' health access. In England, healthcare was ultimately not restricted for current claimants, but was restricted for rejected asylum seekers, though implementation of these restrictions is uneven. Different outcomes may be traced to differences between chosen cases as well as differences in each movement, including their national cohesiveness, their access to resources, and the presence of agentic movement entrepreneurs. But there are also striking differences among these cases. There are differences in timing, in the depth of policy change, in the institutions underpinning universal healthcare and immigration in each case, in the qualitative compositions of the social movements, and in movements' access to resources, among others. Comparisons to England and Germany permit me to identify causal factors at each level of analysis, first by identifying a framework within the Canadian case and examining these factors' impact in the peripheral cases. For example, comparing Canada to England draws attention to the impact of system of government (federal versus unitary), whereas comparison to Germany makes clear the impact of institutional features in federal systems. Comparing to both England and Germany evinces the top-down, shaping effects of norms (in healthcare, in immigration) and illustrates the role of mid-range institutional factors, such as the impact of variation in healthcare sectoral features (e.g., healthcare billing methods) within universal healthcare systems on movement strategies. Comparisons to both peripheral cases also highlight the importance of several organizational and individual factors that vary across cases, including access to resources in social mobilization and the role of individual issue champions.

While I study policy change at the national level in each of these countries, I focus on the advocacy movements that emanated from main urban centres. This makes sense for two reasons.

First, advocacy was localized to major cities. Second, comparisons across unitary and federal states but also federal states with differing degrees of decentralization creates practical differences in policymaking processes that make a city-level focus necessary. Thus, this thesis places a specific focus on activities and policy trajectories within specified cities, but contextualizes these within broader national contexts to create appropriate comparisons.

The cities chosen are Toronto (Canada), London (England), and Berlin (Germany). Cities were chosen for their relatively large refugee claimant populations and strong advocacy movements. It is clear why Toronto and London were chosen; both cities are home to their country's largest asylum seeker populations, and their respective national regulatory medical colleges and professional associations. In the same vein, Berlin is also a clear choice; it is the capital of Germany as well as its largest city. It is also geopolitically notable as it functions as a city-state within Germany, holding both municipal (*Kommune*) and substate (*Länder*) status. This coterminous authority provides city-state Berlin with substantive policy-making autonomy in both immigration and health care. These policymaking abilities are why a city focus is necessary in this comparison. In the case of Berlin, this municipal authority translated to a temporary stay on the exclusion of asylum claimants from primary care following Germany's major national reform (introduction of the *Asylbewerberleistungsgesetz* [*AsylbLG*]) in 1993 (Boettcher et al., 2003). Berlin is also an ongoing site of pro-refugee health activism, arguably more so than other potential case studies such as Hamburg and Bremen. Both of these states are also city-states and have introduced state-level reforms to provide asylum seeker healthcare access above and beyond what is legally required by the *AsylbLG* – specifically, both have introduced health cards to ease claimants' access. Berlin followed this model in 2015. I chose Berlin as a third case because initially at the time of selection, health cards had not been introduced; save for a temporary stay on *AsylbLG* introduction in 1993, there had been no apparent shift in policy despite ongoing pro-access pressure. This provided a third case outcome: ongoing, long-term pressure but no policy change.

Berlin's power is amplified by its close relationship with Brandenburg (Berlin Government, 2016), with which it holds several joint authorities, institutions, and courts. Further, the Berlin Constitution (1995) states legislation can be proposed by the Senate of Berlin, the House of Representatives, or the citizens of Berlin. While various factors can presumably limit the practice of citizens successfully introducing legislation, why this channel was not pursued to

counteract health reform is of interest to this project. Other *Länder* or *Kommune* present as potential cases here. Baden-Württemberg, a traditionally right-leaning, Christian Democratic Union-led state. Similarly, Bavaria (capital: Munich) is a common entry point for asylum seekers arriving on foot. However further inquiry reveals factors that would immediately suggest limited success potential for those looking to overturn 1993 *AsylbLG* reform at the federal level, or to initiate comparable policy (as in Ontario) at the *Länder* level (e.g., lack of popular support for immigration or refugees amongst the population). Further, there is great variation in institutional arrangements at the *Länder* level; for example, while Baden-Württemberg has a unicameral system and abolished its Senate, the bicameral *Länder* of Berlin has both a House of Representatives and Senate. These arrangements block off and create opportunities for movements to affect change.

Consideration of these arrangements in key states led to the decision to focus on Berlin, for its arrangement creates multiple points of access for experts, and its Constitution limits party discipline by permitting free votes of conscience by members of its Senate and House of Representatives. Finally, as the largest city in Germany, Berlin is an international city where the majority of residents speak English, making unencumbered interviews possible. Various factors would also lead researchers to expect Berlin to have implemented reforms such as an asylum seeker healthcare card first, creating an empirically and theoretically interesting puzzle, explained below. For these reasons, Berlin was chosen as the German case through which to examine the pro-access movement and its effects. While cross-national studies are not new, Giugni's 2004 argument that "there is still a huge void in the literature as opposed to case studies of single movements or countries" (28) remains true, and analyses that parse out factors of social movements to understand their applicability in different contexts (Meyer & Minkoff, 2004) are needed.

Puzzle

Posing these research questions across the chosen cases evinces unexpected variations in policy trajectories that are of theoretical and empirical interest. First, while variation in asylum seeker healthcare provision between Canada, Germany and England is expected given the well-documented differences in the three countries' histories with immigration, what is unexpected is the direction this variation takes within each case, with some countries providing more than what

would be presumed and others providing less, at different points in time. Second, the impact of physicians’ movements across cases is counter to what is expected.

Table 1: Variation in Asylum Seeker Healthcare Provision

	T1: Pre-Reform		T2: Reform		T3: Present Day	
	Expected	Observed	Expected	Observed	Expected	Observed
Canada	Full	Full	None	Full	Full reinstatement	Expanded reinstatement
Germany	Unsure	Full	Limited	Full	Full	Limited
England	Limited	Full	Full	Limited	Limited	Limited reinstatement

Table 1³ maps the specific variation in healthcare provision across three time points. It observes multiple variations in policy outcomes:

T1: Pre-reform expectations were formed in light of the country’s broader policy context as it relates to healthcare and immigration. The state of complimentary social policies, including housing and welfare weigh heavily in the expectation for healthcare provision.

T2: Reform expectations were informed by any complimentary policy reforms (e.g., restrictions on asylum seeker housing support) in the time immediately preceding the healthcare retrenchment.

T3: Post-reform expectations are what would have been expected in light of the strength of the pro-access movement and other contributing factors identified in each country’s chapter.

Full provision indicates full healthcare provision. It is undifferentiated from citizens in terms of substance, but may still be accessed differently (i.e., through a different policy or dedicated program).

Limited provision indicates that healthcare is less than what is delivered to citizens; typically, this indicates emergency healthcare only.

³ At no point was *no* healthcare expected in any case. Despite differing histories of immigration, each country had strong universal healthcare systems that offered free at the point of access care to its users. While citizenship is a strong differentiator in access to care in each country, that Germany, Canada and England were all signatories to the UNHCR Convention 1951 signaled a commitment to asylum seekers’ resettlement that makes reasonable the assumption that at least basic health services would be provided.

Canada, Germany and England reveal unexpected outcomes at different time points with regards to (i) their history of providing asylum seeker healthcare, and (ii) the ability for the pro-access movement to create impact. Collectively, the discrepancies in expected versus actual outcomes create a valid and interesting puzzle to examine. Given what we know about Canada, multiculturalism and refugee inclusion, the dramatic changes introduced to the IFHP in 2012 were the most unexpected. Pre-reform policy provided full coverage to asylum seekers as expected, but in 2012 healthcare was cut to emergencies only, despite claimants maintaining full access to social assistance, work permits, social housing, legal aid and settlement services such as language training. Also unexpected: the response of Canadian physicians and healthcare community. Canadian doctors have a limited history advocating for policy change by taking to the streets, but took to the streets and airwaves in unprecedented numbers from 2012-2016. The strength of the pro-access movement created an expectation for full reinstatement, which was ultimately realized in 2016.

In pre-reform Germany, asylum seekers received full healthcare services, equivalent to unemployed citizens. It is unclear if this is unexpected. On the one hand, Germany's healthcare system is tied to contributions made through the workplace. Social citizenship is extended to those who make contributions; it would be expected that if entering for non-economic reasons (i.e., not intending to work), one would not have access to healthcare system. On the other hand, asylum seekers do contribute economically, through consumption taxes and when permitted, through work permits. Moreover, Germany's refugee social policies were relatively generous at the time of reform and continue to be today. Claimants are housed in government housing, receive meal vouchers or payments and had access to social assistance. This was linked to a constitutionally-embedded commitment Germany made to asylum seekers following the Second World War, whereby Germany pledged an asylum hearing to anyone fleeing political persecution. It would follow that claimants had access to healthcare pre-1993 was unexpected. At the time of the reform, the *extent* of retrenchment was expected because of the anti-refugee sentiment that emerged in the year prior.

Finally, at present day, one would expect the pro-access movement in Berlin to have a strong impact on reinstating asylum seeker healthcare. This is true at the city-state level, but not at the federal level, both of which are located in Berlin. Impact at the national level would be expected because the movement has been sustained in Berlin and across multiple major cities. The

movement is also supported by national and state-level professional associations, which have relative societal clout (Kamke, 1998), as well as individual German doctors across Berlin and greater Germany. Moreover, Berlin also has a more open history of embracing asylum seekers and a more socially liberal perspective relative to other German states. Fellow city-states Bremen and Hamburg expanded asylum seeker healthcare access in 2005 and 2012 respectively, leading one to expect Berlin physicians to have made more progress at the state or national level. Furthermore, the *AsylbLG* – the asylum seeker healthcare bill – governs both health access *and* social assistance levels, and it was successfully challenged in German constitutional court in 2011 –the challenge pertained *only* to the *AsylbLG's* social assistance levels, and did not challenge health access provisions.

England's trajectory shows discrepancies at each of the three time points. Before reform, one would expect England to deliver limited healthcare services to asylum seekers because claimants had access to very limited social assistance, no settlement services, and if available at all, limited housing support. Policy was designed to disincentivize asylum seekers' arrival (Sales, 2002), yet claimants had full and undifferentiated access to the National Health Service (NHS). At the time of reform, one would expect sweeping reform to limit all asylum seekers' access given their access to other social services such as social assistance had been further retrenched in the years immediately prior. However, only *rejected* asylum seekers saw their access potentially challenged, and ultimately, are now only limited in their access to secondary care services – primary care remained fully available. Finally, one would expect physicians to have limited impact on changing policy. Like Canada, physicians in England had limited history advocating for healthcare access. But unlike in Canada, they were advocating for an unpopular cause that would receive limited public support. Yet still, the outcome is perplexing: physicians were not able to reverse policy reforms but were able to build a coalition of providers willing to subvert official policy where possible, and continue to resist to ongoing attempts to charge claimants for care.

Approach

This study takes a case-oriented approach to comparative analysis. In an early treatise on the comparative method, Lijphart (1971, 1975) framed comparative analysis as akin to statistical comparisons in its assumptions, but qualitative, and for a small number of cases. At present, two approaches that build on Lijphart's work dominate comparative analyses – the variable-oriented

approach and the case-oriented approach. With their differences parsed out in present day, these two approaches signal different ontological perspectives as well as assumptions about causation and appropriate methodologies.

The historically favoured variable-oriented approach is associated with larger-N analyses, often uses statistical analyses, focuses on establishing causality, and is geared towards generalizability. However, this approach poses limitations that make it inappropriate for this study. Primarily, the variable-oriented approach assumes unit homogeneity, or that a change in a causal variable's value will elicit the same effects across studied cases (Hall, 2006). In actuality, causal and contextual variables interact, creating interaction effects and differing outcomes (Hall, 2006). A case-oriented approach allows for examination of mid-level, or contextual variables that interact with causal variables to create different outcomes. This is precisely why an ecological approach is taken in this study - to paint the macro/meso/micro landscapes that interact with a given feature (e.g., federalism) to drive or stall asylum seeker healthcare reform. Ontologically, this understanding of causation aligns with literature on path dependency. An institution's history matters, such that early developments can realign an institution's trajectory, such that these events may impact explanatory variables' later developments. Fundamentally, this requires agreement that changes in an explanatory variable will not elicit uniform effects across cases (Hall, 2006). These considerations, alongside others below, are why this study takes a case-oriented approach.

Ragin (2004) articulates five core considerations that separate the variable and case-oriented approaches. The first consideration is case selection. The case-oriented allows researchers to do a deep dive into data to gather rich, detailed findings in just a few cases. These findings may not be generalizable to other phenomena writ large, but their empirics offer insights to test and build theory. It is also assumed that the case-learning process is ongoing as researchers unpack, contextualize and compare case dimensions holistically. This approach and relevant methods produce findings that are often not generalizable writ large but do allow researchers to sketch “a complex unity” (della Porta, 2008: 204) and to “identify complex patterns of conjuncture causations” between variables, which encourages the development and refinement of theory (Ragin, 2004 p. 135). Second, and while not applicable to this project, the case-oriented approach permits the selection of cases which show similar outcomes. Third, and related to the first point, case-oriented approaches give space for researchers to identify the populations under consideration. By immersing oneself in a case, the definition of the unit of study becomes

delightfully blurred as persons from different organizations, backgrounds, and/or geographies are interviewed. This is reflected in case-oriented methodologies, such as the snowball method.

The fourth point touches on the cornerstone of the comparative method, and indeed any method: how inferences are made regarding causal relationships, or the rigor behind “assertions that one variable or event (x) exerts a causal effect on another (y)” (Hall, 2006: 373). The case approach invites findings of “complex patterns of conjunctural causation” (Ragin, 2004: 135), or various combinations of factors which lead to the same result. Cases may exhibit similarities across causal factors, but it is not anticipated that a given cause will elicit the same effect across cases. After all, cases are chosen for their complexity, and are analyzed holistically. Instead, different constellations of causes may prompt the same outcome. Whether a condition is causal in Case A but not in Case B may be related to the presence or absence of other underlying institutions, conditions, histories or events that activate or operationalize an effect. Finally, nonconforming cases – or what variable-oriented approaches deem ‘outliers’ – are not discarded in the case-oriented approach. Cases which present similar causal variable configurations but different outcomes should not simply be acknowledged, but unpacked – where did history deviate to lead to this different outcome? This identifies areas of future study and supplies alternative scenarios to examine how factors will behave differently across contexts.

Sampling and Elite Interviews

I undertook 61 semi-structured interviews in English with elites in Toronto, Berlin and London from August - November 2016. Using purposive sampling, I identified an initial sample of stakeholders from policy, government, non-profit organizations and healthcare providers, primarily physicians. Samples consisted mainly of persons who were in favour of the pro-access movement and politicians/policymakers who were in opposition. Initial interviewees were identified from newspaper articles, academic journal publications, and social media platforms including LinkedIn and Twitter. Following Baumgartner et al. (2009), quasi-historic records including advocacy pamphlets and government publications were combed for relevant names, though I differed from the author’s original methodology by consulting publicly-available online historic documents instead of archival research (see *Limitations* for an explanation). Attempts to balance the sample along gender lines were made. Finally, interviewees suggested additional names to facilitate snowball sampling. Interviews were held in respondents’ offices or public

places at the preference of the interviewee. Interviews were semi-structured to permit respondents to answer fully and offer new lines of inquiry (Morris, 2009). Elite interviews are appropriate both for the research question and the theoretical framework. Regarding the research question, elite interviews offer an insider look as to reasons why certain events occur; while archival research provides useful information, a great deal of informal political transactions are not recorded. Findings from interviews were triangulated with additional interviews, published reports, newspaper articles and data from an access to information request. This request was made in November 2017 for email data between former Canadian minister of immigration Jason Kenney and his bureaucratic staff between January – June 2012.

Data Analysis

A note with key interview findings was written immediately following each interview. Interviews were also audio-recorded and transcribed. Transcriptions were analyzed using NVivo coding software, following Corbin and Strauss' (1990) prescribed methods stemming from grounded theory. Grounded theory permits identifying and extracting codes as they emanate from the text. Broad thematic labels and core codes were discerned using open coding, and then selectively coded as contingent codes emerge. This method is established as effective for comparing and contrasting data in order to note interesting discrepancies and similarities. Codes were arranged hierarchically, and aggregate lists created to organize, pair and note thematic connections and relationships between codes. Analysis also engaged Mahoney et al.'s (2009) method of sequence elaboration, which involves identifying a relationship (e.g., between a social movement and its goal), an outcome (e.g., policy change), and all factors that mediate the nature of the outcome. Factors could be antecedent, intervening, or both, though their strength is primarily a result of their sequence; the grounded theory coding and sequence elaboration applied within the ecological theoretical framework, allowed me to identify and analyze multi-level factors in each case, which ultimately shaped this analysis.

Limitations

This study is limited by several factors. First, timelines. The time periods under analysis do not align, with Germany's initial period of reform starting twenty-one years before that of the Canadian case. However, in order to identify meaningfully comparable cases (i.e., those where

universal healthcare systems gave way to asylum seeker healthcare reforms but were later met with strong physician-led pro-access movements) timeline variation was a necessity. Varying timelines gave way to the second limitation – the passage of time. Germany’s case verged on historic, whereas the Canadian and to a lesser degree the English case were fresh in the memories of movement leaders. This informed the decision to approach this analysis as a comparison of a core (Canada) and two peripheral cases (Germany and England), given the data available in each country. I attempted to overcome the limitations in the German case by planning archival research with a German-speaking research assistant. However, I confirmed through a librarian at the German host institution the *Wissenschaftszentrum Berlin für Sozialforschung* and a representative from the German federal agency responsible for refugee claimants, the *Bundesamt für Migration und Flüchtlinge* (BAMF) that the BAMF does not archive press releases. The impact of this restriction was mitigated by interviewing persons involved in the pro-access movement at the time of initial reform. Thirdly, language. I do not speak German, and time limitations restricted by ability to learn to the extent needed in order to conduct research interviews in German. However, this was overcome by choosing an English-speaking city, such that only one interview required a German translator. These factors, alongside pragmatic considerations associated with doctoral research (e.g., resources) further supported the methodological decision of making Canada the core case and England and Germany, the peripheries.

Fourthly, the issue of *voice*, or the notion that studies observing a population ought to include the voice of this population. However, because this research does not seek to understand the lived experiences of claimants vis-à-vis a healthcare system nor to draw conclusions regarding the experiences of refugee claimants, this absence was noted as an area of further study but not methodologically problematic. Finally, a three-case comparison is ambitious, and was necessarily limited by the practical constraints of a PhD thesis – primarily, resources and time. Its ability to do a deep dive into three cases equally is constrained, but the outcome – a broad mapping of factors that are related to a social movement’s outcomes – provides a rich menu of explanatory variables and sequences that can be tested and validated in future research.

Terminology

Refugees, Refugee Claimant and Asylum Seekers

The title ‘refugee’ is often used incorrectly by media and policy officials to denote any person who is in a refugee-like situation or who is seeking asylum outside their country. This masks important differences in legal status and entitlements between a person who is seeking refugee recognition and a person who has been officially recognized. ‘Refugee’ denotes a legal recognition that someone is a ‘Convention’ refugee – a person who has been adjudicated to be a refugee pursuant to the United Nations High Commission on Refugees (UNHCR) 1951 Refugee Convention, referred to also as the ‘Geneva Convention’ or ‘the Convention’. The Convention defines a refugee as:

A person who, by reason of a well-founded fear of persecution, for reasons of race, religion, nationality, membership in a particular social group or political opinion, a) is outside of their countries of nationality and is unable, or by reason of that fear, is unwilling to avail themselves of the protection of each of those countries, or b) not having a country of nationality, is outside their country of former habitual residence and is unable or, by reason of that fear, unwilling to return to that country.

The United Nations (UN) can determine if someone is a refugee through its own adjudication process, though due to resource constraints persons are more often simply registered as refugee claimants through the UN, indicating they pass initial screening and are thus entitled to UN benefits. Country signatories to the 1951 Convention can also create their own processes to adjudicate if someone meets the 1951 definition. Persons do not need to be registered with the UN to make a claim through internal country-specific systems. Claim adjudication processes differ across signatories; for example, while Canada holds an in-person hearing at the Immigration and Refugee Board for initial claims, both the United Kingdom and Germany process paper claims only, meaning a person provides a written detail of their claim along with copies of available evidence and submits their claims via the Home Office and BAMF, respectively⁴. To make a claim, persons must be within the country in which they are seeking asylum. A person who does is a refugee claimant or an asylum seeker; these titles are interchangeable, though the latter is more common in European contexts.

⁴ There exist additional categories or means of being recognized as a refugee by a Convention signatory that are not uniformly recognized by signatories. For example, Canada will at times recognize *Prima Facie* refugees, a UNHCR category that “allows for refugee status on the basis of situations of mass influx...because of readily apparent and objective reasons” (IRCC, 2011). This category was frequently used at the height of the Syrian humanitarian refugee crisis.

3. Case Background

This chapter provides comprehensive overviews of relevant political and policy-related events in each Canada, Germany and England. Tracing the major events immediately preceding each reform contextualizes the healthcare policy retrenchment and provides an empirical base from which each chapter analysis is drawn. Table 2 provides an overview of each country’s policy trajectory, followed by a detailed breakdown of policy contexts below.

Table 2: Overview of Asylum Seeker Health Policy Trajectories

Country	Period of Analysis	Policy Trajectories
Canada	2012-2016	<p>‘U-turn’ expansion:</p> <ul style="list-style-type: none"> • 1957-2012: Full health services provided. Asylum seeker health access is roughly equal to that of citizens on social assistance, and uniform amongst asylum seekers • 2012-2016: IFHP retrenchments enacted. Asylum seeker health access reduced and stratified across refugee claimant sub-groups • 2016: IFHP restored to pre-2012 levels, with some expansion.
Germany	1993-2016	<p>Limited provision:</p> <ul style="list-style-type: none"> • 1962-1993: Full health services provided under <i>Bundessozialhilfegesetz</i> (Federal Social Assistance Act, or <i>BSHG</i>). <i>BSHG</i> also provides care for all other low-income/unemployed German residents • 1993-Present: <i>Asylbewerberleistungsgesetz</i> (the Asylum Seekers Benefits Act, or <i>AsylbLG</i>) separates asylum seeker health care from citizen health care. Asylum seekers permitted health care in emergencies only • 2015: Berlin Senate approves electronic health card to improve access to care for asylum seekers, though <i>AsylbLG</i> remains intact
England	2006-2016	<p>Differentiated provision:</p> <ul style="list-style-type: none"> • 1948-Present: Full health services provided via citizen-based NHS services • 2003-Present: Department of Health consults with stakeholders to probe charging asylum seekers for primary and secondary healthcare • 2006: Rejected asylum seekers excluded from secondary healthcare

Canada: “No More Gold-Plated Benefits”

Canada has a rich, oft-told history of providing asylum to those who seek it. Its national identity weaves together narratives of humanitarianism and multiculturalism, which are fostered in its unique immigration and refugee system known for its policy innovations including the ‘point system’ and private refugee sponsorship, respectively. Through these mechanisms, Canadian systems adjudicate who is worthy of entrance and support and are granted status based on these metrics. Less celebrated are asylum seekers, who enter not on economic or low-risk humanitarian grounds but by fleeing persecution and claim asylum in a country which is a signatory to the 1957 Convention.

The Canadian federal government assumes responsibility for asylum seekers in two key areas: determination (claim adjudication, appeals) and healthcare. The IFHP is unique because it is one of few social programs that is funded and administered by the federal government. Moreover, eligibility to receive IFHP is neither universal nor means tested through income measures; recipients need only be a registered asylum claimant to qualify. Other social services are either shared with other newcomers (e.g., language training) that are funded and/or delivered by the federal and provincial governments or delivered as means tested general services by provincial governments (e.g., social assistance). The Immigration and Refugee Board (IRB), a federal administrative tribunal, is tasked with determining refugee claims. The IRB is staffed by public servants from various backgrounds⁵ (“IRB members”) who are trusted to determine if a claim of persecution is accurate and in-line with the definition of a ‘refugee’. Since its establishment in 1989, the IRB has undergone a series of changes designed ostensibly to improve processing times and the streamlining of applications. It remains today an in-person tribunal process where the onus is on the asylum seeker to prove their persecution. Legal assistance is available to very low-income claimants but wait times are long and resources are limited (Acton, 2015). If a claim is unsuccessful, applicants can request a judicial review to claim an error in law on part of the IRB member, or launch a full appeal through the Refugee Appeal Division (RAD) based on error in fact or the availability of new evidence. Asylum seekers can apply to receive healthcare, social assistance, and settlement supports (e.g., language training) immediately upon

⁵ Until 2011, IRB members were political appointments. Following concern raised around extreme discrepancies in Members’ positive adjudications (Rehaag, 2007) and around the political affiliation of Members, political appointees were made to re-apply for positions alongside a general pool of applicants open to anyone. Notably, just 30% of existing IRB members passed the new IRB exam in 2012 (Keung, 2012).

making a claim. Claimants can also apply for housing assistance, though in major cities such as Toronto and Vancouver the wait list for cost-controlled housing exceeds the length of time persons await refugee determination.

In 2010, CIC minister Jason Kenney declared Canada's determination system 'overloaded' with 'bogus' claimants attempting to access social benefits, as evidenced by increasing number of claims from 'safe' countries (i.e., would-be economic migrants from countries [trade partners] including Hungary, Mexico) alongside declining acceptance rates (Gilbert, 2013)⁶. Government and popular rhetoric cast suspicion over all refugee claimants (Bradimore & Bauder, 2011; Olsen et al., 2014) and raised concern amongst Canadians when the refugee system was declared 'broken' (Kenney, 2012; Keung, 2012) in order to justify a refugee system overhaul. Under the banner of cost-saving and fairness to taxpayers, in 2012 the Conservatives introduced Bill C-31, the *Protecting Canada's Immigration System Act*. Minister of Citizenship Jason Kenney described Bill C-31 as making Canada's system "faster and fairer" (Béchar & Elgersma, 2012: 2) though critics suggest it hardened suspicion towards refugees and authorized discrimination based on nationality. C-31 also introduced the Designated Countries of Origin (DCO) or "safe country" list, which remains in effect today. In 2012, Canada received higher-than-typical volumes of claimants from countries such as Mexico and Hungary. These were often thought of as 'safe', in part because of Canada's strong trading partnerships. 'Safe' country claimants were subject to shorter determination timelines, indicating a presumption these claimants would not be successful. The DCO "narrow[ed] the image of what is an acceptable refugee" (Olsen et al., 2014: 59) as ethnicity and nationality became heuristics to determine trustworthiness and legitimacy.

Finally, C-31 also sought to shorten claim determination timelines. In 2012, the average length of time before IRB hearings was 21 months; Bill C-31 promised an initial IRB hearing within 60 days for general claimants and to 30-45 days for persons from DCO countries Canada considers 'safe' (Béchar & Elgersma, 2012). Asylum seeker advocates argued this provided insufficient time to assemble the documents needed to prove one's persecution, including medical, police and identification records from one's home country. Government attempts to shorten asylum seekers' stay in Canada was argued to save taxpayers an estimated \$1.65 billion dollars

⁶ Fascinatingly and under-examined, the concept of the 'safe country list' was initially approved in Canadian legislation in 1988 (Hailbronner, 1993), though this was not implemented in any form until the Canada-United States Safe Third Country Agreement in 2002 and eventually, Bill C-31.

annually in social assistance claims (CIC, 2012 June 29; Olsen et al., 2014; Sheridan & Shankardass, 2015). Though the law still requires hearings within 60 days, as of 2018 IRB wait times average 20 months long.

Despite Bill C-31's uneven implementation, it was successful in legislating asylum seeker distrust. The message was clear: asylum seekers could not to be trusted with Canadian resources. In institutionalizing suspicion and fear, Bill C-31 ensured claimants were presumed *unworthy* of Canadian support or citizenship, with the burden to prove otherwise firmly on the shoulders of would-be refugees. Understanding IFHP retrenchment in the greater context of asylum seeker determination reforms is critical to understanding how criminalizing asylum seekers was normalized. Seeds of distrust for 'bogus' claimants were sown with each complimentary C-31 shift, preparing Canadians to accept or even celebrate their exclusion from healthcare services under the IFHP changes.

2012 Interim Federal Health Program Reform: Bill C-31's hardening of refugee suspicions set the stage for the unprecedented overhaul of the IFHP in 2012. The Interim Federal Health Program was initiated in 1957 by Order-in-Council *PC 157-11/848* by the Ministry of Health and Welfare Canada (MHWC) to provide health care for uninsured vulnerable groups, including refugee claimants⁷. Unlike Canadian citizens' health care (provincially-funded insurance programs), the IFH is under federal administration, acting as a 'catch all' for uninsured persons who were under the care of the Canadian government. Prior to its reform, the IFHP offered asylum seekers healthcare insurance nearly equivalent to that of persons on social assistance, including primary and emergency healthcare, hospital insurance and prescription drug coverage. When enacted by minister of Citizenship and Immigration Jason Kenney on June 20, 2012, support was reduced, and stratified along four tiers of coverage that corresponded with their country of origin or where their IRB claim stood at the IRB (see Table 2). The new scheme effectively eliminated most preventative and primary care and seriously reduced emergency care access for 86% of asylum

⁷ The IFHP's initial origins are in a 1946 Order-in-Council that provided health coverage for nearly 4000 former Polish Armed Forces members who had been resettled to Canada. This coverage was gradually increased in 1949 to include immigrants more broadly, permitting the federal Department of Citizenship and Immigration to pay hospital bills of indigent newcomers who arrive without adequate finances but require assistance (and again in 1952, to also cover newcomers awaiting workplace visas. Finally, the 1957 Order-in-Council instructed coverage to extend to "a person who at any time is subject to Immigration jurisdiction or for whom Immigration authorities feel responsible"; this Order formed the basis of the IFHP, not immigration or health legislation (Dhand & Diab, 2015: 356-357).

seekers who were previously covered (Dhand & Diab, 2015) (see Table 3 below). In essence, nationality signaled worthiness to access healthcare, and treatment was available for the undeserving only when their health concerns became a ‘risk factor’ for citizens (Raza et al., 2012).

Table 3: Interim Federal Health Program Categories, 2012-2016

Category	Coverage
Refugee claimant	“Health-care coverage”: <ul style="list-style-type: none"> - Preventative care only if condition is a public health risk - Hospital/physician services only in emergency situations
Refugee claimant from a designated country of origin Or Rejected refugee claimant	“Public health or public safety health-care coverage” <ul style="list-style-type: none"> - Preventative care only if condition is a public health risk - Hospital/physician services only in emergency situations
Government assisted refugees (GARs) and privately sponsored refugees (PSRs) who receive Resettlement Assistance Program (RAP) funding (minority of PSRs) <i>Note: This category is not under analysis here as it pertains to persons who arrive as Convention refugees</i>	“Expanded health care coverage” <ul style="list-style-type: none"> - Full access to medical, diagnostic and hospital services typically covered by provincial programs - Supplemental services including therapies and long-term care - Prescription medications

The federal government identified various goals through the reformed IFHP: to eliminate disparities between the level of coverage received by claimants and that by the average Canadian, to instill fairness, and to eliminate incentives to come to Canada and to contain costs (Enns et al., 2017). Canadian provinces responded by introducing ‘gap fill’ support for asylums seekers. Quebec was the first to offer asylum seekers support in June 2012, followed by Manitoba in September 2012 and Ontario in January 2014; New Brunswick offered access to Medicare cards, while BC offers insurance to employed asylum seekers. More ad hoc responses have also been introduced in Alberta, Nova Scotia and Saskatchewan.

IFHP reforms were overturned in a physician-led federal court challenge in 2015, and the federal appeal of the decision was dropped after Trudeau’s Liberal government was elected in 2016. Following that election and relatedly, the arrival of more than 40,000 Syrian newcomers,

the IFHP was re-introduced in an expanded form in February 2016, restoring all previous coverage while also including overseas medical checks for approved refugees.

Germany: National Reforms and Asylum Seeker Fallout

Germany's asylum seeker policy depicts a country that has been at times unsure of the national mythologies it wishes to own, and how it can best confront historical injustices vis-à-vis current policy. These tensions manifest as uneven social assistance distribution for asylum seekers and refugees, across geographies and across areas of assistance but also over time. Indeed, Germany's asylum seeker healthcare story spans 22 years, during which its federal-level asylum seeker admission laws have also been in a steady flux. Because the German case spans decades, the factors shaping advocates' efforts are vast and varied and thus, a more detailed examination of its history and policy context is provided here.

Germany was described as a 'reluctant' immigration state until normative and pragmatic shifts began in mid-1990s till 2005 and demanded Germany's recognition of its multicultural population (Bade, 2004; Bauder, 2009; Meier-Braun, 2002). Indeed, despite hosting a large, heterogeneous population of non-German residents (*Ausländer*), both pre- and post-unification governments maintained the line: *Deutschland ist kein Einwanderungsland* ('Germany is not a country of immigration'). If considering 'immigration' to be synonymous with permanent residency and citizenship, this is partially true. Germany observed *jus sanguinis* ancestral lines of citizenship until the acknowledgement of *jus soli* territorial citizenship in 1999 (Bauder, 2009), and did not have an official immigration policy on the books until the 2005 'Migration Act' (*Zuwanderungsgesetz*) (Soennecken, 2014). Still, many cities adopted and promoted integration and concepts around multi- and interculturalism since the 1980s (Bendel, 2014). Immigrants arrived in Germany either through its asylum seeker channels (enshrined in into Germany's Basic Law in 1949 until the 1993 reform) or through its oft-criticized guest worker program, through which nearly four million persons enter Germany as 'temporary' workers during the German 'economic miracle' (*gastarbeiter*) of the 1960s until 1973 (Schönwälder, 1999). Workers primarily came from Turkey, Yugoslavia and Italy, until the recruitment of foreign labour was banned in 1973. Temporary guest workers were not initially permitted access to citizenship; by 1989, half of

all foreigners had lived in Germany for more than 10 years, but few were able to apply for citizenship (Green, 2001).

Germany's fraught relationship with migrants of all streams – including asylum seekers, immigrants, and guest workers – is particularly interesting given Germany's role in the creation of the international refugee regime. The Second World War was a 'critical juncture' in the international human rights regime (Triadafilopoulos, 2012), the event that led to the creation of the supranational refugee regime, including the 1951 Convention Relating to the Status of Refugees. Europe's genocide and expulsion of Jewish refugees was not the sole factor in its creation; their subsequent denial into Canada and the United Kingdom shows how the events of WWII held a mirror to exclusionary societies. Collectively, these events produced the global regime and institutions which define who is a refugee as well as the rights to which they are entitled, a framework that signatory nations still abide by today.

It is fascinating to consider how this history has informed Germany's domestic institutions, and the impact this has on asylum seekers' experiences today. WWII's punctuations into German institutions, as well as its erasures, can be charted over time. For example, the Federal Republic of Germany's 1949 Basic Law was crafted with a self-awareness of the need to protect itself from the institutional weaknesses that facilitated the rise of the Weimar Republic and Nazi regime. Consciously, it also aligned West Germany with the liberal Western powers that shared in its occupation, as at the time West Germany was occupied by British and American forces. This culminated in the implementation of the constitutional *right* to claim political asylum in its 1949 Basic Law (Schuster, 2003). Article 16(2) of the Basic Law (*Grundgesetz*) was a "deliberate measure of atonement for the persecution of Jews during the National Socialist era" (Green, 2001: 90). In addition to atonement, this provision worked in concert with other Basic Law articles to attempt to limit the power of the German executive. It was not without debate but ultimately, it was taken as a progressive signal of Germany's re-alignment with Western ideals and first efforts to reconcile the events of WWII. Member of Parliament, Carlo Schmid said in 1948:

Granting asylum is always a question of generosity, and if one wants to be generous, one has to risk helping the wrong people. This is the other side of the coin, and this at the same time probably constitutes the dignity of such an act (quoted in Kreuzberg 1984: 39 in Bosswick,

2000: 44⁸).

The development of asylum seeker determination law in Germany is one marked by contestation at the subnational and national levels. Until 1978, an average of 7,100 persons claimed political asylum in Germany; however, this increased dramatically, and by 1980 the number of claimants exceeded 100,000 (Green, 2001). Anti-immigrant sentiment rose, and pressure increased for politicians to restrict entry to Germany. This included emergency measures enacted by the SDP-FDP coalition to accelerate determination processes in 1980 and in 1982 with the passing of the Asylum Procedure Code (*Asylverfahrensgesetz*, or *AsylVfG*). The *AsylVfG* restricted appeals and reducing welfare allowances (Bosswick, 2000:46). In 1982, Germany began the practice of mass accommodation for asylum seekers, and issued residence permits that restricted them to the Länder in which they were housed (Zetter et al., 2003). The number of arrivals dipped from 1981-1983, but by 1988 the number exceeded 100,000 again (Green, 2001).

While the right to *make* a claim was enshrined, the right to stay was not, and by 1989, the acceptance rate was just 9%, down from 29% in 1985. Discursively, this decline in acceptance rate was framed as indicative of the higher number of ‘fake’ claims made by economically-motivated migrants (*Wirtschaftsfluchtlinge*). In the media and political discourse, claimants were framed as taking advantage of German generosity and placing a heavy strain on the German social system (Bosswick, 2000⁹). In the late 1980s, attacks on claimants rose and public discourse shifted to frame claimants as bogus entrants (*Asylant*) whose presence threatened German national identity (*Überfremdung*) (Wolken, 1988 in Bosswick, 2000)¹⁰. Discursive shifts amplified xenophobic fears in the late 1980s as claimants were framed as responsible for

⁸ A rich detailing of the development of German asylum seeker determination law is not within the scope of this dissertation. Bosswick (2000) provides a detailed explanation of German refugee policy analysis, tracing its evolution, from 1949 to the late 1990s, and aligning major socioeconomic developments to changes in asylum seeker outputs (i.e., number of arrivals) and outcomes (including violence levied against asylum seekers). See also Soennecken (2014).

⁹ It is important to again note that Germany lacked alternative means of immigration; persons could enter as an asylum seeker or temporary worker, but economic migration was all but non-existent.

¹⁰ For a fascinating examination of discourse and the politicization of asylum seekers, see Young’s (1995) analysis on discursive practices and the ‘contagion from the right’. The author argues that “the change in the political rhetoric of the conservative faction within the CDU/CSI that assumed power in 1982 made it possible to construct a new space for fundamental policy changes to asylum seekers in the early 1990s”, and ultimately move the left-leaning SPD to the right (Young, 1995:64). Asylum seekers became scapegoats for multitude of problems and perceived problems, including unemployment and the increasing homogeneity of the German state (Faist, 1994).

unemployment and Germany's loss of a national ethnic identity (Young, 2008¹¹). The perceived 'refugee problem' led to debates on constitutional change in the late 1980s as claimants continued to enter in unprecedented numbers, despite low acceptance rates. From 1984-1993, nearly half of the 3.5 million asylum seekers with registered applications in Europe were living in Germany (Zetter et al., 2003).

However, asylum seekers were not the only newcomers entering Germany at this time. Major exogenous shocks each triggered the entrance of two major groups: "ethnic" Germans and asylum seekers. First, the 1989 fall of the Iron Curtain and 1990 end of the Cold War created massive disruption and uncertainty in Communist regimes surrounding the German state. This included a massive migration of 'ethnic Germans'. The "return of the German diaspora" (Green, 2001: 92) saw persons with ancestral connections to Germany enter Germany after the fall of Communist regimes, under which they often faced challenges or persecution. 'Ethnic Germans' right to return was constitutionally permitted according to Article 116 of the Basic Law, an enshrined political signal that was used with regularity. In 1986, 43,000 persons took advantage of this provision; in 1990, 400,000 did the same.

The lifting of Eastern Bloc travel restrictions dovetailed with the start of a civil war in neighboring Yugoslavia, leading to further increases in the number of claimants in Germany; in 1992, 438,191 persons claimed asylum. Like the 'returning' ethnic Germans, many claimants did not speak German, and required supports and assistance to reestablish a life in Germany following violence and persecution. However, claimants' *Otherness* placed them lower on the foreigner hierarchy relative to 'ethnic' Germans. Violence against claimants rose alongside Neo-Nazi propaganda as asylum seekers were seen as the population *least* worth making accommodations for, when compared to the perceived deservingness of post-USSR ethnic Germans returnees¹² and the reintegration of East Germans into the West. In November 1992, arsonists killed a family of Turkish guest workers in the city of Mölln, a "crucial incident" in the mobilization of pro-inclusion German citizens (Bosswick, 2000: 49). On December 6, 1992 the governing CDU-SPD coalition agreed to a dramatic policy response with the intent of limiting

¹¹ Analyses of discourse, asylum seekers and German policy from 1993-2015 include Young (2008), Bauder (2008, 2009), Holmes and Castañeda (2016) and Semetko and Valkenburg (2000).

¹² While ethnic Germans were frequently framed as "returnees", in fact many had not been born in Germany, or had arguably spotty lineage to German ancestry. Still, ethnicity trumped claims of persecution. This primacy on ethnicity also reflected Germany's preference for blood-based connections and its *jus sanguinis* policies at the time.

the number of claimants entering Germany and simultaneously, quelling the political discontent erupting on both sides of the political aisle. Asylum seekers became a symbol of Germany's crumbling ethno-cultural conception of citizenship, and their removal was seen as a means of denying Germany's de facto identity as an immigration country (Faist, 1994).

The "Asylum Compromise" was subsequently implemented on July 1, 1993. Pertinent to this project is the reform's first and most consequential tenet for asylum seekers: Article 16's amendment to include a safe third country restriction. The clause removed the right to asylum for any person entering Germany through a 'safe' state, such as members of the European Community, signatories to the Geneva Convention, and states that entered into bilateral agreements with Germany¹³. This was in fact, all of Germany's neighbors: Austria, Poland, the Czech Republic, France or the Netherlands. Persons were now required to make a claim in the first 'safe' state they entered, virtually eliminating the possibility of making a claim after entering Germany via land. The number of claimants declined. Total claims dropped from 438,191 in 1992 to 322,599 in 1993, to 127,210 in 1994. This decline followed Article 16(2)'s implementation but also new restrictions on claimants' work permissions and accelerated determination timelines implemented under the 1993 Alien Act.

The constitutional amendment was also accompanied by the introduction of the Asylum Seekers' Benefits Act on November 1, 1993 (*Asylbewerberleistungsgesetz*, herein the *AsylbLG*). As a constituent element of the Asylum Compromise, the *AsylbLG* was a tool to limit the high number of claimants who were entering Germany while also lowering the costs of social services for state-level governments (*Bundesverfassungsgericht [BVerfG]*, 2012: n.p.). Previously, refugee healthcare was covered by the Federal Social Assistance Act (*Bundessozialhilfegesetz*) which also governed unemployed German citizens' access to services. The *AsylbLG* was created to manage asylum seekers' social services separately from that of citizens and set "significantly lower benefits and primary benefits in kind rather than in cash" (*BVerfG*, 2012: n.p.). The *AsylbLG* now governed asylum seekers' (i) healthcare and (ii) social supports as largely in-kind benefits, including food, accommodation, heating and clothes. A small amount of cash is also

¹³ The Schengen (14 June 1985) and Dublin (15 June 1990) Agreements outlined common rules on asylum and safe third country considerations that predated the Asylum Compromise. See Achermann and Gattiker (1995) for a fulsome discussion of their impacts.

provided to cover personal needs (Federal Office for Migration and Refugees, 2016). Healthcare is administered by the local health and social office.

AsylbLG § 4 entitles claimants to “emergency medical care; treatment of acute and painful conditions; care during pregnancy, child birth, and delivery; vaccinations and indicated preventative measures”, while § 6 also stipulates “additional care upon formal request if the measures are deemed to be essential to preserve health” (Bozorgmehr & Razum, 2015; see Table 4). Critically, what is considered “emergency”, “painful”, and “essential” is open to interpretation by individual providers. There is no codified list of ailments that are covered. Often, it is “taken to mean that only absolutely unavoidable medical care is provided” (AIDA, 2018 n.p.). Claimants are covered under the *AsylbLG* for their first 15 months in Germany, after which they are entitled to the same social benefits as unemployed German citizens. Asylum seekers found to have “abused the law to affect the duration of their stay” (e.g., to misrepresent a case to prolong their stay in Germany) are covered by the *AsylbLG* for 48 months (AIDA, 2018, n.p.). Otherwise, the *AsylbLG*’s healthcare provisions are otherwise identical to when it was drafted in 1993. However, complementary policies that govern how services are rendered have changed considerably with the introduction of state-level electronic health cards for claimants, which can ease barriers to access (Bozorgmehr & Razum, 2016). Not surprisingly The *AsylbLG* has thus long been the subject of protest and critique, for both its health and social welfare provisions. In addition to its emphasis on collective housing, its restrictions on mobility (i.e., requiring claimants to remain in their assigned *Land*), and its provision of benefits as in-kind limit claimants’ visibility in greater German society. These provisions are also critiqued as “vastly uneconomic” (Zetter et al., 2003: 67; see also Bozorgmehr & Razum, 2015), and a violation of Germany’s commitment to human rights at the national and supranational levels.

While *AsylbLG* dictates minimum standards from the federal level, state-level and municipal-level governments fund and administer refugee social service needs, including health for claimants¹⁴. In city-state Berlin, these offices are one in the same: the *Landesamt für Gesundheit und Soziales* (State Office for Health and Social Affairs, herein *LAGeSo*). This high level of state autonomy results in high levels of variation in state-led asylum seeker healthcare provisions. The federal government determines procedures for asylum seeker adjudication

¹⁴ In practice, multiple organizations and non-government bodies provide social services and settlement supports, including religious and non-profit organizations; see Chapter 6.

through the *Bundesamt für Migration und Flüchtlinge* (Federal Office for Migration and Refugees, herein *BAMF*). Upon arrival, BAMF officials collect claimants’ biometrics and, provided they are not arriving from a ‘safe’ third country, claimants are assigned a *Land* via computerized algorithm¹⁵. They are then required to stay in the assigned *Land*, where they wait for an in-person interview with a federal representative¹⁶. While waiting, claimants are intended to stay in centralized reception centres, where healthcare and in-kind supports are delivered. However, due to overcrowding, especially following the arrival of 1.4 million claimants starting in 2015, many claimants are decentralized into private housing. All asylum claims are assessed by a case worker, who considers the interview’s findings, verification of the claimant’s identity and a security clearance (Gesley, 2016). If successful, claimants receive a three-year residence permit (*Aufenthaltserlaubnis*) that permits them to work, followed by a settlement permit (*Niederlassungserlaubnis*). If a claimant does not fit the definition of a refugee but faces serious harm or threat if they return to their country, they are classified as *Duldung*, or ‘tolerated’. Tolerated persons are granted residency in one-year increments and must be granted permission to work. It is similar to the *Aufenthaltserlaubnis* materially, in accordance with requirements under the Common European Asylum System, but places different limits on factors such as family reunification. Both categories are then eligible to apply for naturalization after approximately 8 years in Germany.¹⁷

Table 4: *AsylbLG* Entitlement, 1993-Present

Category	Definition	Coverage
Asylum seeker	Person who files an asylum application with the BAMF	Medical services for acute illness for the first 15 months or until asylum claim is decided.
Tolerated Person	Non-citizens whose deportation is temporarily stayed because of unsafe conditions in the home country or administrative issues (e.g., lack of	Full access to the German healthcare

¹⁵ This algorithm does not account for the individual needs of claimants, such as existing family in Germany.

¹⁶ It should be noted that German migration law is complex and ever-changing. Pross (1998), speaking to Germany’s changing asylum seeker regulations, suggests that “political bodies and authorities have shown impressive creativity in inventing new laws every couple of years” (49). A full detailed account of these changes cannot be included here, but Soenneken (2014) provides a thorough examinations of policy change over time.

¹⁷ Naturalization occurs via two channels: either by entitlement (meet all outlined requirements [see *Gesley*, 2016] and reside in Germany legally for 8 years, including the time spent with their application under review) or by discretion (if one requirement is not fulfilled but the government agency perceives their naturalization as in the public interest).

	passport). Adults can apply for residency (with participating local authorities) after eight years, and children can apply after six	system is granted after 15 months (Note: This is reduced from a 48 month wait in March 2015)
Rejected Asylum Claimant	Person whose claim for asylum is rejected and all appeals are exhausted	

England: Social Service Reform and “Pushing the NHS Envelope”

England’s relationship with refugees and asylum seekers, as well as immigration more broadly, is historically closer to that of Germany than to that of Canada. England’s immigration system is marked by efforts to deter and control entrants, instead of perceiving migration as an asset to be leveraged (Shutter, 1997). Still, citizens across the UK are increasingly opposed to all types of immigration, and largely do not support social services for non-citizens; this is especially true outside of major metropolises like London (Migration Observatory, 2012). Indeed, recent watershed moments have consolidated England’s opposition to asylum and distanced it from Germany vis-à-vis its position on immigration and refugees. The decision to close Britain’s doors in reaction to the 2015 arrival of asylum seekers to Europe, alongside its xenophobia-fueled decision to ‘Brexit’ in 2016 are bellwethers of the country’s support for refugees. At the same time, these make England’s continued inclusion of asylum seekers in the much-beloved NHS even more puzzling.

As a unitary state, the national government is responsible for determining who gets in and what is accessible once they arrive. The Home Office manages all asylum claims and controls. It also administers asylum seekers’ housing support and social assistance payments, but healthcare and education are streamlined into mainstream British social service systems. When making an asylum claim, persons register their claim with an immigration official, who records their biometrics. Within a few weeks, an asylum interview is held with a caseworker to determine if the claim will be accepted; claimants may qualify for legal assistance, though backlogs and strict requirements limit this in practice. The caseworker makes a decision within six months, on average. If a claim is accepted, persons are given ‘leave to remain’, or permission to stay in the UK for five years, after which they can apply for permanent residence¹⁸. If rejected, claimants

¹⁸ Claimants may also be permitted to stay for humanitarian reasons and are subject to the same five year waiting period as refugees, or be permitted to stay ‘for other reasons’ which are undefined and may not result in permanency.

can appeal the decision to an independent tribunal where both claimant and government can submit their positions. If the appeal is rejected, claimants can ‘voluntarily repatriate’ or be subject to immigration removal.

Britain is unique in its approach to asylum legislation – namely, in that it did not pass any until the 1990s. As unwilling to institutionalize asylum support as Germany was to recognize immigration, Britain’s first bills governing asylum control and social service access were the Asylum and Immigration Appeals Act 1993 and Asylum and Immigration Act 1996. The latter shifted the responsibility to support asylum seekers’ welfare and housing to local authorities, which placed pressure on high-volume areas within London. The Immigration and Asylum Act 1999 was introduced following a Home Office 1998 White Paper that suggested ‘generous’ welfare benefits were a draw for fake refugees – at that time, claimants accessed mainstream welfare support at 90% of the prescribed rate for permanent residents. The new Act introduced vouchers in lieu of cash benefits, which limited claimants’ purchasing options and eliminated local governments’ direct role in supporting asylum seekers via the creation of the National Asylum Support Service (NASS) within the Home Office. The Act also introduced dispersal policies to move claimants away from London and into less populated areas. Finally, welfare provisions were further restricted via the Nationality, Immigration and Asylum Act 2002.

At present, the Home Office’s NASS still governs housing and social support, often in concert with local authorities, though the Home Office warns: “You can’t choose where you live. It’s unlikely you’ll get to live in London or south-east England” (Government of the United Kingdom, 2018: n.p.). Instead of vouchers, claimants now receive a pre-paid Home Office ‘debit’ card, with a £35.39 ‘allowance’ loaded each week per person. Claimants are typically not permitted to work while awaiting asylum determination. Everyday processes border mainstream life and inculcate a sense of burden, such as the demarcated Home Office debit cards. But as in Germany claimants are simultaneously denied the opportunity to signal their willingness to contribute or participate by working. However, *unlike* in Germany, social citizenship is not as directly tied to labour force participation, as the British system permits anyone resident in Britain to be included in key services such as primary care and education.

In contrast to housing and social assistance, asylum seekers receive full access to the National Health Service (NHS). This includes primary care, accident and emergency (A&E) and secondary care, prescriptions, dental, and some optometry support. Rejected claimants who are

awaiting deportation receive NHS primary care and A&E but will be charged for non-urgent secondary care, such as x-rays and blood tests. Secondary care required in the interest of public health, such as care needed to diagnose and treat infectious diseases, is free. Rejected asylum seekers can be exempted from secondary charges if they are deemed financially destitute under Section 4(2) of the Immigration and Asylum Act 1999 (which provides rejected claimants with financial support from the Home Office); if they receive Section 21 support from their local authority; or, if they receive Part 1 (care and support) under the Care Act 2014.

Rejected asylum seekers thus have less access to care than persons with active claims (“current claimants”). Efforts to restrict rejected claimants’ access to secondary care initiated in 2003. The Department of Health (DH) initiated a public consultation to amend NHS regulations to charge ‘overseas visitors’ who were not ‘ordinarily resident¹⁹’ for secondary care (i.e., x-rays, blood tests, and some hospital stays, though not for any accident or emergency care). This built on a 1989 reform that obliged NHS hospitals to identify persons not ordinarily resident in the UK and charge for treatment if appropriate, though efforts to define what was ‘appropriate’ to charge were not initiated the 2003 DH consultations. In 2004, charges for secondary care for persons not ordinarily resident in the UK were officially implemented in NHS hospitals²⁰. In 2008, pro-access proponents successfully argued that rejected claimants’ stay on deportation defined them as legal and thus ordinarily resident, and rejected claimants’ secondary healthcare was restored. However, in 2009 the DH successfully appealed the judgement at the Court of Appeal; the pro-access movement did not challenge this decision at House of Lords, and thus rejected claimants’ secondary charges remain today. However, the Court of Appeal also found that contrary to guidance provided by the DH to NHS Trusts, chargeable healthcare that is of immediate need could *not* be withheld pending payment; healthcare provision must supersede payment collections. Moreover, it affirmed that NHS Trusts have the discretion to register asylum seekers as they see fit, meaning secondary care *can* be provided without cost for rejected asylum seekers.

¹⁹ ‘Ordinarily resident’ was defined in *R v Barnett LBC ex parte Shah* as persons “lawfully living in the UK voluntarily and for a settled purpose” (Department of Health, 2004: 6). This common law concept did not initially articulate a time period by which someone would be considered ordinarily resident. This ambiguity prompted the 2008 and 2009 court decisions, which ultimately found rejected claimants to not be ordinarily resident. Thus reforms include but are not limited to restricting care for rejected asylum seekers.

²⁰ The restrictions limited care for refused asylum seekers (persons with appeals exhausted and awaiting removal), undocumented persons, and ‘Section IV’ recipients (persons unable to be deported due to current medical or security reasons, but who are awaiting deportation).

Critically, this also provides some protection to refugee claimants, should additional charging reforms be implemented in the future.

In 2004, the Department of Health sought unsuccessfully to also impose restrictions on *primary care* through the publication of *A Consultation on Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Service*. In a foreword, Labour Minister of Health John Hutton stated the proposal aimed “to ensure that the NHS is first and foremost for the benefit of residents of this country” (iii). It sought stakeholder input on rejected asylum seekers for primary care and secondary care. While both suggestions were controversial, charging for primary care was particularly unpopular as this would compromise GPs’ discretion to register and provide care to all patients free-of-charge, a long-entrenched principle of NHS universality²¹. Ultimately, in 2005 it was announced that secondary care charging restrictions were implemented for rejected claimants. But, the DH also stated their position that rejected claimants not be registered for primary care by GP practice (Reeves et al., 2006). Thus, a formal charging change and informal charging recommendation were contained in the same text. This conflation would prove confusing for many practitioners and greatly disrupted claimants’ access to primary care, even at present day.

The DH’s statement was controversial, but also confusing – most stakeholder groups felt these findings were maligned with what they recommended during the 2004 consultation. The DH stated the consultation’s findings would be made public in November 2004, however the results were not published. Key members of the pro-access movement demanded the consultation’s findings be released. It was not until 2007 that the DH’s Customer Service Centre wrote a letter summarizing the 2004 consultation’s findings as ‘divided’. The letter also stated that respondents supported further clarity on who should be entitled to GP access, and that respondents perceived ‘health tourism’ as a significant and growing problem. However, neither primary data nor comprehensive summaries of the consultation’s findings were made public.

This prompted pro-access physicians to question the validity of the reforms, which were touted as, at least in part, responding to the consultation’s findings. The Global Health Advocacy Project (GHAP), a refugee and refugee claimant-supporting organization comprised primarily of

²¹ Regulatory amendments to NHS entitlement are rooted in two statutory provisions: Section 121 of the National Health Service Act 1977, as amended by sections 7(12) and (14) of the Health and Medicines Act 1988, which authorized the Secretary of State for Health to enact regulatory changes to charge any person not ordinarily resident in Great Britain for NHS services (Department of Health, 2004: 7).

medical students and residents, began aggressively pursuing the consultation's public release through Freedom of Information (FOI) requests²². In 2009, GHAP published their findings, including data gathered through FOI requests, in a report entitled *Four Years Later: Charging Vulnerable Migrants for NHS Primary Medical Services – Students and Junior Doctors Reveal Findings of an Unpublished Department of Health Consultation*. GHAP's report was supported by major organizations including the British Medical Association and the Royal College of General Practitioners, and found that the majority of stakeholders opposed charging any asylum seeker for primary care based on concerns for public health and the use of health as an immigration control. Consultation respondents questioned the proposal's cost-effectiveness and the administrative burden it would impose on physicians' primary care practices. Overall, the GHAP found that "very few of the submissions we obtained were supportive of the proposed charges and some organizations have informed us they no longer hold these views" (GHAP, 2009: 10).

The DH did not respond to the GHAP report. However, since the 2004 regulatory changes the DH and Home Office have conducted a series of additional consultations that revisit the idea of charging for primary care as well as other forms of healthcare control. The DH and Home Office have also enacted additional regulatory changes that pertain to specific subsections of the population. A selection of the DH's consultations and reform proposals are outlined in Table 6, demonstrating the intensity of the DH's efforts to probe and cause confusion amongst stakeholders. Of the additional regulatory changes, most critiqued is the DH and Home Office's information-sharing agreement, whereby any persons with a £500+ debt to the NHS is subject to having their information shared with the Home Office. Reaching a £500 bill for secondary services is not difficult because of an amendment passed in 2015 that charges overseas visitors 150% of the NHS national tariff – 1.5 times the 'sticker price' of an NHS procedure or resource. Having this debt reported to the Home Office prevents a person from attempting an extension to their stay, be it through a visitor visa or by launching an asylum claim²³. Reporting of this debt is the discretion of the NHS Trust. This use of healthcare as immigration control has a freezing effect on many irregular migrants' access to secondary care, including rejected asylum seekers²⁴.

²² The DH delayed releasing these responses for 16 months, and did so following intervention from the Information Commissioner (GHAP, 2009: 7).

²³ While most people launch asylum claims at the border, some register a claim after entering the UK.

²⁴ Anna Miller, Interview by author

Table 6: Selection of Consultations and Regulatory Changes on NHS Charges

Title and Type	Relevant Implications
2003; Consultation <i>Proposed amendments to the National Health Services (Charges to Overseas Visitors) Regulations 1989</i>	<ul style="list-style-type: none"> • Proposal charging overseas visitors, including rejected asylum seekers for secondary services
2004; Consultation <i>Proposals to exclude overseas visitors from eligibility to free NHS primary medical services</i>	<ul style="list-style-type: none"> • Proposal charging overseas visitors, including rejected asylum seekers for primary services • Implemented: 2004
2010; Consultation <i>Home Office Consultation on Refusing Entry or Stay to NHS Debtors</i>	<ul style="list-style-type: none"> • Signaled new collaborations between Home Office and DH; this is the self-described “biggest shake-up of our immigration system in a generation” (4). Two authorities to share information regarding overseas visitors with bills of £1000 to limit re-entry to the UK, or ability to file asylum claim (later amended to £500)
2011; Regulatory Change <i>NHS (Charges to Overseas Visitors) Regulations 2011</i>	<ul style="list-style-type: none"> • NHS Trusts and NHS Foundation Trusts in England are <i>legally obligated</i> to determine if a person is not ordinarily resident in the UK (i.e., rejected asylum seeker) and thus subject to secondary care charges (does not apply to GP practices)
2012; Regulatory Change <i>HIV Treatment for Overseas Visitors – Guidance for the NHS</i>	<ul style="list-style-type: none"> • HIV treatment now free for all persons, regardless of status
2014; Consultation <i>Sustaining Services, Ensuring Fairness</i>	<ul style="list-style-type: none"> • Explored perceptions of permitting all persons ‘ordinarily resident’ to access NHS primary, as well as new ways of identifying chargeable patients and recovering costs
2014; Program Change <i>Visitor and Migrant Cost Recovery Programme (2014)</i>	<ul style="list-style-type: none"> • Increased support for Overseas Visitor Managers (OVMs)²⁵

²⁵ Overseas Visitors Managers (OVMs) are now present in many but not all NHS Trusts. Their role is to charge and collect payment from non-ordinary residents using secondary services, including rejected asylum seekers. OVMS connect the NHS to the Home Office. In recent years, considerable efforts were made by the DH to educate stakeholders on OVMS’ role, and how GPs can support charging efforts made in NHS hospitals, including e-learning modules, posters, a Twitter account and instructional videos (ELH, 2018). The video urges clinicians to recognize “the responsibility to ensure we have the NHS for the future”, and that “the NHS is a national health service, not an international one” (ELH, 2018) and ultimately, support the mandate of OVMS. It encourages GPs to connect with OVMS before referring patients for secondary care; however, this is not mandated.

2015; Consultation <i>Making a Fair Contribution: Consultation on the Extension of Charging Overseas Visitors and Migrants using the NHS in England</i>	<ul style="list-style-type: none"> Proposed applying to restrictions to primary care, A&E and community healthcare for rejected asylum seekers; restrictions would parallel those in secondary care.
2015; Regulatory Change <i>NHS (Charges to Overseas Visitors) Regulations 2015</i>	<ul style="list-style-type: none"> Exempts rejected asylum seekers receiving Section 4(2) support from the Home Office or Section 21 support under the National Assistance Act 1948 (i.e., rejected claimants who are destitute) Increased costs for secondary care for all overseas visitors, including eligible rejected asylum seekers, to 150% of the NHS national tariff

Yet despite ongoing consultations and a highly critical public discourse that singles out asylum seekers’ healthcare usage, charges for primary care have not been implemented and charges for secondary care have not been extended to current claimants. Indeed, unlike the 1990s reforms to housing and cash allowances, healthcare proposals were met with resolute refusal from those who would be implementing the changes: physicians. Moreover, despite general popular appeal, the notion of bracketing off access to the NHS also raised ire amongst many everyday citizens. However, these consultations succeed in keeping the topic of charging in the public’s eye, and by muddying the waters on what is actually covered, and what is not.

Table 5: NHS Asylum Seeker Entitlement, 2018

Category	Coverage
Asylum seeker	<ul style="list-style-type: none"> Full access to the NHS including primary care, secondary care, accident and emergency (A&E), prescriptions, dental, and some optometry supports
Rejected asylum seeker	<ul style="list-style-type: none"> Full access to NHS primary care and A&E Full access to treatment for infectious disease and sexual health support, including HIV medication Full access to maternity care Charged 150% of cost for secondary care Charged regular cost for prescriptions, dental, and optometry

	<p><i>Rejected claimants who receive these supports are exempt from charges for secondary care and receive prescription/dental support</i></p> <ul style="list-style-type: none">• Section 4(2) from the Home Office• Section 21 support from local authority• Part 1 (care and support) from Care Act 2014
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Conclusion

This thesis takes a case-oriented approach to understand how reforms happen, and what factors determine available and effective collective action responses. It examines national reforms and local responses in three universal healthcare countries, across three timelines. In examining asylum seeker healthcare reform, it touches on broader, well-established themes as well as prompts identification of areas for future research. This includes the relationship between citizenship, deservingness and care; the extension of social or postnational citizenship rights to refugee claimants; variations of universal healthcare systems and policy change; and, the nexus between competing national identities (e.g., norms around healthcare versus those around immigration) and policy creation. Turning to this project's research questions, the following chapter explores the theoretical underpinnings that flow from this method's ontological position. It then explains how this literature informs this project's empirical analysis.

4. Literature Review

The three physician-led movements shared many similarities in their protest repertoires. All movements publicly demonstrated, published opinions in trade and academic journals, and saw key organizations release statements demanding change from politicians, for example. However, broader strategic choices - including target audiences, messaging, and movement centralization – varied. Individual leaders and guiding organizations made choices that impacted how the movement interacted and received by society and politics. The nature of these decisions is unpacked in social movement literatures, though are infrequently subject to comparative analysis. However, a movement’s strategy also reflects the greater contexts in which the movement is developed and operates. The decisions that shape a movement’s direction, conscious or otherwise, are shaped by the characteristics, histories, opportunities, and constraints of the institutional contexts in which actors and organizations are operating.

I thus take an ecological approach to integrate social movement literatures that identify organizational and individual-level factors with a focus on institutions and the tools we use to examine them. I define institutions broadly to include systems-level (systems of government, ideational institutions) and meso-level factors (policy venues). Collectively, these three levels – systems (macro), institutions and organizations (meso), and individuals (micro) – are linked, and inform each other’s trajectories. This approach allows me to more comprehensively sketch the landscapes that produced policy change as well as shaped opportunities for physicians in each country.

I begin this chapter with an overview of the discussion of my core organizing framework, the ecological model. I follow this with an overview of the factors that shape movements at each the three levels of analysis. A summary of discussions on adjacent debates concludes this chapter.

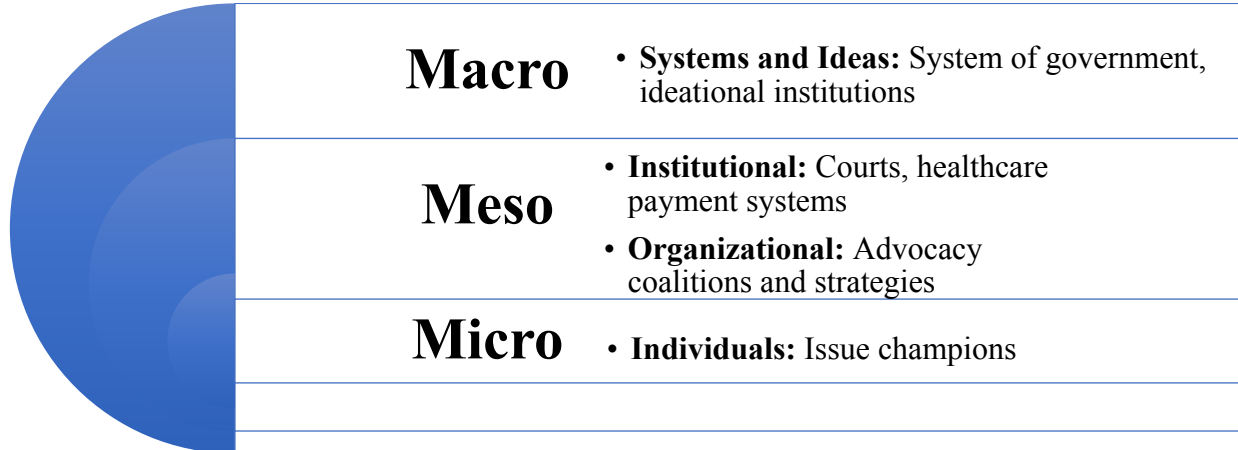
Ecological Model

This dissertation’s multi-level ecological analysis aims to advance a cohesive theory of physician activism and a variant ecological model of social mobilization. It is used as a tool to unpack the conditions that facilitated asylum health policy retrenchment, and the conditions that shaped the social movements spawned in response. The ecological model was originally proposed by Bronfenbrenner (1977) and is used widely in public health (Thurston & Vissandje, 2005) and

organizational studies (Cukier et al., 2016). Theoretical elements are stitched together here not out of convenience but for the interdependent explanations they provide when organized ecologically (see Figure 1). With macro (societal norms, policies), meso (organizational features, strategic choices), and micro (individual leaders) levels, the ecological model is used to map interdependent yet distinct features of asylum seeker healthcare movements to understand how features inform and shape one another. It builds on nested institutional literatures while still affording agency to individual actors. Context (macro) and actors (micro) matter, while institutions (meso) act as critical intermediaries.

This approach complicates understandings of the role of institutions in social movements. It threads a movement’s contextual and operational factors together to identify the importance of institutions while avoiding the black box of political opportunity structure, which can overlook the individual leaders and existing organizations that determines a movement’s ability to identify and take advantage of opportunities.

Figure 1: Ecological Model to Understanding Social Movements



Macro Level: Systems of Government, Policy Venues and Change

At the macro level of analysis, what differs across analyzed countries is the opportunity to shift responsibility for asylum-seeker care. In Canada, it could be shifted to provinces, and from health to immigration venues; in Germany, it could be shifted from policy that was undifferentiated from citizens to one specific to asylum seekers; and finally, in England there were no opportunities for movement across levels of government or across venues. With regards to asylum seeker health

policy, (i) system of government (federal, unitary), (ii) the policy's initial venue (as a federal policy but also its ministerial location) and (iii) norms elicit cascading effects on meso-level policy and micro-level decisions, including how a central government can withdraw from a policy and how subnational and civil society might react. This section unpacks these factors to understand their roles in the asylum seeker healthcare debate.

At the macro-level, differences between government systems (e.g., federal versus unitary) as well as within (e.g., varieties of federalism) can erect barriers or foster prospects for policy reform (e.g., Bache & Flinders, 2004; Béland & Myles, 2011; Broschek, 2011). Such structural differences will not only channel policy retrenchment in different directions but also produce feedback effects that shape advocacy and organizing. This literature focusing on varieties of federalism and unitary systems forms the bedrock, or macro layer of this ecological model. Unitary and federal systems²⁶ provide differing institutional roadmaps that policymakers and policy protestors must navigate to effect austere or expansionary change. Unitary systems, concentrate decision-making power and provide fewer veto points, and thus have a higher potential for substantive or wide-reaching reforms. In contrast, federal systems diffuse power across government units, thereby increasing the number of veto points and limiting the likelihood for widespread reform (Coleman & Bhatia, 2003; Scharpf, 2006). Federal systems also have historically lower levels of welfare spending (Crepaz, 1998; Hicks, 1999; Hicks and Misra, 1993; Huber and Stephens, 2001; Huber et al, 1993; Swank, 2002). Still, the federal/unitary binary denotes a somewhat crude distinction, and masks significant variation within these categories including variance between the forms of federalism found in Germany and Canada.

Varieties of federalism exist along a continuum, with highly integrated and highly dualistic federations marking divergent poles. Understanding where Germany and Canada sit on this continuum is thus critical to understanding the strategies of either country's physician-led lobbies, both in terms of the menu of options available and how their tactics were formed. Canada and Germany represent near best-fit examples of contrasting varieties of federalism. As interinstitutional and intrainstitutional federations, respectively, Broschek (2011) finds they differ on three key institutional features: allocation of competencies, subnational units' role in federal

²⁶ 'Unitary' state refers to the government structure of England. While England is indeed part a country within a devolved, multi-nation federation of states, for reasons explained in *Case Selection*, England alone is the focus of this study.

legislating, and the nature of intergovernmental relations. Canada is prototypical of a *dualistic* system that permits federal and provincial governments to act (e.g., legislate, tax) with relative independence, has weak provisions incorporating provincial legislators into federal processes and has few areas of joint decision making (e.g., the Canada Pension Plan), allowing the federal and provincial governments to act unilaterally or through a cooperative system. Finally, Canadian intergovernmental relations are relatively informal and flexible (Bolleyer 2006).

In contrast, Germany represents an integrated allocation of competencies between federal and *Länder* governments; while technically many policy areas are joint jurisdiction, in practice, the federal government leads in policy framing while *Länder* implement, and sometimes add to, a policy's framework. However, *Länder* are fundamental to the federal policymaking process, holding both de facto and de jure decision-making powers in the German *Bundesrat*, the federal council of German states (Broschek, 2011). Finally, Germany's national and *Länder* governments are highly integrated and interdependent, leading to a pre-eminence of joint decision making across most policy areas, though federal unilateralism often pervades over "real cooperation" (Kropp, 2010 in Broschek, 2011: 669). National agendas still prevail in federal states and may be expressed in the form of funding incentives, as with the Canadian federal government's healthcare transfer payment model, or in the form of legal minimum standards, as with Germany's welfare support spending whereby subnational units deliver self-funded programs but must meet federally-mandated minimums.

Still, federal states share many features that reasonably differentiate them from unitary states with regards to shaping policy outcomes. The existence of multiple levels of government, regardless of degree of autonomy, increases the number of institutional players involved in policy making, and thus the number of players who may potentially frustrate the process or veto legislation (Braun, 2009; Scharpf, 1998; Tsebelis, 2002). This indicates that federal systems will be less likely to undergo dramatic change, such as through the rapid expansion or sudden reduction of welfare entitlements for immigrants or refugees (Koning, 2017). Competition between levels of government for policy authority or may also occur as subnational and national governments seek the political benefit that comes with social provisions (Banting, 2006; Boushey & Luedtke, 2011). This may be more likely in nations such as Canada where territorial minorities reside (Pierson, 1995), especially if constituent units are constitutionally-empowered to produce policies that differ from the federation (Joppke & Seidle, 2012). However, it is notable that existing literature

presupposes delivery of social policies to citizens; replacing the recipient population with non-citizens likely limits governments' want to underwrite most social policies. Within-country competition for policy jurisdiction or being first to deliver a service will only be stoked when governments see political or economic benefits to delivery. Otherwise, being a policy laggard has strong incentives (Feigenbaum et al., 1993).

Governments can 'devolve' or 'download' responsibilities to lower government levels. While devolution "involves delegating resources along with responsibilities", downloading "involves passing responsibilities onto other public bodies but not the commensurate resources to undertake adequately those service and policy duties" (Rice & Prince, 2013: 128). When central governments download a program to lower state governments, funding is rarely provided to support the program's execution, meaning downloaded programs are often curtailed or eliminated by their new subnational owners (Evans, 2002). Pierson (1994) describes two key types of welfare state retrenchment: systemic retrenchment, which alters the fiscal or policy context to elicit reforms over the long term, and programmatic retrenchment, which describes sector-specific reforms. Systemic retrenchment is more likely to happen at the federal level (Rice & Prince, 2013).

Playing "pass the buck" to another tier of government is not uncommon, especially in times of austerity, and risks a "race to the bottom" in service delivery and create uncertainties in locating policy blame (Pierson, 1995: 458). Federal exit or downloading often entails a national government lessening its policy commitments and placing de facto higher demands on subnational governments, who because of lesser infrastructure or related resources, face disproportionately inflated costs (Newton & Adams, 2009). When exit is impossible, or a national government must cooperate with subnational units (e.g., for program delivery), strongly rooted subnational governments can create "lowest common denominator" policy traps by forcing agreements around the least contentious (i.e., least ambitious) policy options, as what often happens in Germany (Pierson, 1995: 460). The results of downloading include fragmentation, as standards become difficult to enforce and uniformity in social programming diminishes. Where the newly responsible government cannot provide services, often, voluntary and non-profit sector actors fill the gap, or private players (i.e., physicians) bear the cost.

A policy's location also matters. This is true in terms of level of government (e.g., as a federal, state, or municipal policy), as well as ministerial location. In both cases, a policy's venue affects the policy's immediate and secondary actors, as well as public expectations based on

historical precedents (e.g., expectation for free and accessible healthcare in countries with universal healthcare) and funding opportunities. Thus, where policies are located impacts how they change. For example, locating seniors' housing policy in a social service department versus a health department would lead to fundamental differences in how issues are conceived, how programs are devised, and which actors are involved (Marier, 2015). It also impacts how the issue of seniors' housing is framed and to some extent, the public's expectations for how it should be managed.

Pluralist literature suggests that changing popular understanding of an issue (i.e., its policy image) and its policymaking venue can lead to a policy's rapid reformation. Baumgartner and Jones (1993) first articulated 'venue shopping' to explain radical, non-incremental policy shifts in the United States. The authors argued that this form of policy change is often initiated by a change in the institutional venue where the decision-making is occurring, using the example of the nuclear energy debate being shifted to involve, among others, environmental committees in US Congress to reframe and resituate the debate. Political actors will shift venues as a result of rational calculus – which venue offers the most political opportunity for their efforts (Mazey & Richardson, 2001). Policy change is thus a function of interest groups' – here, social movement actors' – ability to identify and leverage the institutional venue most receptive to its issue frames. The political opportunity lay in the institutional venue's receptiveness to the deployed policy/issue frame, or put simply, how well the issue frame melds with the institutional venue's own toolbox and purpose (Princen & Kerremans, 2008).

While most policies have a clear institutional home, asylum seeker healthcare is complex. To some policy actors, it is primarily an issue of healthcare delivery; to others, it is a tool in immigration reform. Because it straddles multiple policy venues, governments have considerable ability to shift the portfolio across ministries or across government levels. Watts (2016) argues that in parliamentary executive federations such as Canada a clear jurisdictional division between federal and provincial governments enforces either government's autonomy and responsibilities. In civil law-based European federations such as Germany, power over administration and legislation is often assigned to different levels of government, creating a "virtually interlocking relationship" between a country's governments (16). As I am interested in these relationships insofar as they shape actors' choices and strategies, this underscores the need for the above examination of varieties of federalism and unitary states. Finally, venue shifting might be

described as either horizontal (across ministries, such as from health to immigration) or vertical (between levels of government). Both forms produce implications for funding structures, norms and ideas, and the surrounding policy actors and policy interlocutors (e.g., doctors versus border guards) (e.g., Guiraudon, 2003).

Systems-level institutions can also be ideational. Understanding institutions strictly as structures limits the ability to explain policy change in the absence of critical junctures (Lieberman, 2002 p. 698). Understanding ‘institutions’ as ideational (‘ideas’) illustrates how norms and beliefs can shape the behaviour of actors, similar to how structural institutions can open or constrain opportunities. To be causal, ‘ideas’ must: (i) exist prior to the policy behaviour being explained, (ii) not be reducible to a structural feature, (iii) have definable programmatic belief, and (iv), be logically correlated to policy outcome at hand (Berman, 1998). The ideational literature provides numerous concepts through which to understand how *ideas* are used by policymakers, including ‘frames’ and ‘programmatic beliefs’; frames exist at the systems-level, while programmatic beliefs are at the meso-level. Frames are means through which actors understand issues and engage preferences. A frame includes normative and moral understandings of how information is to be organized, actors are empowered, goals are defined, and actions are constrained (Bleich, 2002; Surel, 2000). Cognitively, frames are constituted by metaphors, symbols, and scripts – such as the ‘bogus refugee’ through which political actors process issues and decide which actions are to be taken.

Meso-Institutional and Meso-Organizational Levels: Social Movements

The meso-institutional level of the ecological model of understanding social movements consists of two sub-components: the meso-institutional and the meso-organizational. The meso-institutional level can be confusing because it contains the key word “institutions”, but here, it refers to both institutions in the theoretical sense, as it is used throughout all levels of the ecological model, and to its specific location in the model – the venues and frameworks a step below the norms, rules, and social forces that shape movements at the macro level. Indeed, targeted analysis at this level is needed because federal institutions do not alone tell the story of policy reform. Just as institutions’ interactions with other variables including political parties and the political economy create policy effects (Pierson, 1995), so too does their interaction with political actors and their social movements. Indeed, “[i]nstitutions alone – which establish the “rules” but tell an

observer only a little about the preferences, identities, and resources of the “players” – can never fully explain outcomes (Pierson, 1995: 473, citing Steinmo, Thelen and Longstreth, 1992). A turn to social movement literature helps to understand movements as meso-level forces, as well as their individual charismatic leaders as micro-level factors is thus in order. As noted above, social movements are examined from two angles: first, for their impact (as an exogenous shock or factor impacting asylum seeker healthcare policy) and second, for their strategy (as organizations impacted by institutional constraints and opportunities). In both instances, tenets and tools from institutionalist literature are engaged.

Social movements are again central to the study of politics. The rise of events including the Arab Spring, the Occupy Wall Street movement, and the Women’s March on Washington have pushed protest politics into the media spotlight. As the stakeholders, their means of action, and the ideas that weave movements together become increasingly more complex, so too are the theoretical models devised to make sense of their actions and impact. Deep dives into singular movements in particular countries marked political movement studies at their onset and present day. Research focuses on identifying a movement’s characteristics and mechanisms of success, including networks that knit organizations into a cohesive movement (della Porta & Diani, 2006) the ideas that drive action (Johnson et al., 2014), the performativity of social movement tactics (Tilly, 2008), how movements leverage expertise (Orsini & Smith, 2010), and finally, how we can understand when a movement is successful (Gamson, 1990; Rochon & Mazmanian, 1993). Another leg of social movement literature focuses on the broader institutional containers in which movements are formed (Giugni, 2004).

Included in this are analyses of political opportunity structures. Focusing on the “mutual influence of context and strategy”, political opportunity analyses highlight the role of institutional and normative structures in shaping movements’ ability to impart change (Meyer, 2004: 125). Political opportunities are the “constraints, possibilities, and threats that originate outside the mobilizing group” that “affect its chances of mobilizing and/or realizing its collective interests” (Koopmans, 1999: 96) and are core components of political process frameworks. Cultural narratives, system of government and its structural characteristics, as well as the behavior of allies and economic developments may all serve as political opportunities. Accordingly, literature takes seriously the greater context in which social movements operate, and in doing so, highlights the tension between structure and agency that is embedded in political analyses (Meyer, 2004).

Broadly, this approach emphasizes how characteristics of institutions will provide actors with points of access or resistance to enacting institutional reforms (e.g., Miki & Kobayashi, 1991). It requires considerable efforts made to understand the context surrounding a movement, as the ‘outside world’ will shape movements’ ability to mobilize, advance specific claims over others, foster specific political and social alliances over others, engage with specific repertoires of protest actions over others, and impart change on everyday politics and policy (Meyer, 2004: 126).

The notions of political opportunity structures and venue shopping (Baumgartner and Jones, 1993) draw on related conceptual foundations, explain Princen and Kerremans (2008). A movement can shop for a new institutional venue that provides more advantageous allies or general receptiveness to an issue – put differently, movements shift venues to find new political opportunities. Moreover, in the same vein venue-shopping interest groups will exhibit similar “outcome maximizing behaviour” as social movement actors (Princen & Kerremans, 2008: 1138). Early political opportunity literature analyzed the broad, normative institutions in which movements operate to determine the degree to which a state is ‘open’ or ‘closed’ to uprising. Eisinger’s (1973) pioneering work argued that governments who are responsive to citizen demand and create opportunity for movements to impact change are ‘open’, while those with highly concentrated power and few opportunities for movements to insert themselves into formal and informal political processes are ‘closed’. Indicators of degree of openness include a state’s propensity for repression (McAdam, 1996) or legitimacy in the international context (Oberschall, 1994).

Subsequent research complicates Eisinger’s (1973) binary; while Tarrow (1989) found that increased access to systems and allies increased mobilization, Goldstone and Tilly (2001) found that the threat of repression is also positively associated with levels of mobilization. Literature on political opportunity structure is marked with contradictions, primarily because of competing definition of variables: while some analyze government structures (Tarrow, 1998), others look at geography (Boudreau, 1996) and others still look at connections to pre-existing social movements (Meyer & Staggenbourg, 1996; in Ramos-Rodriguez et al., 2010). Meyer and Minkoff (2004) responded to the critique of political opportunity structure’s overuse as an explanatory model for *all* factors shaping a movement’s impact, from institutions to culture to alliances, by calling for categorizing political opportunities across three types based on Eisinger (1973) and Tilly’s (1978) initial conceptions: (i) structural, representing formalized changes to

policies and law that change political access for a specific movement; (ii) signaling, representing perceived changes in political climate or culture that shape mobilization of a specific movement; and (iii) general, which may be either structural or symbolic but are available to all social movements (in Ramos-Rodriguez et al., 2010). Indeed, the critique of political opportunity structure as an overextended, ineffective “sponge” that absorbs all aspects of social movement analyses is telling (Goodwin & Jasper, 2004: 7). A broadly defined approach linking any and all context to social movement mobilization, behavior and impact is not helpful to advancing understanding on these three cases or on political opportunity structure.

This suggests that traditional resource mobilization and political process theorists will look to pre-existing institutional structures, organizations and a movement’s informal networks to understand what instigates and sustains action. Morris (2000) urges additional consideration of five causal factors: agency-laden institutions and frame lifting, tactical solutions, transformative events, leadership configuration and protest histories. These factors are not simply features of a movement; they have the potential to spark a social movement and sustain collective action. The first three are applicable at the *meso-organizational* level. First, *agency-laden* institutions are pre-existing institutions that have deep-rooted identities, and members who align strongly with their values and tenets. Cultural and organizational resources including belief systems and ways of organizing members are embedded in these institutions; in Morris’ (2000) example of the civil rights movement, the African-American church served as the agentic institution through which Dr. King framed and mobilized his message and articulated the movement’s values. Even within a closed political system, these institutions can foster and drive collective action. Relatedly, *tactical solutions* are strategies that resonate with the movement’s broader agentic institution. Impactful tactics will operationalize the values that underpin the movement – for example, the civil rights’ movement boycotted the Montgomery bus system as a means of nonviolent noncooperation which aligned with their church-based movement’s values (Morris, 2000: 449). *Transformative events* are akin to critical junctures. They are often singular events which solidify or define a movement’s purpose, membership, and approach. They test protest actions to determine potential impact, and thus inform the movement’s future protest actions.

What agency-laden institutions are to social movements, programmatic beliefs are to government ministries. Programmatic beliefs are multidimensional versions of frames, described above. Programmatic beliefs are composed of an actor’s opinions, goals, and understanding of

the world, such beliefs pertaining solely to specific, particular domains. In such arenas, programmatic beliefs provide strategies and prescribe actions to solve political issues; “in other words, the ideational framework within which programs of action are formulated” (Berman, 1998 p. 21). Structural institutions such as government ministries are guided by programmatic beliefs, as the operationalization of political ideologies.

To avoid a theoretical kitchen sink, I engage with social movement literature vis-à-vis a historical institutionalist framework (e.g., Pierson & Skocpol, 2002; Smith, 2014), drawing on its mechanisms to make sense of why political opportunities emerge and how they became useful to movements. While historical institutionalism typically focuses on factors that foster gradual institutional change (Hall, 2010), I engage concepts including the role of early events and path dependency to examine features of political institutions in order to understand how they interacted with asylum seeker health movements and shaped political opportunities. This approach is informed greatly by Smith (2005: 183), who articulated that “political institutions affect mobilization and the possibilities for policy change”; more than impacting likelihood for success, they also influence movements’ organizing structures. Marrying the study of social movements to the study of institutions embeds them in one another, recognizing their relationships as mutually constitutive.

Smith (2005) suggests that political opportunities are not necessarily seismic; they can be slow to develop and can be institutions unto themselves, such as the Charter in Canadian politics. Unlike critical junctures, which are moments of openness within an institutional setting, political opportunities are points of openness that are structural and ongoing, often emerging over time. From the courts to the Canadian Charter of Rights and Freedoms to the election of a new governing party, political opportunities do more than just shape the likelihood for success. They also influence the “preferences, organizing structures, and mobilizing frames of social movements” (183). They signal an opening or ability to act following an accumulation of frustrations, and are identifiable only to some within a movement (Ramos-Rodriguez et al., 2010). This is in contrast to the events which spark attention from stakeholders and the general public. These ‘critical events’ precede political opportunity by “suddenly imposing grievances” on a population (Walsh & Warland, 1983: 772).

Social movements are “networks of informal interactions between a plurality of individuals, groups and/or organizations, engaged in political or cultural conflicts, on the basis of

shared collective identities” (Diani, 1992: 3). They differ from protests in their duration and the multiplicity of their actions, or what is termed a movement’s *repertoire*. Contentious actions constitute a repertoire of tools, and include any “act outside the dominant political process with a clear target, actor, place, action and goal” (Ramos, 2008: 802). Social movements, as the collective sum of multiple actors’ or organizations’ contentious actions towards a given target, can be defined or measured along a variety of characteristics: their size, motive, goal, expanse (i.e., across cities, countries, or internationally), organizing structure, leadership, and discursive framing. While discursive analyses are not explicitly conducted here, discursive politics and message framing of social movements are identified through interviews with movement participants. The politics of messaging is what Hajer (1995) calls “a struggle for discursive hegemony in which actors try to secure support for the definition of reality” (59)²⁷. Discursively (re)framing social groups or concepts can be powerfully transformative, and if convincing, can legitimize and facilitate reforms, as in the case of the *bogus refugee* discourse (e.g., Sköglstad, 2011). Political actors and popular media successfully reframed refugee populations from a humanitarian cause worthy of protection to a population of would-be economic migrants’ intent on abusing social services. Inward messaging within movements may differ from that which is directed to the general public or specific power targets; it may be polished and approved by defined leadership, or it may spread by self-appointed representatives.

Social movements that call for policy change may make strategic decisions around the specificity of their ‘ask’, the outlets through which demands are expressed, who is entrusted to disperse their message, and precisely what messaging is used. The forging of collective action frames – strategic issue ‘maps’ that serve to mobilize movement members and targets – is critical to soliciting a response from fellow protestors as well as the movement’s target issue (Johnston & Noakes, 2005). Borrowing from discursive institutionalist literature, movements’ politicized discourse can be classified as *coordinative* (i.e., ideas shared, formed *between* elite policy actors) or *communicative discourse* (i.e., ideas transmitted *from* policy players to the public), both of which serve as vehicles through which ideas are construed, conveyed, and legitimized (Schmidt, 2008). Issue campaigns are often successful when they span policy spheres to create a coordinated discursive coalition to endogenously lobby for policy reform, followed by communicative

²⁷ This project does not engage in discourse analysis. However, organizing concepts from discursive institutionalism are helpful here to understand policy and movements’ strategic messaging, as understood by interview participants.

discourse to persuade the public of the need for legitimized change to the very structures in which the discourse is located (Schmidt, 2008). However, while discursively employed ideas can work to (re)shape institutions by changing public and political perceptions towards a policy issue, the historical and entrenched value-laden norms that define the venue in which an idea is deployed dramatically affect an idea's ability to take root, including its potential breadth and pace of change.

Micro-Level: Social Movement Entrepreneurs and Expertise

A movement's leaders can impact whether a movement can achieve *buy-in* from members and potential members but also everyday citizens. Returning again to Morris (2002), two factors can shape impact: leadership configuration and protest histories. Movement leaders will bring with them resources, including people and experience that can bring to populate a movement. Leaders will be impacted by how society perceives them – their social location, their public presence, their gender as well as their race and ethnicity, all of which are used as heuristics for leadership suitability. Leaders' ability to strategically leverage points of their identity can increase internal cohesion and help make their messages legible to everyday citizens. Next, *protest traditions* provide critical backdrops to a movement. The previous experiences of organizers, members, and a movement's organizations will provide reference points, advice, and experience from which a new movement can draw lessons and devise strategies (Rupp & Taylor, 1987). Finally, Morris (2002) contends that successful mobilizations often mobilize quickly. The ability to rapidly mobilize is in part a function of having the 'right' organizations and people on board with a movement – this can reduce lag time as a movement prepares to launch.

In political-sociological usage, the term 'entrepreneur' indicates persons who are agentic and driven to meet political goals. Just as policy entrepreneurs are "political actors who promote policy ideas" (Minstrom, 1997: 739), social movement entrepreneurs are actors who are central to a given social effort and "exhibit strategic initiative in spreading the word about their cause and promoting its message" (Noakes & Johnston, 2005: 8). Social movement entrepreneurs ensure a movement's frames, messaging, and purpose is communicated to movement members, potential recruits and to the greater public. Entrepreneurs also identify a movement's narratives, such as their accomplishments and conquests, to articulate and amplify a movement's frame (Benford & Snow, 2000: 614). Ensuring frames and messaging resonates is essential. Snow and Benford's (1992) articulation of six factors impacting frame resonance is helpful to understanding when and

why frames strike a chord with movement members and observers: frame consistency (a movement's frames are cohesive, copacetic and complimentary to one another); empirical credibility (a frame's legibility to target audiences and how they make sense of an issue); promote credibility (whether movement entrepreneurs and champions are trusted and credible); experiential credibility related to empirical credibility; the relatability of a frame to the target's lived experiences); centrality (degree of alignment between the frame's core values and beliefs and those of the target audience); and, narrative fidelity (how well the frame interlocks with existing cultural norms, assumptions, and narratives). Accordingly, 'target audience' can also be understood as frame 'receivers' (Johnston & Noakes, 2005).

The characteristics of a frame's promoter are critical. Intangible qualities like charisma and relatability can amplify a movement's frame and impact (Johnston & Noakes, 2005). In the movements studied here, movement entrepreneurs held considerable social and cultural capital as recognized experts in asylum seeker healthcare and healthcare more generally. This characteristic is important; experts' political power is connected to public perceptions of their legitimacy and ability to make claims on the topic subject, as derived from their intimacy with the subject matter (Tetlock, 2005). Social movements will often present their champions and entrepreneurs as experts in order to increase frame resonance and amplify their impact (Coy & Woehrle, 1996). Experts "truth-tracing testimonies, publicity, and standards of inquiry bestow on them a tentative, context-dependent epistemic authority", a power reliant entirely on recognition by non-expert persons and bodies and critically, their ability to communicate their competence (Hardoš, 2014: 2). 'Expertise' may be claimed by or project unto its title bearers, though is not an absolute or uncontested status (Campbell, 2013; McLaughlin, 2009). It may be derived from experience (e.g., seniority) or perceived competence (Davies & Burgess, 2004) within a given field (ranging from "academic, government, or private sector background, access to classified information, doctoral degree...or status of university affiliation" (Tetlock, 2005 p. 54)²⁸.

Scholars have examined the role of experts in Canadian, German, and British policy. Examinations include policymaking vis-à-vis legitimacy making in policy design (Montpetit,

²⁸ While I am examining the work of elite experts and the specific mechanisms this particular form of expertise executes, 'expertise' should be understood broadly, especially within the realm of refugee resettlement and advocacy. An assertion of 'expertise' can exist outside the confines of class, education, and societal location-based claims to exclusive knowledge, and to include expertise based on experience using or providing services (McLaughlin, 2009). However, this form of expertise is "accorded a different status to expert knowledge, being of insufficient generality to contribute to advancing epistemic understanding" (Davies & Burgess, 2004 p. 351).

2008; see also Schneider & Ingram, 1997 for American context); as consultants in public policy formation (Howlett, 2009; Saint-Martin, 2012) including in immigration (Boswell, 2009) and citizenship policies (including how the structure of third-party consultation may create sites of expert resistance to neoliberal government agendas (Merolli, 2015)); as instruments in their own sectoral and professional association reform (Greenwood, Hinings, & Suddaby, 2002); as scientific analysts and panels to aid in issues ranging from environmental policy (Wurzel, 2002) to refugee credibility assessment (Campbell, 2013); the role of expert political judgment in forecasting events such as war outcomes (Tetlock, 2005); as well as the highly contentious, political, and subjective debates ensconced in deciding who can be an ‘expert’ (Hoppe, 2009). Further related research examines the use of technocrats in public policy formation, or the centering on scientific knowledge and claims to inform policy (Howlett, 2009).

However, in each instance analyzing the role of experts in policy formation, assumed here is *inviting in* of experts to weigh in on government proposals or policies. Conversely, I am interested in the uninvited expert-led interventions into policy making and public discourse. This is distinct from open letters, public statements, and policy critiques made by professional associations or broadly configured subject experts in response to government action. In the instance of expert resistance to refugee health care retrenchment, expert inclusion (and ultimately, power in steering) in the debate is the function of experts *opting in* to the debate in order to resist or attack policy in the public forum, without invitation by government. Moreover, the actions of doctors in Canada, England and Germany were targeted and direct, with the intention of not simply voicing discontent but of reversing specific policies.

While I posit the health care experts-as-advocates were particularly effective because of their perceived legitimacy to speak to the issue, the public does not necessarily perceive experts as trustworthy or in a positive light. The public often perceives scientific experts as purporting a political agenda (Webler, 1995). Indeed, the inclusion of experts in policy design may actually lead to a ‘legitimacy deficit’, or a perceived lack of legitimacy (Montpetit, 2008). However, the considerable impact of the Canadian, English, and German physician-led campaigns suggests that physicians are perceived as particularly legitimate or trustworthy.

Indeed, the active participation of professional and regulatory medical associations in this issue adds an important dimension of institutional and statutory legitimacy to health experts’ advocacy. Greenwood et al. (2002) note that professional-association driven sectoral change is

often seen as justifiable when the professional association has defined itself “in terms of its values, disconnected from any reference to particular knowledge” such that the “identity of the profession thus [becomes] bound up in a configuration of values (service, objectivity, expertise) whose applicability was more easily mutable” (p. 73). The authors note that further research is “clearly needed to draw out the complex ways through which associations contribute to continuity and change and the connections between their actions and different types of legitimacy” (p. 74).

II. Context: Immigration and the Welfare State

While institutionalist and social movement approaches form the backbone of this analysis, additional literatures substantiate the analytical interstices.

Immigration and the Welfare State

Asylum seeker healthcare straddles two policy areas that are driven by divergent norms: healthcare and immigration. While the former takes a universalist approach in each case studied, offering a full complement of care to citizens and often with services delivered by providers who do not or will not render verdicts on citizens’ status or deservingness, the latter is one guided by control and gatekeeper functions, especially for asylum seekers – those who enter based on humanitarian need, not human capital. These policy areas and their related elements are of perennial interest to political scientists – healthcare policy, immigration policy, the welfare state and immigration, among others – providing a rich landscape of literatures from which to draw and build on. However, this analysis makes clear that asylum seeker healthcare policy poses analytical difficulties; depending on the case in question and the actors interviewed, asylum seeker healthcare can be understood as a political symbol of healthcare universalism or a powerful tool in immigration control.

Within federations, social entitlements can vary widely across subnational arenas and citizenship statuses (Filindra, 2013). System of government is an important, though not decisive predictor of how a state interacts with immigration and welfare politics. Federal states are more likely to pass restrictive admission policies to reduce immigrant dependency on the welfare state, to exhibit policy conflict between national and constituent government units, and to present higher within-country variation on social service provision than unitary states (Koning, 2017). Scholars

point out the tensions between federalism and the welfare state, which Wallner (2010) articulates as federalism's diversity of policies clashing with the welfare state's underlying principles of uniformity and similarity. While federalism preserves diversity of social programming, the welfare state espouses social citizenship, or equal provisions for equal citizens. These concepts are not incongruent, however, as the central government can act as the standards enforcer, the common glue holding subnational social policies together (Banting, 1987, Scharpf, 2006), though some argue this is not necessary to continually enact social citizenship in even diverse federations (Wallner, 2009). The welfare state and immigration can also be contextualized again within the concepts of decentralization and devolution to unpack two key debates: the effect of decentralization on the strength of the welfare state, and, whether decentralization will result in high regional variation in social services (Banting & Costa-Font, 2010). Decentralization is oft perceived as permitting subnational (including municipal or regional governments) to create locally-appropriate solutions, but so too are devolved processes subject to the potential trappings of path dependency and thus vulnerable to losing their responsive, agile benefits.

Perhaps accordingly, federalism is consistently cited as a factor accounting for lower social spending (Wallner, 2009). This study is not concerned as much with social spending generally – Canada, Germany, and England are each relatively high-spending social welfare states – but rather, social spending on specific cohorts of the population: asylum seekers, who are oft viewed at best as non-citizens and at worst as fraudulent temporary residents. Analyses of immigration and the welfare state often focus on immigration's impact on citizens' support for redistribution, or the so-called "progressive's dilemma". The progressive's dilemma suggests immigration-spurred diversity will fracture social cohesion and lower support for redistribution (Banting, 2010; Eger & Breznau, 2017). This is conceptually distinct from general concern that immigration will lead to an overreliance on social services and thus increased costs borne by native-born (e.g., Razin et al., 2011). Asylum seekers will provoke ire from both camps and thus present a unique form of perceived threat to the welfare state. Asylum seekers are often uniformly dubbed 'bogus refugees', or persons entering under the humanitarian stream instead of waiting 'in queue' as economic migrants. They are most often racialized, with race becoming a proxy for their likelihood to act as 'benefit scroungers' who arrive at airports and ask, "where they can get their welfare cheque", leading political actors including former minister of Citizenship and Immigration Canada Jason

Kenney to submit that “it’s very clear our generous social benefits are acting as a significant pull factor” (Chase & Baluja, 2012).

Fears around asylum seeker ‘welfare tourism’ persist, despite little evidence to support the notion of refugees being attracted to asylum-assistance countries for purposes of welfare or social services (Bloom, 2016; Dixon, 2015; Hall, 2006). To stave concerns around welfare magnetism, national governments may respond strategically to social retrenchments in neighboring states by enacting similar restrictive social policies of their own, as in the case of EU member states engaging in social ‘races to the bottom’ (Kvist, 2004). Provinces and states may also seek to outpace one another in offering the least amount of support or the most incomplete services, specifically to immigrants, in an attempt to divert apparent would-be social strains to other subnational units (Koning, 2017). Indeed, turf-guarding is oft used to characterize the relationship between federal and provincial governments with regards to health (Maioni, 2002), but jurisdictional power squabbles most often transform to jurisdictional buck-passing when providing for non-citizens. On the other hand, subnational governments with relative autonomy in a policy area may also prove to be fertile testing grounds for policy innovation and testing. Subnational governments’ potential to become democracy “laboratories” (Brandeis, 1932 in Gardner, 1995: 475) speaks to the potential to deliver policy solutions that are tailor-made to their constituents, and is viewed as an advantage of federal systems (Pierson, 1995). However, others including Rose-Ackerman (1983) argue that federal countries’ multiplicity of subnational social offerings is also what renders federations poor deliverers of distributive goals as an array of welfare offerings will incentivize the wealthy to exit a jurisdiction with high taxes and services while incentivizing the economically disadvantaged to stay. While the notion of residents voting with their feet may seem somewhat unlikely, this does highlight that close proximity of highly varied subnational government offerings will cause residents to look to neighboring states and analyze their situation against that of others.

While voter support for specific policies are not variables analyzed here, political preference (by parties, by elected officials) is. Thus, it is interesting to note that while studies in Canada found little support for such a dilemma (Banting, 2010), German studies found that as the share of immigrants in the local population increased, support for social welfare programs declined (Schmidt-Catran & Spies, 2016; Stichnoth, 2012). Similar opposition to welfare spending on immigrants has been observed amongst Britons (Larsen, 2011). Why native-born or naturalized

citizens might oppose welfare spending on non-citizens is predictable. Established residents, richer in financial and social capital are hesitant to support redistribution to newer, poorer residents (a thorough review of factors affecting support for the welfare state can be found in Johnston et al., 2010). While evidence exists that higher immigration rates will lower support for redistribution (Soroka et al., 2013), research suggests that immigration will have little impact on redistributive systems in welfare states (Alesina & Glaeser, 2004; Crepaz 2006, 2008; Soroka et al., 2006; Gerdes, 2011). Miller (2006) argues that programs that redistribute funds on a vertical basis (from the rich to the poor), such as unemployment insurance or welfare, are more likely to be supported in countries with high national identity, which engenders *sympathy* and *trust* between fellow citizens. Programs like universal healthcare, which protect entire populations, are less reliant on national identity to see support. However, as Johnston et al. (2010) argue, national identities in places such as Canada includes support for immigration; this is embedded in the country's recognized identity, complicating this type of analysis.

Recent work by Koning (2017) agrees that high levels of immigration do not produce a disintegration of welfare institutions. However, he finds that citizen concern around newcomers and welfare may lead to two related outcomes: a shift in national admission policies to favour immigrants with high human capital and thus a lesser likelihood of relying on state support (i.e., the Canadian model), and/or increased restrictions on newcomers' access to state support services. The latter, what is referred to as 'welfare chauvinism', exists in the UK, the Netherlands, and the USA, involves imposing residency requirements to specific categories of immigrants in order to limit access to services, or make qualifying for a program generally more difficult for immigrants (Koning, 2017; Sainsbury, 2012). Other countries such as Canada impose restrictions that place it in-between the welfare chauvinism and post-national welfare state (Koning & Banting, 2013)

That voters mobilize around immigration issues is clear. One need not look further than the most recent American election to understand the mobilizing effects of combining nationalism and immigration fears, while previous research confirms that parties remain alert to the societal temperature regarding immigration (Helbling et al., 2015; Odmalm & Super, 2014). However, political parties can also be resistant to populist immigration stances and will support more expansive policies than preferred by voters because the net benefit of immigration outweighs the stresses it places on particular population cohorts (Freeman, 1995). However, most literatures centering on immigration and support for the welfare state analyze 'immigration' broadly defined.

This does not distinguish economic migrants –those selected for their skills and human capital – from humanitarian migrants. Rather, it focuses on the presence of undesirable characteristics across immigration categories, such as an unwillingness to integrate. However, a particular focus on support for the welfare state and asylum seekers is needed, given this category’s predilection towards using state services, especially in their initial years.

The ‘Bogus Refugee’ and Adjudicating Deservingness

Who is truly deserving of access to national health systems – and, how can we tell? What is an appropriate heuristic for worthiness - citizenship status? Country of origin? Skin colour? In everyday and political life, images, discourses, and other discursive artefacts socially construct and characterize groups into buckets such as *deserving* or *undeserving* (Ingram & Schneider, 1993). Such constructions such as “bogus refugees” can inform policy design and agenda setting (Sheridan & Shankardass, 2015) as well as citizen behaviour (Esses et al., 2008). Indeed, asylum seekers are socially constructed in accordance to whether or not they are deserving – a broad and shifting set of criteria which attempts to construct asylum seekers as un/worthy of the care of the political community, locating them in different moral, policy, and legal sites (Harell et al, 2012: 2583). Certainly, this is true for most welfare recipients, though asylum seekers ‘otherness’ – citizenship status, skin colour, accent, residency – thickens the lens of suspicion through which they are observed when seeking access to services (Little, 2001; Herd et al, 2005).

While post-national citizenship ideas based on human rights and personhood sought to transcend the Marshallian framework of citizenship tied firmly to the nation state, the early twenty-first century has seen a ‘re-nationalization’ of citizenship wherein the nation state ‘defends itself’ from multiple threats (Newman, 2013: 44). While this does not suggest a global departure from a citizenship ‘Golden Age’, the reactions by states to various threats, from terrorism to environmental refugees, signals a reversal of gains made during an “emergence of a reinvigorated cosmopolitanism” and further retrenchment to more draconian understandings of the relationship between political membership and human rights (Sassen, 2002: 278).

The literature on citizenship and threat is broad and often focuses on security threats, dividing the polis between citizens and non-citizens (Creese, 1992; Rajkumar et al., 2012). Through policy, legal, and rhetorical shifts, what it means to be a citizen in various contexts is shifted, mediated, and reformulated in an effort to contain ‘threats’ (Nyers, 2006; Huysmans, 2011;

Waeber, 1995). In the context of ‘security’ and securitization, the political community – consisting of ‘legitimate citizens’ and institutions – is what must be secured against external threats which are constructed around legal, racial, cultural, political, and other categories (Guillaume & Huysmans, 2013). Internal threats are also constructed in distinguishing between ‘good’ and ‘bad’ citizens according to various criteria and through various instruments (i.e. law, policy, discourse, etc.). In light of these shifts, the constellations (legal, policy, discourse etc.) which form citizenship have narrowed and become nebulous. For example, the Harper government in 2006 and 2015 attempted to redefine the boundaries of Canadian citizenship to make it more exclusive and circumscribed such that it would be harder to pass on and easier to revoke (Harder & Zhyznomirska, 2012; Abu-Laban, 2015).

This literature, however, is not limited to security – economic threats are also framed as threats to the political community of ‘good citizens’ (Demleitner, 1997; Fassin, 2011; Newman, 2013; Nyers, 2006). Particularly in contexts of economic ‘crisis,’ the future of the political community becomes a more prevalent discourse, often through concerns over general government and specifically social spending (i.e. defense spending is less often criticized or cut than funding for social services and programs) (Clarke & Newman, 2012: 300). While government spending is often the focus, consumption by subjects who are economically and socially marginalized is under more explicit scrutiny as well (Schechter, 2009: 89). The uncertainty inherent and constructed in moments of crisis result in the reassertion of moralized discourses *through* the state and other actors, evincing a growing interest the character of the other (Hay 1999: 317; Olsen et al., 2014; Grove & Ziwi, 2006). This citizenship evolution marks an important juncture through which ‘economic threats’ – such as ‘unsustainable’ welfare states and the ‘undeserving poor’ who rely on them – must be contained so as to sustain the future of the nation (and frequently, the ‘deserving poor’) (Newman, 2013: 44).

Conclusion

Banting and Costa-Font (2010) argue that “institutional design matters a lot” yet, “outcomes are highly contingent” (383). While this may appear self-evident, it bears repeating. Government structure can have important consequences for policymaking, creating impact in “the power, preferences, and strategies of social groups” and “the emergence of important new institutional actors” (Pierson, 1995: 472). Thus, identifying features of individual governments

and contextualizing their characteristics next to their own policy outcomes as well as to other countries is critical to understanding the development and evolution of social policies. However, institutions are not determinative. These combine with additional factors – the nature of organizations and strategies of individuals, amongst others – to create highly differentiated outcomes across and within unitary and federal states. While cross-national comparisons of federations are well-established as valid, including unitary systems in such comparisons provides added insight into how features at the meso and micro levels factor into shaping social movements' strategies and outcomes. Arguably comparison further protects against what Pierson (1995) warned as the threat posed by singular studies of federations, which he cautioned “may lead observers to overlook what is most distinctive about a particular federal system, cutting off potentially fascinating lines of inquiry” (473). Taking an ecological approach to map the factors that shape social movements and their ability to impact policy allows for a comprehensive look into why some social movements succeed, some of the time, and in some contexts while identifying major factors of interest for future in-depth research.

This literature provides the theoretical overtures and context to situate the factors under analysis in this thesis. This section reviewed literature around four factors – discourse, deservingness, political orientation and immigration and the welfare state – to provide insight into underlying issues and themes that are present in the core ecological analysis but may not be dealt with directly. This literature has also provided theoretical and empirical context to understand why particular factors (e.g., immigration norms) rose to prominence in one case but not another. In the following chapters, I will leverage the preceding discussion and theoretical framework to unpack my empirical findings across the three analyzed cases. I apply the ecological approach to each Canada, Germany and England to identify complex patterns of conjunctural causations – the contextual factors that created permissive reform conditions, and, the causal and contextual factors that shaped the responding social movements.

5. Canada and the IFHP Reform

This is one of two chapters that examine the Canadian case. It is guided by the first research question: under what conditions was the asylum seeker policy initially reformed? This core analysis is unique in this project for its recentness: refugee claimant healthcare was restored one year prior to interviews commencing, following a relatively short four-year policy movement. This analysis is thus an ‘up close’ look at the Canadian reform and pro-access movement, with recent memory and a barrage of media coverage available for examination. Given the breadth and depth of data available on the Canadian case, this chapter first unpacks the macro, meso and micro level factors that shaped the initial reform of asylum seeker healthcare policy, while Chapter 5 examines how physicians responded, and the factors related to their strategy and impact. My findings across both chapters are drawn from analysis of 20 interviews with Canadian pro-access physicians and nurses, as well as health administrators, provincial bureaucrats and a federal politician.

Canada occupies a distinctive place in this comparative analysis because it is the sole case where physicians’ actions can be linked to policy restoration with institutionally-bound, causal confidence: physicians led a successful court challenge that reversed the healthcare cuts, after three years of ongoing protest. In this way, the movement – led by the Canadian Doctors for Refugee Care (CDRC) – created measurable impact in the trajectory of IFHP policy reform. However, it is not enough to leave the narrative as-is; to borrow a phrase, no social movement is an island. Or more accurately, no social movement is devoid of systemic, institutional and individual-level forces that shape its actions and constrain its options. How the movement arrived at the courts – including who led it there, how complimentary and preceding events supported this outcome, and why a court challenge was appropriate – are all sub-questions which must be unpacked to understand how the success of *Canadian Doctors for Refugee Care et al. v Canada* came to be.

In this way, the Canadian case raises an interesting question: how do we know when a social movement “succeeds”? Individuals and organizations may be loosely held together by a common overarching goal but may hold different understandings of what is realistic, what is desirable, and which indicators would signal their goal has been achieved (Bernstein, 2003). Despite influencing a clear reversal of the IFHP cuts in 2016, several Canadian actors still expressed a degree of ambivalence or discomfort with raising the victory flag on refugee health

issues. For some, it was the location of the court decision; without reaching the Supreme Court, they felt the issue was not decisively settled. For others, it was the reinstatement's limited scope; while *Canadian Doctors for Refugee Care et al v Canada* reversed the IFHP cuts and prompted a slight expansion of the IFHP's coverage when a new federal government took office in 2016, many felt the exclusion of non-status people from the core movement's list of demands was a missed opportunity, a pandering to populist ideas of who deserves care. Yet still, most interviewed persons viewed the movement as successful, citing the policy's reversal as well as an increasingly defensive federal government and later, a strong Canadian response to the Syrian refugee crisis as important observable implications of their direct and indirect impact.

Still, attributing political outcomes to a social movement is challenging (Bernstein, 2003) and drawing strict causal lines is problematic, given the contemporaneous external factors that impacted the IFHP's reinstatement. These factors include the election of a pro-refugee Liberal federal government in 2015 and relatedly, the pledged resettlement of 25,000 Syrian refugees affected by the unprecedented Syrian humanitarian crisis. These external policy shifts were important but insufficient to achieving IFHP reversals. Their contemporaneous developments would have a methodologically problematic confounding effect if not for the sequencing of events: the CDRC-led coalition was the first explanatory variable to percolate on the pro-IFHP landscape, the first knob turned to initiate a series of actions that culminated in the IFHP's reinstatement. Extraneous policy factors including the 2015 election and the Syrian resettlement pledge were in part influenced by the efforts of the CDRC-led coalition; throughout its duration, the CDRC-led movement kept the pro-access position in the public sphere, and when combined with political mishandling of refugee concerns in summer 2015, elicited important impacts on the 2015 election and relatedly, major parties' position towards asylum seeker reception. As will be demonstrated, the Liberal election and Syrian resettlement were neither necessary nor sufficient on their own to effect change but were powerful in combination with other factors (Mahoney et al., 2009). In this way, extraneous factors had an impact on the IFHP outcome, but were themselves born out of the pro-access movement.

With these factors identified, the following chapter focuses on macro-, meso-, and micro-level factors influencing initial policy reform and shaping the pro-access movement.

Factors Driving Policy Reform

As described in Chapter 2, in 2012 the position of the Conservative government on asylum seeker healthcare and related refugee issues was clear. Political factors that drove the reform were cited frequently, including principally, the influx of Mexican and Roma asylum seekers into Canada. Roma and Mexican claimants hailed from ostensibly safe countries²⁹ who were perceived as coming to Canada because they were unable or unwilling to stand in a traditional immigration queue, or, were incentivized by Canada's generous social supports offered to asylum seekers. Discourse and content analyses that unpack media and policy documents during the reform era find the Conservative government deployed the "bogus" frame (Beatson, 2016) to construct claimants as persons seeking to take advantage of Canada's health and welfare systems and receive unfair benefits relative to the average Canadian (Harris & Zuberi, 2014). Specifically, in the context of IFHP reforms, Olsen et al. (2014) find the Harper Conservatives constructed asylum seekers as threats to Canada's generosity; who, as racialized *Others*, are different and thus a threat; who, as *Others*, are so helpless they should to be grateful for any degree of charity they receive. However, conditions must be met for even unilateral reform to occur and to succeed over time. Structural features influence institutional changes and eventually, facilitated the ability to translate anti-refugee healthcare politics into a substantive policy reform.

Macro (Systems) Level

Systems Shaping Central Government Action. Structural-institutional factors at the macro (systems) level in part shaped the feasibility and form of the 2012 IFHP reforms. This is seen in two ways: first, provincial responsibility over citizen healthcare created a supporting subnational infrastructure that incentivized federal downloading. Second, the IFHP's unique positioning as a federally-funded and federally-administered program also contributed to its unilateral reform. Its creation as an Order-in-Council created a unique veto point, or opportunity for change for the federal government that did not require provincial consultation. These features created structural incentives that made the reform of a longstanding, cost-efficient program possible (e.g., Barnes,

²⁹ The number of Roma claimants increased from 288 in 2008 to 4,423 in 2011, and totalled 11,333 claims from 2008-2012 (Rehaag et al., 2014). The number of Mexican claimants decreased from 9,472 in 2008 to just 36 in 2013, following the 2009 visa imposition (Meurrens, 2015).

2013), though as discussed in the following chapter, these features also bolstered the resistance movement.

To the first point, the provincially-driven Canadian healthcare system created an institutional context that made the federal government's exit from the IFHP structurally feasible. The IFHP's federal location is unusual given that Canadian healthcare infrastructure centered around the provinces. Canadian provinces' extensive healthcare cladding made its subnational governments well-positioned to absorb the IFHP's burden in a functional sense. In such instances, federalism creates opportunities for politically-inclined governments to "exit" from jurisdictions when politically beneficial (Hacker, 1998). Once the Conservative government excised asylum seeker healthcare from its vision of worthwhile programming, the provinces' robust health infrastructure and bureaucratic competencies created opportunity for federal exit (e.g., Epstein, 1992). From a pragmatic perspective, this downloading may also be framed as an attempt to reduce service duplication by leveraging existing provincial infrastructures. However, as will be discussed, provincial delivery of asylum seeker healthcare was not actually intended by the federal government. Moreover, without additional funding, downloading responsibility to provinces – as well as the non-profit and voluntary sectors, who absorbed considerable responsibility – was unsustainable (Dhand & Diab, 2015: 363; Evans et al., 2014).

IFH reforms shifted the levels at which care is given – from federal to provincial, and from preventative to emergency – with evidence suggesting these shifts led to a dramatic increase in health care costs (Evans et al., 2014). Overall, the federal government had much to gain from exiting from the IFH, including not least a strong reinforcement of complimentary reforms and messages embedded in Bill C-31. At the same time, provincial governments³⁰ were unable to afford the cost of uninsured claimants and their more-complex acute healthcare needs, and predictably, launched gap-fill policies and provincially-based insurance schemes to lessen the financial burden. Exiting the IFHP offered political benefit and ostensibly fewer costs to the federal government, while filling the federal IFHP gap would be financially responsible for provinces. This suggests that while the federal government presumably anticipated having to spend some

³⁰ Ontario and Quebec received 51,410 and 23,690 claims respectively between January 2011-October 2017. As the two largest refugee claim-receiving province by a considerable margin, their participation in provincial asylum seeker healthcare policy development was most financially and, arguably, morally pressing. Alberta (4,175) and British Columbia (3,340) received the next highest number of claims, respectively; neither implemented a gap-fill program (IRCC, 2017).

political capital on reframing the IFHP and its beneficiaries in order to make its reformation palatable to Canadians, the federal government had a strong incentive to exit.

However, the Canadian case raises important questions around what constitutes downloading. While IFHP reform demonstrated the features of any federal exit - unilateral withdrawal by the federal government resulting in mounting costs for subnational units and individual providers –the federal government lacked the *intention* for subnational units to formally adopt the program, or, to informally pay for its fallout. Interviews indicate that the federal government intended exit from the IFHP but not download it to provinces; rather, the Conservatives aimed to eliminate asylum seeker healthcare outside for the policy to be eliminated altogether, even though institutional opportunities for downloading existed. This suggests an underexplored theoretical tension in federal downloading: what role does intent play? This complicates the presumption that *downloading* is synonymous with offloading policy burdens to other governments (e.g., Newton & Adams, 2009). Still, despite the federal government’s intent to eliminate the policy, the results were the same as if they were intending to download: a patchwork of subnational responses leading to policy and service fragmentation.

In many ways, the IFHP retrenchment was in line with the Harper government’s approach to social policy through what it termed ‘open federalism’, which aimed “to limit the federal spending power in areas of provincial responsibility” (Rice & Prince, 2013: 122) and privilege provincial autonomy “to restore the decentralist vision of Canada...by disengaging Ottawa from social policy” (Cody, 2008: 34). While the success of open federalism remains disputed (Wallner, 2017), IFHP reforms presented a clear opportunity for this perspective to be leveraged. Yet, the Harper government did not once articulate that refugee healthcare was the responsibility of provinces; indeed, they went to lengths to frustrate provincial implementation (see *Provincial Healthcare Infrastructure and Physician Advocacy*). An interview with former Minister of Citizenship and Immigration, Chris Alexander stated that provincial uptake of the program was not the federal government’s intention; this perspective was shared by a provincial bureaucrat close to the Ontario file. This, combined with the uncharacteristically autonomous nature of the ministerial seat governing immigration and citizenship (see *Individual Action and Championing Reform*) suggests the federal government perceived the IFHP file as distinct in its goals and execution. Importantly, these unique institutional foundations that underpinned IFHP reforms would also later inform the strategies taken up by the pro-access social movement.

The outward public rhetoric regarding the IFHP's intentions aligned with the internal political motivations: reducing healthcare benefits would make Canada less appealing to refugee claimants, who were understood as a group populated largely by persons who wished to enter Canada but were unable or unwilling to use the economic or family sponsorship routes; these persons were distinguishable by their country of origin. What was not intended was for the provinces to offer an alternative insurance scheme. Interviews former Minister of Citizenship, Chris Alexander and provincial bureaucrats signal that the federal Conservatives did not intend or desire for the provinces to begin delivering services to asylum seekers, nor for individual clinicians to absorb costs, despite these being arguably inevitable and predictable outcomes. Alexander stated:

We were reforming the IFHP and we had not, in the reform that predated my arrival, contemplated any transition to the provinces. We did not expect them to be in this business of refugee health. This was completely on their own initiative, without coordination. And for political gain.³¹

Emails released by reporter Stephanie Levitz (2013) under an access-to-information request reveal an email from Debra Presse, former director of refugee resettlement at CIC, that seem to indicate that no plan or expectation was in place for the provinces to 'step up'; Presse argued in the letter that "it cannot be presumed they [claimants] will simply find the medication another way".

Insights from a provincial policymaker who worked under Ontario provincial Minister of Health Deb Matthews in 2013 to launch the Ontario Temporary Health Program stated that Ontario perceived IFHP reforms as "policy by stealth"; regardless of apparent federal intention, the policymaker believed "The feds were effectively downloading the responsibility onto us, and other provinces". A colleague in the Liberal Cabinet Office viewed the federal government as "shifting risk and spending through the veneer of law and order" and as absolving their role in providing for asylum seekers but not considering the practical requirements that would implore a province to respond. Both felt that CIC intended the gap to remain unfilled, and for the program to simply fall. This, suggested the policymaker, was indicative of the federal government's surprise at the response by provinces, organizations, and providers: "The feds weren't seen as sinister or

³¹ Christopher Alexander, interview by author, June 13, 2017.

purposefully doing these things to punish the provinces; it was more unintended, but, if they'd thought it out, a clear consequence would be that the provinces would fill the gap. They probably didn't think that Ontario would react the way that it did", signaling an elementary grasp of the program's demands (by refugee claimants, and, on health infrastructures) and relative unimportance of asylum seekers as policy recipients; not surprisingly, citizenship is used a tool to demarcate worthiness (Harell et al, 2012). The observed implications – asylum seekers going without healthcare as a result of federal cancellation – indicate that the policy was motivated by strong anti-refugee ideas and the bogus frame that pervaded federal discourse.

Federalism's multiplication of veto points will sometimes create legislative gridlock, preventing social policy reform (Smith, 1995). Without provincial involvement in its funding or administration, there exists no mechanisms or policies that require advanced provincial notice and consultation before major social policy changes. To the second point, the IFHP's location firmly within federal jurisdiction heightened its vulnerability to reform. The impact of heightened executive power is perhaps most clearly signalled by the IFHP's legislative form as an Order-in-Council (OIC)³². OICs are legal instruments made on the recommendation of the relevant Cabinet Minister and approved by the Governor General. OICs can amplify Canada's concentrated executive power as they are formed by Cabinet and recommended by a specific Minister. This is not unlike typical legislation; however, while OICs can be legislative, they can be formulated under the authority of a statute, or less often, pursuant to the royal prerogative (LAC, 2016). But when formed pursuant to the royal prerogative, as in the case of the IFHP, OICs bypass parliamentary scrutiny and debate. They need not pass through the House of Commons, nor must the responsible Minister answer questions from the opposition. Thus, OICs are not easily debated, suggesting a legislative tool highly insulated from democratic scrutiny and processes and highly amenable to unilateral social policy reform. Governing "through regulation rather than legislation...limit[s] public scrutiny", argue Rice and Prince (2013); "No longer does the government need to seek input from the community, which can no longer influence directly the

³² Orders-in-Council were used for Canada's most controversial immigration decisions, including *Order-in-Council PC 1911-1324*, banning "any immigrant belonging to the Negro race, which is deemed unsuitable to the climate and requirements of Canada", though it was not invoked officially; *Order-in-Councils 1913-920* and *926*, the continuous journey and Asiatic immigrant money requirement intended to create obstacles for Asian immigrants to arrive in Canada, though this was deemed invalid because technical issues; *Order-in-Council PC 1931-695* admitting only American and British subjects with sufficient capital to sustain themselves. *Order-in-Council PC 1962-86* was later invoked to eliminate race as an explicit selection tool in Canadian immigration policy (Van Dyk, 2017).

retrenchment agenda through its elected representatives” (122). While systemic policy retrenchment that instigates long-term resource changes more often occurs at the federal level in Canada, healthcare is particularly vulnerable to programmatic retrenchment (Pierson, 1994). IFHP arguably has heightened vulnerability, as its reform allowed for change at both levels – a programmatic edit that resulted in a systemic shift. Indeed, the IFHP’s reform sent a strong signal regarding the federal government’s priorities as they pertain to immigration, healthcare, and citizenship; in this way, this programmatic shift bolstered a broader systemic shift that was occurring in Canadian social policy at the federal level.

In many ways, the retrenchment was a canary in the policy mine, if only ideationally. Its removal opened the door for new ideas to be voiced legislatively around Canada’s obligation to refugees and asylum seekers. First, in Bill C-585, a private members’ bill from a Conservative Ontario MP sought to amend the Canada Social Transfer to permit a minimum length of residency requirement before permitting access to social benefits, which ultimately failed; these provisions were then tabled in the omnibus budget Bill C-43, which ultimately passed but has not yet led to a change in policy at the provincial level (Bryden, 2014; Keung, 2014). Through these effects, the IFHP signalled a reimagining of Canada’s relationship with refugees and also with universal healthcare, and a dramatic furthering of Canada’s neoliberal agenda, especially with regards to immigration and refugee policy (Tolley, 2017). These macro-level factors – federal institutions permitting downloading, even if unintentionally; federal unilateral control of the program; and, OICs as legislative mechanisms – collectively helped political will translate into policy change.

Meso (Institutional) Level

Policy Venue and Vulnerability to Reform. Building off analysis of the IFHP’s unique location and potential for reform, this section examines the IFHP’s 1995 policy venue shift from Health Canada to Citizenship and Immigration Canada as an important early event that shaped the IFHP’s trajectory and openness to reform. A policy’s ministry (venue) matters because where a policy is housed impacts which norms, actors, and complimentary policies surround it. As noted, Canada’s IFH program was launched in 1957 to provide health care for uninsured vulnerable groups, including destitute immigrants and resettled refugees (both GARs and PSRs), but, not refugee claimants. Asylum seekers were covered by provincial plans until 1995 when the federal

government took on the mandate under the IFHP (CDRC et al v AG of Canada & Minister of CIC, 2014: 2).

The same year, the IFHP mandate moved ministries. Until 1995, the IFHP was under the purview of Health Canada's Non-Insured Benefit Program (NIBP). After refugee claimants were added to the IFHP coverage umbrella that same year, the mandate was moved to CIC and administered by the Medical Services Branch, a CIC policy subunit (Internal Audit, 2004). When housed under the Ministry of Health, the IFHP was buttressed by the history, emotional attachment, and norms consistent with Canadian healthcare such as universality and access. But while under the NIBP, it also only served those more easily understood as 'deserving' – immigrants who arrived through the economic or family class who had become indigent. The addition of refugee claimants, whose deservingness had yet to be adjudicated, coincided with the move to CIC, where the IFHP was no longer a healthcare mandate pursuant to Canada's universal healthcare commitments, but a burdensome program that risked attracting persons to Canada and supporting those who jumped traditional immigration queues.

These ministries operate through different programmatic beliefs with regards to asylum seekers. Under CIC, IFH could be reimagined as a tool of immigration reform and control as well as a political symbol fortifying the Conservative's commitment to stopping bogus refugees. This endogenous critical juncture for refugee health care in Canada, and its critical antecedent, inclusion of claimants under the IRCC collectively created the necessary institutional conditions for future politically-driven change. While a venue shift alone will not *cause* IFH reform, such junctures are determinative in that they "close off alternative options and lead to the establishment of institutions that generate self-reinforcing, path-dependent processes" (Capoccia & Kelemen, 2007: 341). In time, the IFHP would become adjacent to policies intended to exclude claimants, such as Bill C-31. Moreover, while the policy's institutional venue change went virtually unnoticed by the public, it changed the cast of political actors surrounding the policy, as well as the demands and limitations placed on them by the public. These actors "control the prevailing image of the policy problem through the use of rhetoric, symbols, and policy analysis" (Baumgartner and Jones, 1993: 1045) as well as the nature of complimentary policies.

This venue shift's strongest implication is the change of minister. As will be discussed, Minister of Citizenship and Immigration, Jason Kenney operationalized the CIC's policies to become tools of exclusion against asylum seekers. A change in bureaucrats may have also

theoretically made an impact, but interviews indicate that federal public servants, along with their provincial counterparts, were historically very committed to the IFHP as a refugee-serving policy and opposed its reform. Dr. Meb Rashid, co-founder of the Canadian Doctors for Refugee Care, described interacting with an IFHP advisory committee he joined in the late 2000s. He stated that “it might be overstating it to say they spoke like advocates”, but pre-reform, IFH bureaucrats “really wanted the program to work and to work well. They were looking at costs, but they also spoke about what were the needs of refugees and refugee claimants, so nothing but respect for the people at that table.” Similarly, Zaynab Abadi³³, a provincial public servant who worked on the Ontario Temporary Health Program (OTHP), Ontario’s temporary stop-gap initiative stated that “The FPS [Federal Public Service] was trying to help the OPS [Ontario Public Service] with the OTHP set-up; they felt bad about the reforms and many of them were personally against it”³⁴, suggesting public servants worked to resist or slow reforms under a Prime Minister who expressly limited civil servants’ influence (Lawlor, 2017). Public reporting on the issue confirmed the anonymous interviewee’s recollection; following an access-to-information request, journalist Stephanie Levitz published email correspondence that suggested bureaucrats worked to convince their political masters to reconsider the reforms. Quoting an email from former director of refugee resettlement Debra Presse, Levitz (2013) reported:

"We also need to understand what is going to be the medical/health fallout post June 30 for all current IFH beneficiaries who will no longer receive the medication we are not paying for...", wrote Ms. Presse.

The emails suggest particular opposition to GARs and PSRs’ IFHP removal, an initial feature of the reforms. Quoting a paper circulated within CIC five days before the reforms were implemented (Levitz, 2013):

"The pending elimination of coverage for supplemental benefits under the IFH program for resettled refugees may significantly reduce the effectiveness of these options in improving refugee outcomes. The elimination of supplemental coverage may also have a significant impact on resettled refugees' health and settlement experience..."

³³ Name has been changed.

³⁴ Zaynab Abadi, interview by author, February 2017.

But in 2012, federal efforts to cut costs led to massive layoffs in the federal public service totalling 19,200 people (May 2014). Interviews suggest that CIC and its Medical Services branch in particular were affected. Dr. Rashid stated that many of the IFH workers he coordinated with previously “weren’t there in 2012, the program had shrunk dramatically”³⁵; Nicholas Keung, Toronto Star immigration reporter corroborated this, noting it made interviewing public servants more difficult: “We all know that they actually cut many people from the department and resources were an issue”³⁶.

Micro (Individual) Level

Individual Action and Championing Reform. Micro-level analyses refer to factors at the individual level, including key actors and their role in messaging, coordinating, and developing an issue. IFHP revisions were supported by the Harper government, but were spearheaded by the minister responsible, Jason Kenney. Kenney was the minister who recommended the Order-in-Council’s reform. A former Reform Party of Canada and Canadian Alliance party member who rose to prominence under Harper’s Conservative banner, Kenney served first as Minister of Citizenship, Immigration (2008-2013), a portfolio that was taken over by Chris Alexander (2013-2015). Kenney then served as the Minister of Employment and Social Development (2013-2015), before closing his tenure as the Minister of National Defense in 2015. He stepped down from federal politics in 2016 after maintaining his seat in the 2015 election, and currently leads the United Conservative Party, a right-leaning provincial party in Alberta.

Kenney has been called a political “rock star” for his ability to attract immigrant voters. His socially conservative messaging was attractive for some, but attendance at a high number of cultural events and ceremonies (Toronto Star, 2013) was highly unorthodox for Canadian politics, and proved highly rewarding. He is also credited as “chang[ing] the vocabulary used by immigration officials”, mainstreaming phrases such as queue jumper, bogus, and gold-plated benefits as he worked to “systematically convince Canadians – even those who took pride in their country’s reputation for openness – that they were being duped, used and ridiculed abroad” (Goar, 2014). His ability to attract a “Bieber-like following” amongst Canada’s minority communities

³⁵ Dr. Meb Rashid, interview by author, May 29, 2017.

³⁶ Nicholas Keung, interview by author, February 10, 2017.

played an important role courting the ethnic vote in the 2011 federal election (Black & Keung, 2013; Friesen & Sher, 2011; Tolley, 2017). Toronto Star immigration reporter Nicholas Keung had many interactions with Minister Kenney and described him as strategic and pioneering in his communications. Kenney, felt Keung, “was the first one who actually proactively reached out to ethnic media to explain his agenda and his policies. Now you see that across the three parties.”³⁷

This type of ethnic community engagement was critical for building an unexpected base of immigration reform supporters in Canada’s immigrant communities. Targeted and strong relationships with ethnic media (Lawlor, 2017) and relationships with minority communities across Canada were intended to build trust and buy-in to Kenney’s controversial immigration reforms (e.g., Curran, 2017). Politically, Kenney spearheaded a massive neoliberal immigration reform package (Alboim & Cohl, 2012). As the “prime architect and force behind Canadian immigration reform” (Root et al., 2014: 9), Kenney’s office initiated changes including introducing the grandparent Super Visa to replace permanent sponsorship of grandparents; expanding the temporary foreign worker program; revamping the citizenship guide to focus on military history and values rhetoric; and, tightening language requirements for new citizens, amongst other employer-centered reforms that signaled a reimagining of Canada’s social landscape (Fleras, 2014). By all accounts, these reforms were not immigrant-friendly. Instead, Kenney earned the trust of ethnic communities the same way he communicated to the rest of Canada: by suggesting their hard work should not be supplanted by those looking to skip the queue. Kenney became contemporaneous with IFHP reforms, speaking frequently and openly to the all media outlets about their cost-savings and their fairness (Kenney, 2012), mainstreaming phrases like ‘bogus refugee’ in Canadian politics and media (Olsen et al., 2014).

Notably, Kenney’s political openness stood in stark contrast to his Prime Minister, Stephen Harper, whose communications style and relationship with the press were routinely criticized (CAJ, 2010; Lawlor, 2017). Yet still, Kenney remained open and available to the media. While this was presumably with the permission of the PMO, this provided a human face and unbridled press access, elevating the IHFP reform’s profile and increasing coverage of Kenney’s positions and justifications of the policy change. Toronto Star reporter Keung identified Kenney’s role as the public face of IFHP and indeed, all immigration reforms as an important factor for garnering

³⁷ Nicholas Keung, interview by author, February 10, 2017.

public support, in part because he was always willing to engage with the media. Keung stated Kenney “probably had the most transparent, open access to the media. He was so often available to us. He was the minister I spoke to most, in terms of 1:1 interviews.” Keung further described him as a rare personality in politics:

Kenney was probably the most knowledgeable and my impression was that he micro-managed everything within the operation of the immigration department. He probably knew more about the health coverage for refugees than even the bureaucratic staff... What was interesting was he was very good at his messaging; he is an ingenious communicator. He is very principled, and he always sticks to what he believed in in his response. I wouldn't say there was actually an official line, but...there was always that clear messaging, very consistent.³⁸

Moreover, Kenney and later, Alexander stand out in the Harper era because Harper's government was marked by strong centralization and heavy control from the PMO. Cabinet ministers were perceived as marginalized under Harper; Cody (2008) wrote that Harper “allegedly treats his cabinet ministers as ‘servile minions’” (36). Lewis (2017) provides a detailed account of the extent to which Harper exercised control over his ministers, citing the “PMO's omnipresence in the lives of Cabinet ministers” and the propensity for the “PMO's control [to] spill[] over into more trivial or meddling concerns” such as limiting social media engagement and public social events (271). Further means of Cabinet control and reducing ministers' power and roles included cancelling weekly Cabinet meetings (a tradition of his predecessors) and emphasizing the role of the Priorities and Planning Committee, both of which “reduced the majority of ministers' roles as decision-makers” (277).

Yet, a select few ministers were high-profile and played key roles as “the public faces of Cabinet” (Lewis, 2017: 275). Kenney, a member of the agenda-setting “policies and priorities” committee since 2011, held clear autonomy and public-facing authority within the Harper Conservatives. Indeed, even if Kenney and Alexander, both rising stars in the Conservative leadership, were instructed by the PMO to usher the CIC portfolio towards massive reform through public and media engagement, their actions stand out. Kenney, for his positive media relationship and Alexander, for his repeated blunders. Indeed, for Alexander, it is inconceivable that the PMO was heavy-handing his media engagements; his gaffes arguably signal Harper had disconnected

³⁸ Nicholas Keung, interview by author, February 10, 2017.

from this issue, a conclusion supported by Alexander’s assertion that he and Harper spoke “just once” on the issue of IFHP³⁹.

As a policy systems architect and “exception to the political mute button” (Fleras, 2014: xiii) Kenney held a very public office. Yet, he did not engage with any known member of the medical community on the issue of IFH reform. Kenney did initiate what interviewees described as “personal and hyperbolic” attacks in the public domain, including framing anti-reform physicians as “militant leftists” and suggesting data on the impacts of the reform was fabricated⁴⁰. His public celebrity and personal championing of the reforms were elements in the initial reform’s success, and their absence as a result of Kenney being shuffled throughout the Cabinet likely impacted the IFHP’s ultimate failure.

Conclusion

In 2012, the federal Conservative government significantly reduced Canada’s asylum seeker healthcare offerings as part of a package of reforms designed to excise asylum seekers from the Canadian identity narrative and policy landscape. However, it takes more than political posturing and intent to dramatically reimagine a previously uncontroversial policy. The IFHP’s unique position as a federal health policy in an increasingly securitized immigration ministry, the opportunities created by provincial healthcare infrastructure, and the IFHP’s form as an Order-in-Council rendered it particularly vulnerable to a retrenchment campaign driven by political protégée, Minister Jason Kenney. However, this context, as well as additional factors at each level also created conditions that ushered in a successful anti-reform, pro-access movement. These are discussed in the following chapter.

³⁹ Christopher Alexander, interview by author, June 13, 2017.

⁴⁰ Dr. Philip Berger, interview by author, February 22, 2017.

6. Canada and the Pro-Access Movement

Responding to Reform: A Multi-Pronged, National Response Led by Physicians

This chapter examines the Canadian case in response to the second research question: what conditions shaped the physician-led pro-access movement's strategy, strength and ability to create impact? Ultimately, Harper's IFHP reforms were overturned in a physician-led federal court challenge in 2014. However, the Charter of Rights and Freedoms challenge did not happen in isolation, nor can it be exclusively linked as the sole driver behind the IFHP's reinstatement. Indeed, events subsequent to the challenge, including the election of the Trudeau Liberals in 2016 and relatedly, the influx of Syrian refugees also played an important role in the return of asylum seeker healthcare. However, it was the events leading up to the Charter challenge that are of primary interest here – the sustained, targeted actions of physician and healthcare advocates that stitched together individual protests into a national movement, culminating with decision to use the Canadian courts as a venue for social action. Of course, sustained action by healthcare gatekeepers alone does not a successful movement make, and this section again engages the ecological model to understand factors at each the macro, meso, and micro-levels that influenced physicians' ability to impart influence and change on the IFHP.

The Canadian pro-refugee health access movement was comprised of diverse people from a variety of personal and professional backgrounds, including refugee-serving such as the Canadian Association of Refugee Lawyers, the Canadian Council for Refugees, the Canadian Immigrant Settlement Sector Alliance, and the Ontario Council of Agencies Serving Immigrants (OCASI), the City of Toronto's Medical Officer of Health and similarly situated city representatives in Vancouver and Calgary. These organizations were joined by representatives from the nonprofit sector and everyday citizens. Organizations released research and evidence concerning the impacts of the reform on public health in Canada and to the health needs of asylum seekers with a particular focus on claimants from DCO countries (e.g., City of Toronto Medical Officer of Health, 2012).

Most recognizable in terms of size and presence were healthcare workers, including nurses, physiotherapists, midwives and personal support workers, led by a national group of physicians, many of whom regularly served refugees and many who did not. Physicians are clearly identifiable as leaders of the movement overall, organizing the diverse movement's major protest actions that

were inclusive of all physician, healthcare and non-healthcare who were pro-refugee healthcare access (“pro-access”) supporters (e.g., an annual National Day of Action), as well as physician-specific, highly impactful actions (e.g., interrupting Ministers in public venues). By leveraging the power of the universally recognizable white lab coat, doctors led the asylum seeker healthcare movement in direct response to Minister Kenney’s 2012 IFHP retrenchment. The physician-led movement’s repertoire was narrow in its messaging but wide in its scope, expressed as actions ranging from the highly unorthodox (e.g., occupying political offices), to the highly visible (e.g., leveraging support from national health associations), to the highly tactical (e.g., launching a Charter challenge). Each centered around select messaging that deliberately targeted key audiences. These and other strategic organizational choices (expanded upon in *Meso: Organizational*) reflect macro and meso-level institutional features of the contexts in which physicians were operating, as well as micro-level changemakers who shaped the movements’ actions and ability to impact change.

Physicians were led by the Canadian Doctors for Refugee Care (CDRC), a non-partisan physician group that was launched in 2012 immediately following the announcement of IFHP reform⁴¹. The CDRC defined the strategic direction of the physician movement’s and, by extension, the movement overall and thus, physicians broadly and the CDRC specifically are the primary focus of this analysis. Founded by Dr. Meb Rashid, medical director of the Crossroads Clinic at Women’s College Hospital (Toronto) and Dr. Philip Berger, Chief of Family and Community Medicine at St. Michael’s Hospital (Toronto), the CDRC was led by a steering committee, and had the sole, express purpose of demanding the full return of the IFHP as it was previously written. Comprising a loose network of physicians across Canada, the CDRC allowed any doctor, regardless of previous experience serving refugees, to join its listserv and call themselves a member of CDRC. Founder Dr. Berger recalled:

Not that it was a formal group with a governance structure. We had a steering committee but no governance document; that would be too much work. We needed agility and flexibility... The steering committee gave us [Dr. Philip Berger & Dr. Meb Rashid] permission

⁴¹ While non-partisan in their support, the CDRC’s contempt for the federal Conservatives was clear. Dr. Berger described attending a meeting of immigrant community members in Toronto where there was new, strong support for the Conservative party; “they were planning to vote for Harper, we wanted to convince them not to... We wanted to use the refugee healthcare issue to show, look, these guys are not your friends, they are not friends of refugees and immigrants”.

to go issue press releases and do interviews without going back and having a meeting every single time, which paralyzes a lot of political groups who sacrifice political agility and effectiveness.⁴²

The section below identifies major factors that shaped the pro-access movement in Canada at each level. Clearly woven throughout each analytical layer is the importance of resources, understood as financial resources but also the cultural and social capital held by the physicians leading the fight (e.g., Bernstein, 2003; McAdam et al., 1996). Still, while the resource model is featured most prominently these findings support a diverse range of factors that the social movement canon has identified as important determinants for social movements impact. Factors identified as critical antecedents of the pro-access movement (or generally, factors which amplified the movement's impact) are consistent with tenets from the resource model, rational choice, communications framing, and political opportunity structure. These findings are novel however because they illustrate that these approaches are complimentary and prime for layering to explain a movement's outcome. Each approach speaks to the conditions at a given level of analysis, from the systems level to the individual. These findings suggest these approaches are useful not because they can explain a single slice of a social movement, but because taken collectively, they can help unpack the wide breadth of systems, institutions, organizations and individuals that each represent necessary but insufficient conditions for a movement to take off.

At the macro level, I examine how Canadian healthcare and immigration norms troubled the Harper government's ability to cleanly exit the IFHP and shaped provincial responses and shed further light on why 'intent' behind federal downloading (i.e., intent to cancel, not download a policy) may not matter – intent may instead be subsumed by massive normative and pragmatic forces that force a policy's continuation despite political intention to cancel its delivery. Relatedly, I identify the stealth nature of the Harper exit and its use of an Order-in-Council to execute its reform as a key factor fueling physicians' resolve. At the meso-institutional level, I examine the impact of the province's gap-fill policy on the pro-access movement: while it responded to the movement's demands by insuring services for claimants, it created new administrative burdens that made the IHFP replacement untenable. Second, I look at the political opportunity created by the *Charter of Rights and Freedoms*, and how advocates targeted their behaviour to maximize the

⁴² Dr. Philip Berger, interview by author, February 22, 2017.

venue's potential. At the meso-organizational level, the CDRC's strategic choices that fully leveraged their institutional context are examined. Finally, at the micro-level, the actions of individual issue champions are unpacked. Collectively, these factors constitute the political opportunities afforded to the pro-access movement, though specific opportunities seized by the movement are also identified.

Macro (Systems) Level

Exit by Stealth and IFHP Advocacy. The Conservative's unilateral IFHP exit was in part made possible by Canada's federal system and the IFHP's unique legislative form. But, the nature of the exit also played an important role sparking the initial advocacy movement. In the years following, the Conservative's decision to freeze out physicians from conversation or debate deepened advocates' pro-access resolve. Interviewees resolutely agreed that *how* the Harper government announced the IFHP reforms played an important role in galvanizing the movement. This happened in two ways. First, the federal government's ability to withdraw unilaterally was also accompanied by a blackout on engagement with healthcare stakeholders, who received no advanced warning, hampering their ability to respond, and were then denied all subsequent requests to meet. All interviewed bureaucrats, political staffers, physicians, providers and health administrators stated they learned of the cuts from each other or from the public announcement, and all interviewed persons described hospitals and healthcare providers as perceiving the reform as unexpected. Interviewees cited the announcement's wording (referencing bogus refugees, fairness), its delivery (without warning, without consultation), and its form as an Order-in-Council (without Parliamentary debate or scrutiny) as particular sites of contention. Dr. Berger described his reaction to the "surprise reform" as "quite taken aback and astonished", stating "my juvenile rage I had in the 1970s erected itself and I emailed Meb and I said, let's talk"⁴³. This experience was echoed by many as the trigger of the pro-access movement.

The unanticipated nature of the IFHP announcement created what one administrator described as "near chaos" as provincial and healthcare stakeholders worked to understand the implications of the reforms, and devise procedures to accommodate the new IFHP program.

⁴³ Dr. Philip Berger, interview by author, February 22, 2017.

Further unannounced changes included an erroneous website update indicating coverage had been partially restored (July 2012), and the removal of government-assisted refugees from the scope of IFHP cuts (see also CDRC, 2012). The federal government's communication difficulties were taken by some as indicators to physicians that policymakers were unfamiliar with the policy and led to greater confusion on the ground⁴⁴. Dr. Tim O'Shea, a Hamilton-based physician noted that Refuge, a refugee-serving Hamilton clinic, had opened just two months before the cuts with the intention of operating on IFHP billings, as evidence of the reform's surprise. As noted, the federal government was not required to consult or seek approval from physicians or provinces. In this way, the IFHP echoed the contentious, highly-opposed Canada Health Act (CHA) in 1984, where despite "powerful actors arrayed against the bill – doctors and provincial governments – these interests were not in a position to threaten its passage" (Tuohy, 1988: 3).

To be sure, Harper's PMO routinely made announcements without warning or preamble (Lawlor, 2017). However, the degree to which legislation was routinely launched without prior consultation of stakeholders is not clear. Even if it was within the government's rights to launch unilaterally, advanced warning on major systemic changes in healthcare or at minimum, consultations with affected stakeholders are keeping with good policymaking, especially given the IFHP's complex billing procedures and vulnerable recipient base. Interestingly, consultation with physician stakeholders was historically the case for IFHP. Dr. Meb Rashid described being on an IFH advisory committee in the late 2000s, one of several examples, he argued, of alternative problem-solving avenues, referencing also parliamentary committees focusing on the IFHP formulary in the 2000s. To the committee, Dr. Rashid recalled:

Was it 2008? Somewhere around there. There were people there at CIC and the IFH program who were just committed to making it more responsive and more cost-effective. So they pulled together a meeting or two in Ottawa, and there were a bunch of issues that were outlined, some of which were resolved...So, you actually had some tremendous people who were deeply committed to making the program cost-effective but also functional. And there was a movement at that point to try to bring people to the table who could make the program work more effectively⁴⁵.

⁴⁴ This however does not appear to be the case. Data contained in the aforementioned access-to-information release (Levitz, 2013) indicates that Kenney's office had deep knowledge of the policy and the initial plan to also eliminate GAR and PSR coverage from the IFHP was not an oversight

⁴⁵ See, for example, House of Commons Committee Meeting minutes for the Standing Committee on Citizenship and Immigration (HCCCM, 2011).

Interviewees felt the power to reform policy unchecked informed the Harper government's decision to not consult with or inform asylum seeker health providers or their associations, and to refuse requests for meetings and consultations in the years following. Harper's style of governing was marked by limited engagement with civil society; his approach to communications has been described as "combative" (Cody, 2008: 36). At the reform's onset, eight national health associations wrote to Minister Kenney requesting to meet to discuss their concerns around the cuts (Linton et al., 2012); these requests were not met. Numerous other organizations did the same, including the Canadian Council for Refugees (2012) but were denied meetings. The CDRC similarly wrote to Kenney on two occasions "with a counter proposal we thought would meet his alleged concern of people abusing the system, but never had a response at all", said Dr. Berger⁴⁶. Lorne Waldman, president of the Canadian Association of Refugee Lawyers (CARL) and Charter challenge co-applicant, summarized:

Politically, there was no discourse. There was no interest in any kind of discourse. That was pretty clear right from the beginning; this is part of a political agenda of the immigration minister and of the Harper government.⁴⁷

Throughout the CDRC's existence, relations between the federal government, healthcare workers and physician advocates were virtually non-existent. In an interview with the author, Dr. Meb Rashid stated:

We spoke to [head of the IFHP, Dr. Danielle Grondin] on a few occasions around that time in 2012 where she was able to clarify some of the ambiguities of the program. But it was definitely us reaching out to her. To the best of my knowledge there was no program in place to deal with healthcare workers to explain the impact of the cuts. In terms of healthcare workers, I have not met anyone who met to discuss this issue with government officials, either before that announcement in April or after.

CDRC released statements commenting on their exclusion from debate (e.g., Harris & Zuberi, 2014; Rashid & Berger, 2013). Communicating their exclusion to the wider public was

⁴⁶ Dr. Philip Berger (Founder, CDRC), interview by author, February 22, 2017. Notably, non-medical groups were similarly excluded from discussion or refused consultation, including the CCR, OCASI, and the Canadian Immigrant Settlement Sector Alliance (City of Toronto Medical Officer of Health, 2012).

⁴⁷ Lorne Waldman (President, CARL), interview by author, June 7, 2017.

perceived by interviewed members as important for broadening the issues' appeal to audiences who may have been indifferent to asylum seeker healthcare but concerned about democratic decline. Their exclusion shifted the movement's efforts to be fighting for asylum seeker healthcare but also, according to CDRC communications manager Chris Holcroft called "an access to democracy issue" that "fit into a values debate"⁴⁸. This was perceived as widening their overall appeal by providing new ways of framing and discussing the reforms.

Dr. Philip Berger and Chris Holcroft both felt that the CDRC and other healthcare workers' exclusion from democratic debate ultimately worked in the CDRC's favour, painting the Conservatives as at best, mean-spirited, and at worst, anti-democratic. Interestingly, Alexander did not disagree with interviewees' characterization of government-movement relations, though offered this explanation:

I never had a meeting with this group because they were against what we had done. If I had met with them, I was not in the position to act on the basis of the meeting [*referencing the IFHP's status before the court at the time he took the role as Minister of Citizenship and Immigration*]. I knew I wasn't going to convince them. I kind of wanted to meet with them but I knew it wasn't going to get me very far. I spoke with a couple of them on the phone. But, in these few conversations I had with them, I said, if you really want to help refugees, why don't you go join MSF, or go work in a refugee camp? This is the way you could really help.⁴⁹

While this exclusion was in line with the Harper administration's approach to intergovernmental relations (e.g., Wallner, 2017), for asylum seeker healthcare advocates the stealth nature of the IFHP reforms was particularly problematic given the population that stood to be affected, whose health access until the time of reform was largely uncontested and perceived as in-line with Canada's universal healthcare commitments. These norms and their impact on the IFHP's delivery are discussed below.

Norms and Programmatic Inertia. Norms around healthcare universality and culturally-competent care, as well as pragmatic considerations regarding costs and health service delivery greatly frustrated the adoption of new IFHP guidelines by spurring a service continuation amidst

⁴⁸ Christopher Holcroft (Public Relations, CDRC), interview by author, May 11, 2017.

⁴⁹ Christopher Alexander, interview by author, June 13, 2017.

providers and a sense of frustrated indignation within the pro-access movement. To start, the cultural and historic environments in which Canadian physicians delivered asylum seeker healthcare and indeed healthcare more broadly is important. Historic legal and normative contexts around universal, inclusive healthcare and multicultural, pro-refugee immigration systems and indeed, their intersections are celebrated in everyday Canadian life and defined the professional lives of immigrant and refugee healthcare specialists, who worked at their intersection. While frontline workers will ask for provincial health insurance cards or federal IFHP paper documents, these documents signal full, undifferentiated access to ambulatory and hospital care. Until 2012, refugees' scope of care was untouched since the IFH's creation in 1957, while Canadians have not paid point-of-service fees since 1966. When providing care, physicians are thus not trained to inquire about a person's specific immigration status, or after admitting a patient, to inquire about insurance provisions prior to providing specific services.

The IFHP's self-reinforcing, normative effects can in part explain service continuance amidst policy cancellation. Changes in institutionalized, normative beliefs amongst those who enact policy systems (e.g., health care providers) are unlikely to disappear quickly because of tertiary-level policy changes (e.g., Barnes, 2013). Especially in urban Canadian life, immigration and cultural diversity is largely normalized. Diversity is present in most public spaces and in most doctor's offices; racialization is not a proxy for refugee status – Canada's focus on 'merit-based' economic migration makes the identification of asylum seekers and refugees from economic immigrants difficult. This complicates discrimination; place of origin, skin colour, or accent is made difficult to engage as a heuristic or marker of *refugeeness* as it is more readily in countries without histories of immigration, such as Germany. Immigration and multiculturalism, and relatedly, the need for culturally-competent care has been normalized in many physician's office and in broader Canadian life.

Efforts to build an inclusive system are deliberate; Canadian medical students receive training in providing culturally-competent care, take electives on refugee health, and join their colleagues to work in clinics designed to serve diverse populations. Indeed, a complimentary infrastructure exists within the general Canadian health system to serve the needs of diverse groups, including the pre-reform IFHP, on-call translation services, holistic cultural care options, and clinics for people without any legal status. The IFHP's significance as a long-serving program that created expectations amongst providers and patients was identified by the CARL-CDRC

Charter challenge as important contextual information. Service delivery had acquired a path dependent, normative inertia, underpinned by deep-seated national values and programmatic norms. It was the adaptive expectations of policy *providers*, not recipients, that erected barriers to change (Stevens, 2010), signaling that policy change requires political will not just from politicians but also from service providers – physicians, nurses, and other healthcare workers.

Canada and the Canadian healthcare system is not without racism, anti-refugee sentiment, or providers in favour of the cuts (Kalich et al., 2016). Interviewed physicians identified several colleagues who were in support of the IFHP cuts and suggested that those who supported the reforms were most often working outside of primary or refugee care⁵⁰. But, it is clear that the entrenchment of multicultural care in Canada's universal health systems made the policy decision difficult for many physicians to understand or accept. In many ways – cultural sensitivity training, multi-lingual translations of healthcare literature, clinics designated for those receiving IFHP – the system signaled that newcomers belonged. The notion of excluding persons legally in Canada from an otherwise universal healthcare system based solely on their place in the refugee determination process, or for their country of origin in the case of DCO claimants was “a complete non-starter for many”⁵¹. IFH reform evoked moral ire from health care providers and citizens alike because it challenged personal as ostensibly, national commitments to universal health care and humanitarian aid (Olsen et al., 2014). Interviewed persons described continuing to serve many of their patients who were no longer covered by the new IFHP because it refusing service seemed ‘un-Canadian’. Requiring physicians and/or their administrators to request and understand their IFHP status (importantly, not a legal status) used nowhere else in the Canadian system, and to inquire about their country of origin to determine eligibility countered the normative values and practices of healthcare providers and added new layers of complexity to these roles. Interviewees argued that this turned physicians into immigration officers, forcing them to ration care based on where they were in their IRB claim⁵².

⁵⁰ There were also real consequences in the scope, accessibility, and quality of refugee health care amongst providers who were pro-access but unable to provide full services. Practitioners sometimes turned away persons seeking care. Increased system complexity, alongside fear of reprisal also discourages refugees from accessing services (Marwah, 2014).

⁵¹ Dr. Andrea Hunter (physician), interview by author, March 27, 2017.

⁵² Interestingly, Chris Alexander refuted this suggestion, stating: “Anyone who thought that that was their job to determine someone’s immigration status, was really out there beyond the bounds of what I would call ‘sound professional behaviour’. You’re either a claimant, or you’re not. Your claim has either been upheld, or it hasn’t. All claimants have documents that show this”. This arguably signals a disconnect between elected immigration

Second, pragmatic legal and macro-financial considerations also made the outright or even gradual cancellation of asylum seeker health services impractical and difficult. Claimants not insured even for emergency rooms (rejected claimants and those from ‘safe’ countries) continued to arrive at hospitals to access and receive care, which hospitals are obliged to provide under the 1984 *Canada Health Act*. A Toronto hospital reported that following IFH cuts, the number of refugee children admitted to the emergency room doubled in 2013, many of whom were uninsured but still serviced, with costs paid by the hospital directly (Evans et al., 2014; Marwah, 2014).

Eliminating insurance for preventative care thus placed financial burden on provinces, transforming relatively inexpensive primary care coverage to costlier uninsured emergency visits to provincially-funded hospitals (IMCC, 2012; Keung, 2013). Researchers found that because hospitals treat patients regardless of ability to pay, IFHP cuts “provide healthcare savings at the federal level, but ultimately the cost is transferred to the institutions...and therefore, provinces” (Evans et al., 2014: 3). Federal exit from IFH funding also increased pressure on the non-profit sector, as claimants who lost coverage increased visits to donations-funded open-access clinics (Hathout, 2012; Keung, 2012; 2015), as well as on individual healthcare providers, who were encouraged to absorb patient costs (Sheikh et al., 2013). For example, the Canadian Centre for Refugee and Immigrant Health Care, a free Toronto clinic, reported an increase of 300% in patient load after the cuts (CTVNews.ca, 2015). Interviewed physicians, health administrators, and provincial bureaucrats all stated they experienced or foresaw an increased burden on the provinces and higher health costs overall after the IFHP reforms. While the federal government predicted annual savings of \$20 million when the cuts were announced, physicians questioned this number publicly; Dr. Rashid stated in-interview that the number lacked evidence and no data was shared to its support. However, former Minister Chris Alexander maintained \$20 million was accurate, the result of “calculations done internally by our Department and validated by the Treasury Board”. Interestingly, Minister Alexander also questioned the government’s calculations on projected savings. In response to claims that the reforms would save \$20 million annually, Alexander stated: “At peak it might have saved \$5 million. The bigger save would have been in ending the duplication of having a niche federal program”⁵³. The absence of clear financial savings

leadership and the experience of those on the ground, as substantial research suggests that asylum seekers often faced barriers articulating their status and knowing their entitlements even *prior* to the 2012 reforms when status nuances were inconsequential.

⁵³ Christopher Alexander (Minister of Citizenship and Immigration Canada), interview by author, June 13, 2017.

signals ideational and not material incentives for the federal government and suggests the party's communicative discourse relied on potentially empty or misleading rhetoric to be made policy (Berman, 2013).

Meso (Institutional) Level

Provincial Healthcare Infrastructure and Physician Advocacy. Building on the examination of the role of normative considerations, this section considers how two features of the Ontario Temporary Health Plan (OTHP), the province of Ontario's refugee health insurance solution, provoked instead of placated physician advocacy efforts. This was done first by amplifying the administrative frustrations of the IFHP, and second, by being perceived as validation of the pro-access movement's position. The OTHP's announcement as a gap-fill insurance policy for all asylum claimants in Ontario was welcomed by the movement as a pro-refugee policy. Dr. Meb Rashid recalled: "We thought it was fantastic. It certainly showed goodwill. We commended the provincial government for trying to ease the suffering that many were seeing"⁵⁴. However, while OTHP sought to cover all services that were previously covered by the IFHP, its introduction did not signal a return to pre-reform norms. Instead, it added layers of complexity to new post-reform IFHP system, which was described as placing new burdens on providers and administrators.

Unpacking the administrative burdens imposed by the new IFHP is first in order. Interviewed community health centre's administrator Evan Baker⁵⁵ described the requirement to cross-check what was covered and what was not as impractical and burdensome. The new IFHP tripartite categorizing of claimants was described in interviews and published media articles as unclear; the categories ("failed refugee claimant"; "refugee claimant from a designated country of origin") were proprietary to the IFHP. Entitlement descriptions of some IFHP categories as "emergencies only" were described as vague and difficult to decipher. Without a clear formulary of what was covered and what was not, interviewees described "providing care now, figuring out how and if it was covered later"⁵⁶ as a common practice, leaving many on the hook for services

⁵⁴ Dr. Meb Rashid (Founder, CDRC), interview by author, May 29, 2017.

⁵⁵ Name has been changed.

⁵⁶ Evan Baker (Director, Community Health Centre in Toronto) interview by author, February 20, 2017.

out of their own pocket when IFHP refused coverage, or writing off expenses to their constituent hospital budgets. In a published interview (CDRC, 2014) Dr. Tim O’Shea stated that because of the complexity of the new IFHP program, physicians reported cases of claimants not seeking care because the IFHP categories required a deep understanding of the immigration system, or they incorrectly believed they were not covered. Similarly, he reported that physicians were largely unfamiliar with the program as their role had thus far not required an appreciation for the IRB determination system and its stages in order to establish IFHP eligibility. “This roll out has been a nightmare and has unnecessarily put patients at risk,” he stated. In the same interview, Dr. O’Shea stated:

Physicians are asked to contact the administrator of the health insurance program to confirm eligibility before each patient visit. This is impossible in any busy office. Also, their offices close at 4:30 pm and when they are reached they often state they will call back in 24 to 48 hours. It is absurd.⁵⁷

Dr. Berger agreed, and reiterated the role confusion felt by practitioners: “What outraged doctors is that we were expected to be agents of the state by telling people they can’t get healthcare because the government wouldn’t pay for it”⁵⁸. Respondents felt the reform placed physicians in a role counter to their duty to provide equitable care, and critically, to enforce a complex law at great cost to their patient-physician relationship and to their own resources, which were often used to cover treatment that was not covered by the new IFHP, or, that they lacked the resources to claim or fight for (Evans et al., 2014; Antonipillai et al., 2017).

In addition to pushing against the federal reforms, the pro-access movement also sought responses from provincial governments. As discussed in *Macro (Systems) Level*, a country’s system of government matters for social movements because it in part shapes entry points for advocates seeking reform. Canada’s federal/provincial division of powers produced opportunities for advocates by creating an additional government target where advocates could simultaneously direct their efforts: provincial healthcare systems. Federalism duplicates venues for policy reform. Provincial-level capacity for alternative policy development is also notable for its impact on policy experimentation (Rocher & Smith, 2003). Interviews with providers, administrators, and

⁵⁷ Dr. Tim O’Shea (physician), interview by author, April 24, 2017.

⁵⁸ Dr. Philip Berger (Founder, CDRC), interview by author, February 22, 2017.

provincial bureaucrats found that physicians pushed for Ontario to create a gap-fill response by contacting existing provincial contacts, describing the OTHP as another front they were quietly attacking. Those connected to physicians' provincial lobbying included health minister Deb Matthews, who was also described as having a personal belief in the file. Two interviewed provincial policymakers reported that the Ontario government was interested in creating a gap-fill program both because it was the moral and financially sound step to take.

The Ontario Temporary Health Program (OTHP) was publicly introduced by minister Matthews in December 2013. The official announcement made clear the province's perspective by calling upon the "federal government to live up to its responsibilities to provide health coverage for all claimants" and pledging to "send them the bill to pay for OTHP" (Ontario, 2013). The OTHP sought to fill the gaps created by the IFHP's new tripartite system, and cover services that were no longer IFHP-eligible. Dr. Meb Rashid explained that the OTHP was intended to layer on top of the new IFHP program. Most importantly, it would also use the IFHP's private insurer, Medavie Blue Cross, to allow physicians to submit a single billing to Medavie. If the billing was not covered under IFH, it would theoretically be then handed to the Medavie representative processing OTHP claims, which would be the payer of last resort. Dr. Rashid explained:

And I thought, great because in the end what happens is determining what program was going to provide coverage was back-ended – the clinician, we didn't really need to know what type of refugee they were, what was covered, if they were failed claimants. We just send it, someone sends the payment, and that whole thing would get more physicians on board to see refugees.

However, this streamlined processing did not come to fruition. Zaynab Abadi, the Ontario policymaker close to the file stated that initially, there was cooperation between federal and provincial bureaucrats as Ontario prepared to launch the OTHP. To this, Minister Alexander replied:

Yes, I do recall something about that but my mind it was not a serious request because if the provinces had been serious about looking after refugees they would have done it through the existing healthcare system, not reinventing the highly inefficient and duplicative IFHP. I think that the fact that they made such a request underlines that this

was for political positioning and not actually to benefit refugees and those who needs Canada's help.⁵⁹

The policymaker explained that their team at the OPS were quietly coordinating with the Federal Public Service (FPS) at the managerial level to share the IFHP's Medavie Blue Cross infrastructure with Ontario, and exploring options around sharing data on current claimants' existing insurance files. According to the policymaker, the federal government was displeased with the OTHP's creation, but acknowledged Ontario's difficult position. Moreover, FPS members who were personally distraught by the IFHP's elimination were especially supportive of helping the OPS. However, coordination ceased after Ontario's 2013 public announcement of the OTHP outwardly condemned the federal government's reform. In the OTHP's release, Ontario's Minister of Health, Deb Matthews, was quoted as saying the OTHP would be "stepping in to fill gaps left by the federal cuts to Canada's Interim Federal Health Program", and that the Ontario government would "send the federal government the bill to pay back what they owe" (Ontario, 2013). Minister Matthews' aggressive stance was described as unexpected by the federal government and was followed by a much-publicized feud between federal Minister of Citizenship and Immigration, Chris Alexander and Minister Matthews (CBC, 2014). Minister Alexander described Ontario's choice to implement the OTHP as a "scandalous" and "irresponsible" move that gives claimants better benefits than Ontarians and also makes Ontario a magnet for "bogus", fake refugees. In response, MPP Matthews argued that under the OTHP, claimants were to receive the same level of care as many Ontario residents, and accused Minister Alexander of playing politics (CBC, 2014, n.p.). Interview participants spoke to Alexander's well-publicized "scolding" of Minister Matthews as a lightning rod for advocates (e.g., Goar, 2014). In a published interview (Wingrove, 2014, n.p.), Alexander stated:

Deb Matthews – her approach wastes taxpayers' money...we will continue to criticize if they continue down this road. And I'm certainly not afraid of doing that, because this is a federal field of responsibility which they have chosen to enter for absolutely the wrong reasons.

⁵⁹ Christopher Alexander (Minister of Citizenship and Immigration Canada), interview by author, June 13, 2017.

Without federal support, the OTHP launched in January 2014. The OTHP program and other provincially-supported asylum seeker gap-fills in Quebec, New Brunswick, Newfoundland and Manitoba improved asylum seekers' healthcare access and became a symbolic 'win' for physician advocates, who maintained that asylum seeker healthcare was firmly a federal concern (MHLTC, 2013). Interviews with the hired public relations (PR) coordinator Chris Holcroft as well as with board members of Canadian Doctors for Refugee Care described the OTHP as "validating" the physician movement⁶⁰. The OTHP was seen by CDRC members as signaling to physicians and healthcare providers, the federal government, and the greater public that calls for the IFHP's return were legitimate. The PR coordinator stated emphatically: "The OTHP was critical because people got care, but it also reinforced our campaign message and gave us momentum. The issue had fallen out of the public view at that point; this reinvigorated us and told the public that supporting was the right thing to do". Much like the effects of Minister Alexander's discursive attacks on Minister Matthews, the federal government's perceived sabotage of the OTHP further stoked advocacy fires:

I think the feds did a very good job of making sure that the OTHP wasn't going to work...To go to such great lengths to subvert a program that a province is willing to pick up the tab, of a federal program...I don't think it looked good politically.⁶¹

By validating advocates' efforts and proving administratively infeasible, Ontario's gap-fill response ironically hindered the success of federal downloading. Interestingly, the introduction of the Ontario insurance scheme seemingly followed the path of early nationwide Medicare development, whereby "provinces proved to be a crucial incubator of policy activism" (Hacker, 1998: 72) and a policy testing arena to reiterate the practical benefits of providing asylum seeker health care (Evans et al., 2014), validating the movement's claims that providing coverage was a cost-saving measure (MHLTC, 2013).

However, the OTHP proved cumbersome, and health providers immediately faced difficulties making claims. While navigating two insurance systems would presumably be cumbersome, interview participants suggested that the federal government made the reimbursement claims harder than necessary in order to voice their frustration around the OTHP's

⁶⁰ Christopher Holcroft (PR, CDRC), interview by author, May 11, 2017.

⁶¹ Dr. Meb Rashid (Founder, CDRC), interview by author, May 29, 2017.

creation. Despite Medavie Blue Cross being the provider for both OTHP and IFHP and in fact, many workers from both programs working alongside each other in the same office space, there existed almost no coordination. Dr. Rashid stated:

What the federal government did was they completely sabotaged that problem. They sabotaged that program because they wouldn't allow the IFH worker to pass those documents to the OTHP worker. What they did is they would send it back to the clinician, the clinician would have to take a look at the paperwork again, keep that paperwork somehow first of all, and then resend it back to the same office in New Brunswick. And right there, it was a non-starter. Cause you know, it's 4-5 weeks for each attempt.⁶²

Because the OTHP was intended to be the payer of last resort, claims would not be processed by the province until they were formally rejected by the IFHP. Compounding the issue, IFHP claims were routinely returned if completed incorrectly. This required clinicians to still have relatively deep knowledge of the IFHP categories when completing initial paperwork, even if they knew the procedure would only be OTHP. Finally, because billing submissions to the OTHP could not be streamlined, a different application form was then required, creating formidable administrative hurdles and costs for providers. “In most offices, that was a non-starter. The time it took – you'd have to hire someone new to navigate those layers. So, you know, what happens is people just stop accepting patients”, stated Dr. Rashid⁶³. In agreement, Evan Baker, Director of a multicultural community health centre in Toronto characterized the OTHP as “a bureaucratic nightmare. We appreciated the OTHP, but every time we had to learn a new program we diverted energy away from serving clients”, he explained; “The OTHP was not an integrated service, it was a workaround.”⁶⁴

Interviews suggest that for many physicians who were already reluctant to see asylum seeker patients because of IFHP complexities, the new IFHP and OTHP systems had the effect of amplifying their hesitancy; the need to learn both the new IFHP as well as the new OTHP

⁶² Dr. Meb Rashid (Founder, CDRC), interview by author, May 29, 2017.

⁶³ In a published interview, Dr. Rashid predicted inertial effects of the IFHP back-and-forth changes and unclear policy communications. “Harper made it legitimate to discriminate against asylum seekers. Habits like that aren't easy to change” (Goar, 2016). Dr. Bannerman described similar long-lasting impacts: “I go into pharmacies even now, and they say, this isn't covered under IFHP. I challenge them to use their system and they find out it was covered.”

⁶⁴ Evan Baker (Director, Community Health Centre in Toronto) interview by author, February 20, 2017.

decreased the relative benefits of serving patients and heightened the cost of learning the new payment systems, suggesting the interesting phenomenon of decreasing returns to the policy interventions (e.g., Pierson, 2000). Users did not receive a health card for either system and there was no direct billing mechanism available; both were distinct from typical OHIP billing, creating what Dr. Andrea Hunter described as “another hurdle, another reason for physicians to say ‘no’”. However, for those engaged in advocacy, the OTHP was described as emboldening their efforts. Advocacy continued after the OTHP’s introduction because, according to Dr. Rashid:

Because it was an administrative nightmare and because it was perceived by the movement as a federal responsibility. The fact that people in other provinces were still being affected. We knew people were still being affected in many provinces across the country and in Ontario. And absolutely, it’s a federal program and it needs to be taken up federally.⁶⁵

An email listserv acted as a reporting mechanism for Canada’s refugee health network. The listserv was populated by physicians across the country who were interested in refugee health care, and became a tool to share best practices and experiences with their respective provincial gap-fill policies. This story-sharing exposed the different realities on the ground for clinicians across the country, including highlighting the difficulties experienced by OTHP members, and those experienced by physicians in provinces without any gap-fill programs. This spurred physicians’ efforts to continue to push for the federal government to reinstate the full IFHP to ensure coverage was uniform and easy-to-access. Provincial governments became interlocutors, exerting further pressure upwards on the federal government by demanding reimbursement for their new gap-fill programs, an identified social movement strategy in multi-level government situations (Princen & Kerremans, 2008). Progress at the subnational level elicited feedback effects that bolstered advocates’ ability to achieve their ultimate goal of reinstating uniform, high-level coverage at the national level.

In this way, Canada’s decentralized healthcare system worked in favour of pro-asylum seeker healthcare advocates by facilitating the creation of provincial-level health gap-fill programs, seen as short-term gains by the pro-access movement. Despite the OTHP’s undeniable administrative frustrations. Collectively, macro and meso-level factors shaped advocacy:

⁶⁵ Dr. Meb Rashid (Founder, CDRC), interview by author, May 29, 2017.

normative and pragmatic forces compelled the continuation of health services, though in a limited fashion; the gap-fill provincial response bolstered advocacy instead of dampening the movement; and, provincial stakeholders' tense relationships with the federal government over billing administration heightened resolve to push refugee healthcare responsibly back to the federal government.

Charter Challenge and Courts as a Venue. Litigation and the courts play a critical role in shaping the relationship between social movements and public policy (Snow, 2014). In the case of Canada, the most clearly causal, decisive action is the Canadian Doctors for Refugee Care's partnered challenge of the IFHP cuts in federal court. In an exceedingly rare decision, in July 2014 Justice Mactavish found the IFHP cuts violated asylum seekers' rights as guaranteed by the Canadian Charter of Rights and Freedoms. In her ruling, Justice Mactavish found the federal government violated section 12 of the Charter by subjecting asylum seekers to cruel and unusual treatment, as well as section 15, by discriminating based on national origin. The ruling was lauded by both federal opposition parties, including the federal Liberal immigration critic and future minister of immigration, John McCallum, federal NDP immigration critic Lysane Blanchette-Lamothe, as well as Ontario health minister Dr. Eric Hoskins (Black, 2014). Justice Mactavish's ruling would ultimately go unchallenged in court as the newly-elected Liberals chose to abandon the federal appeal upon taking office in 2015⁶⁶.

The shift to Canadian courts was initiated by the Canadian Association of Refugee Lawyers (CARL) in 2013, alongside CDRC, Justice for Children and Youth (JCY), a Toronto-based organization that provides legal representation to low-income children and youth, and two individual asylum seekers who were harmed by the reform. The applicants challenged that the IFHP cuts violated individuals' rights as guaranteed by the Charter of Rights and Freedoms. The

⁶⁶The July 2014 ruling gave the government four months to re-align the IFHP with Charter requirements, or have the IFHP reforms struck down. Minister Alexander appealed the decision in September 2014; the CDRC led-coalition was then joined by the Registered Nurses' Association of Ontario and the Canadian Association of Community Health Centres, who sought intervenor status in the Appeal. In November, the federal government revised again the IFHP to allow all claimants access to basic care. However, in January the following year CARL and the CDRC alleged the IFHP changes did not comply with the court order, an issue Minister Alexander referred to in an interview as the result of "internal partisan politics". Recall that the 2012 IFHP cuts also impacted government-assisted refugees (GARs) as well as privately sponsored refugees (PSRs) regarding their access to supplementary healthcare (vision, physiotherapy, dental, etc.; see Chapter 3). While GARs' coverage was immediately reinstated following protest in 2012, PSRs' coverage was not. The temporary IFHP program in response to Mactavish's ruling still failed to reinstate PSRs' coverage (Labman, 2016).

expanded role of courts in the Canadian political system has greatly impacted rights-based policy for minority groups in Canada. Smith (2005) argues that society's comfort or position on contentious issues can be linked to the impact judicial empowerment has had on social movements and public policy. The process of judicial empowerment, or the judiciary's increased standing in the political and policymaking systems, can create political opportunity for advocates by creating a venue to challenge policy that bypasses partisan politics. It can also shape how advocates mobilize by providing a vocabulary in rights-based discourse.

While the institutional change of the Charter occurred years prior to the 2014 IFHP challenge and organization was catalyzed first within medical and public venues and then litigation, the Charter still presented a clear structural opportunity to change policy. Several including Lorne Waldman perceived the Charter opportunity as the sole avenue through which the IFHP could be meaningfully challenged, stating: "When politically there's no possibility of conversation, then one option as lawyers that we have is to challenge the legality"⁶⁷. The shift to the courts and engagement with the Charter signalled advocates' strategic 'venue shopping' (Baumgartner and Jones, 1993). Advocates will seek new venues as a rational calculus, moving to the venue that offers the most political opportunity (Mazey & Richardson, 2001). Who constitutes the Charter coalition is important, because political opportunity is a function of group resources, expertise, perceived legitimacy and organizational capacity, as well as a group's cohesion (e.g., Berestein, 2003). In the IFHP challenge, each organization brought with it a different institutional logic and legitimacy to create a cohesive application: CARL's legal knowledge, CDRC's health and asylum seeker expertise, and JCY's expertise on the experiences of children, which fostered public interest and empathy. Waldman described the importance of JCY's involvement: "Children are the most compelling part of any argument, always...children are the innocent victims of decisions made by their parents. If their parents made a fruitless refugee claim, they are innocent"⁶⁸. This strategic decision also signals again the willingness of applicants to demarcate who is deserving of support (innocent children, if nothing else), to play with the valences of worthiness within their own argumentation⁶⁹.

⁶⁷ Lorne Waldman (President, CARL), interview by author, June 7, 2017.

⁶⁸ Lorne Waldman (President, CARL), interview by author, June 7, 2017.

⁶⁹ While outside the scope of this research, the CDRC's decision to strategically leverage the courts speaks to broader questions around judicial power versus legislative and executive power in shaping policy in Canada. See research by Miriam Smith on social movements and judicial empowerment (2005), as well as Rory Leishman's work (2006) denouncing activism as symptomatic of democratic decline in Canada.

Waldman stressed that inviting the CDRC to join CARL as the public face of the litigation was not to be taken lightly, given that “the organization had to decide if it was prepared to run the risk of launching litigation because if they lost it could affect their existence. Costs could be in the hundreds of thousands of dollars, depending on how long the case went on,” signalling the importance of resources and capabilities amidst social movement members in order to realize political opportunities (McAdam et al., 1996). Further signalling the importance of organizational capacity and cohesiveness in making political opportunities accessible and therefore real was the relationship between litigates. “This piece of litigation is the best example I’ve seen of a group of people working together”, stated Waldman, recalling the volunteer hours of over 100 persons including legal students, refugee lawyers, general litigators and physicians⁷⁰. The challenge was also publicly supported by high-profile CARL members and members of Toronto’s legal community. This suggests this venue shift increased the scope of public supporters to include even more with substantive social clout. Indeed, if political process theory suggests that mobilization will increase when influential political allies are available (Tarrow, 1996), venue-shifting to the courts created a “policy-specific opportunity” by inviting legal heavyweights to join, amplifying the pro-access movement’s reach (42).

For the venue shift to be impactful, the coalition must identify and leverage the institutional venue’s purpose, preferred tools and frames in order to drive a return on their efforts – what Princen and Kerremans (2008) deem “institutional remit” (1137). CDRC, CARL and JCY did this in two ways: first, by exclusively challenging the repeal of the IFHP’s Order-in-Council, and second, by using a human rights-based framework, signalling a more focused, explicit human-rights frame than what was engaged throughout the broader movement. To the scope of the challenge, the coalition strategically did not seek to expand the IFHP’s definition to include non-status citizens or any persons not previously covered by IFHP coverage. Decisions to approach Charter challenges from a mainstream perspective and through relatively non-radical organizations are not uncommon, as seen in Egale’s Charter challenges made through a human rights framework instead of the broader sexual liberation templates used by more radical LGBTQ groups (Smith, 2005). This made their argument more ‘palatable’, an easier sell to a potentially skeptical judiciary

⁷⁰ Doctors and the CDRC were tasked with providing evidence. The CDRC drew on their research efforts to collect data since the 2012 cuts, including a refugee health database called Refugee-HOMES that catalogued the impacts of the IHFP cuts, evidence Justice Mactavish relied on heavily during her ruling.

and greater public; as argued by Beatson (2016), a belief in the rights of claimants to healthcare elicited an efficient strategy that drove support across ideological and political perspectives (25). However, for the numerous groups within the pro-access movement who pursued a more radical agenda of open borders and healthcare for all (e.g., No One is Illegal), like LGBTQ organizing, the pro-access movements decision to leverage the Charter rendered the human rights-centered argument as the dominant “frame and ideology of the movement” at the expense of more radical pro-access agenda (Smith, 2005: 348), a similar outcome as in the case of the American (Bernstein, 2003) and Canadian (Smith, 2005) LGBTQ movements.

CDRC’s Charter challenge is distinct from other social movements’ use of the courts as a strategic institutional shift. In *CDRC et al. v Canada*, applicants challenged a policy that positively intervened in claimants’ lives. The decision to actively exclude a population from a social good, to extricate resources from a population’s reach differs in principle from Charter challenges that sought to rectify longstanding, latent discrimination from policies which were discriminatory. The IFHP reform is also unique as an example of a federally-initiated, politicized moral policy issue, one Tatalovich and Smith (2001) found that government typically avoids morally sensitive or contentious issues and defers to the courts in three instances.⁷¹

Finding a Section 12 rights violation was a particularly strong message (Dhand & Diab, 2015). Justice Mactavish’s ruling found that while the federal government enjoys the prerogative to assign priorities and set limits on social entitlements, the government’s “intentional targeting of an admittedly poor, vulnerable and disadvantaged group for adverse treatment takes this situation beyond the realm of traditional Charter challenges to social benefit programs” (*CDRC et al v AGC*, 2014 para. 9). Specifically, Justice Mactavish found that the executive branch of government “intentionally set out to make the lives of these disadvantaged individuals even more difficult than they already are in an effort to force those who have sought the protection of this country to leave Canada more quickly, and to deter others from coming here” (*ibid.*, para. 10).

The Charter win was significant. The institutional and legal legitimacy it afforded to the IFHP had continuing effects into the 2016 election. While Minister Alexander decried Justice

⁷¹ The Charter win was further significant because it also represented a win for non-citizens’ rights in Canada. As Dauvergne (2014) notes, the Supreme Court of Canada agreed with Charter challenges favouring non-citizens on two occasions since 1982; “Despite a promising start”, she argues, “the Charter has done very little for non-citizens”. Dauvergne finds that 85% of non-citizen requests to appear before the SCC are denied, a rate higher than that of the United Kingdom.

Mactavish's ruling as "activist", Dr. Berger described it as "scathing": "She used much stronger language than we ever used...It was a real boost to the protest. Now national health associations felt more comfortable, and we were vindicated to not be this extreme, radical group. It gave us credibility". Waldman agreed, "I'm surprised we won. How can I put it? It was an unprecedented; we were going in uncharted waters"⁷². Waldman noted its ripple effects, as he and others have cited the ruling in subsequent immigration cases. The CDRC's rights-based success allowed the federal Liberals and NDP parties to easily and with less political risk, side with the pro-access movement during the 2016 election (CDRC, 2015). Social movements can target specific law and policies, but oft have spillover or even intentional effects in influencing politics and society's 'temperature' towards a given issue (Bernstein, 2003). Justice MacTavish's particularly decisive ruling provided opposing parties the opportunity to align themselves with the Charter decision, which stood in opposition to the Conservative party and its efforts to reimagine asylum seekers' place in the Canadian narrative. Interviewed parties agreed the IFHP movement broadly and the Charter challenge impacted the 2016 election. Waldman characterized the Charter challenge as having:

...An impact on the election campaign, and of public perceptions of the Conservative government...The election was a values election, I think. There was the niqab, there was the citizenship revocation, and there were the refugees, and part of the refugees and the lack of the government response to what happened to the boy who drowned on the beach, the Syrian refugees and part of that package was the RHC cuts. Which we constantly reminded that this is the government that cut healthcare to refugees and wasn't responding to refugees. If the election was a values election and one of the issues was refugees, then refugee healthcare was part of that package.⁷³

Dr. Bannerman⁷⁴, a refugee-serving physician agreed: "Harper dug his heels in...and it cost them Parliament"⁷⁵. Interestingly, Minister Alexander, who took up the immigration portfolio mid-litigation in 2013, also perceived the handling of the refugee file more broadly as negatively impacting the Conservative's electoral outcome. Though, Minister Alexander also offered creative insight into what he perceived as net-positive impacts of the IFHP and Bill C-31 reforms for Syrian

⁷² Lorne Waldman (President, CARL), interview by author, June 7, 2017.

⁷³ Lorne Waldman (President, CARL), interview by author, June 7, 2017.

⁷⁴ Name has been changed.

⁷⁵ Dr. Bannerman, interview by author, March 2018.

refugees, suggesting it “freed up political capital” and “equipped people to be more generous” by quelling public concerns about resources wasted on illegitimate refugees⁷⁶.

Indeed, the Syrian humanitarian crisis’ growing prominence as a 2015 federal election issue again brought the IFHP to the fore, with physicians calling for the full reinstatement of the IFHP as a necessary precondition to a successful Syrian resettlement (CTVNews.ca, 2015). This kept the IFHP in public discourse throughout the election, including through a public event titled the “CDRC National Week of Reckoning” in October 2015. Ultimately, the appeal was postponed on the government’s request in October 2015, the month of the federal election. Minister Alexander’s description of the legal challenge in published interviews suggested the federal government saw the IFHP issue as increasingly politically unfavorable⁷⁷.

Political opportunity is the product of structures shifting or aligning, such that intervention is possible. Dr. Rashid articulated that the Canadian system presented many opportunities, but that presented by the courts perhaps offered the opportunity to make the most impactful change:

I can’t really say I knew what to expect but we felt we needed to challenge this on many levels. There were street protests, editorials in medical journals, and we felt that if the courts were an option then we should use them. We realized questioning this policy at the level of the Canadian charter was a different realm; certainly, arguing that people were being denied care, and there were issues with that. Issues in terms of right to health care and in terms of poor public policy. But we felt this was an option that was available, and we should put it out there as well.⁷⁸

Courts and Evidence: The Federal Court relied strongly on the CDRC’s evidence of the harms caused by IFHP. CDRC members viewed this as particularly symbolic because a consistent argument of the CDRC, its supporters, and the Challenge itself was a dearth of evidence to support government claims of the reform resulting in financial savings or in a reduction of *bogus* claimants. Waldman elaborated:

The government evidence was extremely weak. I don’t think the government really took it seriously. One of the issues in a Charter challenge is, is there a legitimate purpose [to this Charter breach]? And they argued that this was justified because it was deterring false refugee claims. When we asked them for any evidence that this was achieving this

⁷⁶ Christopher Alexander (Minister of Citizenship and Immigration Canada), interview by author, June 13, 2017.

⁷⁷ In total, the government’s efforts to defend their IFHP cuts cost more than \$1.4 million in legal fees (CBC, 2015).

⁷⁸ Dr. Meb Rashid (Founder, CDRC), interview by author, May 29, 2017.

objective, they didn't have any. They also justified as a way of saving money, and when we asked them for proof it was saving money, they didn't have any evidence of that. So, I don't think the government ever thought they would lose, and they didn't take the litigation seriously.⁷⁹

An important phrase in government discourse was the prevalence of 'bogus' claimants, or persons who made an erroneous refugee claim (see *Chapter 1*). Opposing this phrase, advocates argue that it is impossible for a minister or a policy to determine the veracity of a claim; this was the task of an IRB member, and cannot be concluded decisively until after an IRB hearing (Olsen et al., 2014). Advocates also argued that a reduction in claims following the IFHP and accompanying Bill C-31 cannot be causally linked to a reduction in bogus claims, and instead may indicate a 'freezing effect' of asylum seekers perceiving their chances as lower in Canada. Minister Alexander did not disagree: "There was a reduction in those numbers [from DCO countries] as the reforms rolled out. Were most of the claims coming from safe countries not well founded? I can't say that. But, it's a strong indication" He continued, "My main point again is someone who gets here safely in an airplane and has the funds to do it is by definition less vulnerable than someone in camps", signaling his perception of 'vulnerability' and deservingness as a function of financial or political capital⁸⁰. These indicators supplanted the definition of an asylum seeker as set out in the UNHCR definition, where deservingness of refuge protection is defined as a function of persecution based on defined categories⁸¹, which is consistent with the Conservative government's rhetoric.

Meso (Organizational) Level

With the court challenge especially, it was an example of what became, not even deliberately, a multi-pronged approach. There were different domains of attack; there was protest in the public domain because government wouldn't talk to us, so we did interruptions; there were op-eds in the media, and by the way at that point in time there were projects being by students doing Master's degrees, in medical school who wanted to tackle this issue, so there was a research-scholarly front; there were lecture in hospitals and

⁷⁹ Lorne Waldman (President, CARL), interview by author, June 7, 2017.

⁸⁰ Lorne Waldman (President, CARL), interview by author, June 7, 2017.

⁸¹ Recall the UNHCR 1951 Convention relating to the Status of Refugees defines a refugee as a person who, "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country."

universities, so scholarship in a broader way, not only research but teaching. Different people did things in little ways that were really critical.⁸²

As described by CDRC co-founder Dr. Berger, the CDRC's strategy was multi-pronged and expansive. It guided the broader pro-access health campaign and was perceived as the face of the pro-access campaign. It is clear the CDRC held the public dais on asylum seeker healthcare reform by acting as an umbrella organization for any physician who wished to become involved in the movement. It also enjoyed the support of national healthcare associations and allied non-healthcare organizations at CDRC-driven national events. Finally, it created measurable change as named applicants on the successful 2014 Charter challenge. Analysis of the CDRC's strategies can thus be taken as an analysis of the broader movement's overall direction and leadership.

I draw two key lessons from the CDRC experience. First, successful social movements understand their context, and can mobilize sufficient resources, including financial and social capital (e.g., legitimacy) and broad, collective networks. Second, successful social movements invest in communications planning, content, and distribution. They are able to persuade through effectively framing by strategically deploying symbols and cultural mythologies that speak to widely held ideas, values and norms. This is often done through both creative and time-tested protest repertoires that span multiple venues and forms. For example, the CDRC took a multi-level approach to lobbying both federal and provincial governments, and effectively leveraged Canada's decentralized healthcare structure and longstanding commitment to immigrant health to create a national movement. Ultimately, CDRC created a highly impactful strategy that resonated with intended audiences. This section emphasizes how the movement leaders' awareness and understanding of the macro and meso-level contexts gave rise to specific strategic decisions, which were critical to the movement's success.

Protest Repertoire: As the CDRC was less a membership card-issuing organization and more a loose conglomerate of any physician who supported IFHP access led by a central steering committee, it is difficult to determine which physician actions were CDRC-affiliated and which were not. Broadly, it is reasonable to attribute pro-refugee actions by in-Canada physicians after May of 2012 as a 'CDRC' action, given the organization's leading role across Canada. Other

⁸² Dr. Philip Berger (Founder, CDRC), interview by author, February 22, 2017.

actions within the movement, such as those by nurses or midwives were also a part of the movement but not attributable to CDRC.

Table 6: Selected Examples of Canada’s Pro-Access Movement Repertoire

Action	Description
Research	
Data collection	CDRC-supported “Refugee HOMES” data collection project to collect instances and outcomes of asylum seekers who had been denied healthcare. Data was drawn on for court proceedings.
Communications	
Signed letters opposing IFHP cuts	Sent by individual physicians, national healthcare associations, community health associations, local health organizations
Reporting experiences to media	Kept asylum seeker healthcare in the headlines by publishing details of the IHFP’s impacts in-between major policy developments
Direct Action	
National Day of Action	14 cities participated in the CDRC-led day of action each June from 2012-2015. All organizations, people and the public supporting the return of the IFHP were invited.
Occupation of MP Joe Oliver’s office	Approximately 80 physicians occupied federal Finance Minister Joe Oliver’s office in downtown Toronto as a means of drawing attention to the IFHP cuts ⁸³ . As the Minister of Finance, Minister Oliver’s office was chosen as a means of attracting high-profile coverage.
Interrupting speeches of Conservative government officials	Initiated by Dr. Chris Keefer of Toronto, who interrupted MP Joe Oliver on June 30, 2012. Approximately 20 subsequent interruptions.
Young medical resident-led demonstrations	Residents for Refugee Care leads protest, vigil, letter-writing actions in Vancouver, Winnipeg, Kingston and Toronto (December 2013)
Medical schools support student participation in Day of Action	McGill University, University of Toronto Faculties of Medicine grant leave to students participating in the National Day of Action
Protest “inflammatory and misleading constituent flyer”	Healthcare workers in Ottawa and Saskatchewan protest flyer at MP Kelly Block’s office in Ottawa

⁸³ Commenting on the occupation and its role ‘kicking off’ physicians’ IFHP protest movement, Dr. Tim O’Shea said: “I don’t think it was surprising. From my experience in medicine, there are different groups of physicians in medicine and I’m not surprised that some people would do this. I was surprised at the number of people who responded to that request...kind of funny of the way it went about. None of us were very experienced in doing things like that, so it was really about not really knowing how do organize something of that nature” (Tim O’Shea)

distributed by Conservative MP	
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The occupation of MP Joe Oliver’s office was an early, transformative event (e.g., McAdam & Sewell, 2001). Strategically, it was an ideal-type action, serving as a launch pad for the CDRC and the healthcare movement more broadly. The occupation was a media magnet; the discord between what we expect of physicians versus what we saw in MP Joe Oliver’s office drew considerable attention and interest. This tactic of disruption would then be used throughout the movement, and cemented physicians as the movement’s leaders. Protestors were highly visible as doctors in their white coats; the more than 100 physicians who attended was unexpectedly high, and was frequently highlighted in the media. This injected a sense of life and possibility into the movement – if a hastily organized occupation could procure this reaction from the physician community, the media, and everyday Canadians, what else might be possible?

One example of how disruption became a core CDRC tactic is seen in the impact of speech interruptions. “It brought a lot of profile and a lot of media attention because people could not believe doctors were doing this kind of thing. The beauty was, for me, minimal energy, maximal effect. Three people can disrupt a press conference, easily; sometimes two” explained Dr. Berger⁸⁴. Medical student Dr. Chris Keefer’s interruption of a speech by MP Joe Oliver on June 22, 2012, two weeks following the Day of Action initiated interruptions as a CDRC action. The highly-watched (126,000 YouTube viewers at the time of writing) video shows Dr. Keefer declaring the cuts un-Canadian and informing the Minister that he and others “will be disrupted from this point on. Members of the Conservative government will be disrupted from this point on by Canadian doctors across the country” (Fronseca, 2012). President of the CMA John Haggie reached out via email on June 26 to offer the support of the CMA to facilitate a meeting between Dr. Keefer and Minister Kenney; this meeting was not granted by Jason Kenney.

The White Coat, Social Capital and Elite-Driven Social Movements: While widely supported by many healthcare disciplines, the CDRC was deliberately led by physicians, who believed they were best positioned to impact public perception of the healthcare movement. Each Canada, Germany and England were successful in using movement leaders to operationalize a

⁸⁴ Dr. Philip Berger (Founder, CDRC), interview by author, February 22, 2017.

shared agency-laden institution: universal healthcare (Morris, 2000). As a symbol of this institution, the white coat acted as legible cultural material through which advocates could parlay their message in a frame that resonated with the country's members. While this agency-laden institution alone could not mobilize sufficient resources to achieve impact, it formed a necessary precondition to affording physicians legitimacy.

Physicians are in turn afforded considerable social standing and social capital. It is interesting to note that movements are often associated with bottom-up advocacy, grassroots resistance led by 'everyday citizens' and advocates close to the issue. Elite buy-in is often a goal of social movements; specifically, support from medical, political, and legal elites is tantamount to signaling a movement's legitimacy, and, creating opportunity for movements to impact policy and culture (Bernstein, 2003). For the Canadian movement to be initiated and driven by medical and later legal elites was a critical early event and defining feature for the movement, creating increasing returns for those who joined the movement. This included persons who amplified the elite-driven effects such as the fifty "prominent Canadians" who signed a pro-access support petition, including authors, actors and cultural figures (Black, 2013: n.p.)⁸⁵.

Most interviewed physicians felt that the social capital, "stature and power" afforded to their role made their sole leadership in the CDRC particularly effective⁸⁶. This social power then translated to acting as the public face of the movement. Toronto Star immigration reporter Nicholas Keung reflected on physicians' role:

We all tend to have very high regards for medical doctors. We think it's a noble career, because they save lives. And when you see them advocating for refugees, it reshapes or reframes the public perception of the issue, to rethink whether these changes were fair, were not discriminatory.⁸⁷

Physicians leading the CDRC created an entry-point to public support for the issue. Doctors were a legible, respected public face to put next to a highly politicized and divisive issue. Family

⁸⁵ Dr. Meb Rashid contextualized the CDRC's leadership: "We were certainly part of a larger movement. Look at the response of our national healthcare associations – certainly there were much larger authoritative healthcare bodies that were actually onside on this issue. There were many other groups, faith-based organizations, a lot of different groups that had come together to oppose these cuts. In that sense, I think we were part of a much larger movement."

⁸⁶ Dr. Philip Berger (Founder, CDRC), interview by author, February 22, 2017.

⁸⁷ Nicholas Keung (Reporter, Toronto Star), interview by author, February 10, 2017.

practitioners, specialists, and refugee-serving doctors became means of assuring an ambivalent public that asylum seeker healthcare was worthwhile, fair, and an inherently Canadian position; even if the average Canadian did not trust refugee claimants, they might trust Canadian doctors. Dr. Berger explained that the movement's physician-centricity led to concerns of elitism amongst some physicians and other healthcare workers, especially at the beginning of the CDRC movement. However, the CDRC maintained that physicians' social standing was most opportunistically positioned to create a platform⁸⁸.

In particular, the white lab coat worn by physicians was repeatedly noted as an important symbol in the pro-access movement's tactics. If physicians' political role was up for debate⁸⁹, the white coat was unabashedly politicized and deployed as a symbol of the profession's credibility, clout and social power standing behind the movement, a symbolic roadblock between the IFHP cuts and affected asylum seekers. It was worn by supporting doctors to public protests including the annual Day of Action, a visual cue for reporters to document when reporting on the socially-powerful pro-access movement⁹⁰. Lorne Waldman, President of CARL and litigant in the CDRC Charter challenge, reflected on the coat's power at rallies: "There's nothing more impressive than a doctor in a white coat, haranguing a politician"⁹¹. The coat became an important symbol in the movement because it communicated to observers that the strength of a respected profession was behind the cause. Toronto Star immigration reporter Nicholas Keung went further: "When you look at someone wearing the white gown [coat]", he observed, "you associate that with angels, humanitarian sentiments"⁹².

Physicians hold not just social power but scientific expertise on questions of refugee health, which amplifies their impact as movement leaders. Expertise in a given topic is powerful. In technocratic models of policymaking, scientific expertise is celebrated as a form of neutral, highly impactful knowledge (Howlett, 2009). Social movement organizers will go to great lengths to

⁸⁸ Dr. Berger references Dr. Donald Berwick's 2012 convocation address to Harvard Medical School as epitomizing physicians' particular responsibility: "In *Dear Isaiah*, the author had admonished the reader to do pretty much what we were doing; the idea was to use our stature, power and influence to cure the 'killer of injustice'" (Dr. Philip Berger, interview by author, February 22, 2017).

⁸⁹ Interviewees largely perceived physicians' role as inherently political though all interviewed noted that many of their colleagues would disagree with that characterization.

⁹⁰ Not all were able to wear the white coat. McMaster University stood out for its request that students not wear the iconic McMaster lab coat during protests out of a want to distance the university from the pro-access reforms and ensuring controversy.

⁹¹ Lorne Waldman (President, CARL), interview by author, June 7, 2017.

⁹² Nicholas Keung (Reporter, Toronto Star), interview by author, February 10, 2017.

ensure scientific expertise is not framed as ideological or politically-driven, hence the CDRC's strategic decision to remain apolitical, as discussed below (Orsini and Smith, 2010). Doctors are also gatekeepers to the resource that was under apparent threat; as such, their leadership was a particularly salient opposition to the cuts. "The doctors' leadership gave a lot of credentials to the cause and changed the momentum", stated Keung; "Their outspokenness – their voices get heard."⁹³ As experts on the issue of healthcare, healthcare resources, and the genuineness of asylum seekers' health needs, doctors' pro-refugee position was critical to lending legitimacy and validity to the pro-access movement.⁹⁴

Interestingly, the movement was publicly absent one key constituent voice: that of asylum seekers or refugees. The absence of those who stood to be affected may arguably suggest a dearth of 'embodied knowledge' (Orsini & Smith, 2010 drawing on Brown et al., 2004) though as proxies for the experience, refugee-serving physicians still brought with them insight into the lived experiences and challenges faced by claimants. Engaging asylum seekers in public discourse and public-facing advocacy created practical and professional challenges, explained physicians. Clinicians were reluctant to ask claimants to share their story because asylum seekers were often concerned it would negatively impact their chances at the IRB. Dr. Rashid explained this was a challenge throughout the movement: "We were very reticent of approaching our own patients for these requests, even media requests. This put us in an awkward position and it put our patients in an awkward position", he explained; even when submitting evidence for the Charter challenge, "we wouldn't even speak of age or gender unless it was relevant to the issue."⁹⁵ First-hand accounts and lived experiences as a result of the IFHP cuts were published in media (e.g., Keung, 2013) but were rare. Toronto Star immigration reporter Nicholas Keung reflected on his coverage of the IFHP in an interview:

Those who are directly affected by those changes – refused claimants, refugees, people facing deportation- they would not go on the record to talk to the media, to talk to the public directly. We did manage to get a few people... It took me a long time to get them, to talk to them many, many times to come forward, to share their stories, to get that human face so

⁹³ Nicholas Keung (Reporter, Toronto Star), interview by author, February 10, 2017.

⁹⁴ It is interesting to note that it was expertise in healthcare – an expert all Canadians interact with, who is tangible and who is relatable – that led the pro-access movement, not expertise in immigration or refugee-related issues, as such an expert's limited audience applicability would likely signal its unreliability and untrustworthiness. This may be because unlike health, immigration is seen a relatively low-priority item on the public agenda (Fleras, 2014).

⁹⁵ Dr. Meb Rashid (Founder, CDRC), interview by author, May 29, 2017.

people see the consequences. Yes, having the doctors there is great because of their social status in society but to push it even one step further, having the real faces of the refugees in these stories was even more powerful than having other people advocating for them.⁹⁶

However, physicians speaking on behalf of asylum seekers was likely also a net positive choice given the public campaign against asylum seekers. Two clinicians argued that at the onset of the movement, the issue was likely to receive very little public interest if asylum seekers were leading the charge. Yielding slightly, Keung reflected: “Respect for the profession actually gave the whole advocacy and activism even more legitimacy.” Physicians’ legitimacy-lending filled a void in public narrative speaking on behalf of asylum seekers and played an important role in working to recast asylum seekers as ‘worthy’ of Canadian healthcare.

Moreover, the act of physicians speaking *on behalf* of asylum seekers worked to underscore the effects of the IFHP cuts, including increased vulnerability, precariousness, and on this issue, a lack of public voice or credible standing. Erasing a policy subject’s experience from social movement claims can construct subjects as passive recipients who lack agency or decision-making power (Orsini and Smith, 2010). However, it was this very fragility that physicians sought to communicate in order to convince Canadians of asylum seekers’ need for comprehensive health care. Dr. Berger reflected:

Doctors should never speak on behalf of other people, they should support other people and speak on their own behalf. But in this situation, refugees, they couldn’t, they were afraid to speak out at all against the government on which they were depending to grant them refugee status, so we had to be their voice, which is classical medical paternalism, but there was no other choice.⁹⁷

Coalition Building, National Health Associations, and Political Affiliations. Experience matters in forming social movements (Morris, 2000). Collectively, the experiences of organizations and individuals form a historical memory from which Canadian movement leaders pull their repertoire. Individual leaders brought with them a diverse set of experiences. Leaders shared many experiences with leaders in the other analyzed cases – longstanding movement members in Canada, Germany and England referenced involvement in the peace movement with

⁹⁶ Nicholas Keung (Reporter, Toronto Star), interview by author, February 10, 2017.

⁹⁷ Dr. Philip Berger (Founder, CDRC), interview by author, February 22, 2017.

the International Physicians against the Proliferation of Nuclear War (IPPNW) and Amnesty International. Moreover, the movement, like that in Germany and Canada, was supported strongly by students. It is reasonable to assume that many students arrive to medical school as political, empathetic and engaged beings. Interestingly, many movement members, including co-founding leader Dr. Meb Rashid stated they had very little experience organizing people or movements. While their work was inherently political, and this informed their lens and actions, this particular form of political organizing was considered new and they relied heavily on the storied experiences of Dr. Philip Berger (see the *Toronto Star's* profile of his activist career: Boyle, 2017).

Interestingly, the Canadian case shows this *lack of* pre-existing institutional connections can be important. That the CDRC was launched as a new organization that was national in scope and without a direct institutional partner (i.e., university, hospital) was intentional and impactful. Its name was chosen to liken being a Canadian doctor to supporting refugee care, which then evoked nationalist sentiment and idealized understandings of Canadian norms and history. Without an institutional home such as a university or national health association, the CDRC was also without institutional baggage, allowing the organization to be agile and responsive. Indeed, a limitation of elite support can be the subversion of a movement's goals into hegemonic institutions (Bernstein, 2003); while certainly the CDRC movement played their requests safely, the launch of a new organization absolved activist-physicians from adopting the dominant scripts of well-rooted medical organizations. The CDRC was not forced to comply with a greater institution's communications policy or decision-making processes. Thus while protest traditions can "decrease the mobilization, organizational, and cultural costs associated with the rise of new collective action", new organizational forms can also free members from limiting institutional legacies, logics and constraints.

CDRC leaders also described this movement's national approach as critical to its success. A movement with strongholds across the country (including major urban centres like Vancouver and Montreal, as well as smaller cities such as Saskatoon and St. John's) signaled that support for the cause was not limited to a small Toronto-centric network of refugee-serving doctors; rather, it crossed disciplines, cities and included those who did not serve asylum seekers directly⁹⁸. A

⁹⁸ Interestingly, prominent physicians including Dr. Neil Arya joined the movement because IFHP reforms initially also affected Government Assisted Refugees (GARs).

strongly national movement also leveraged Canada’s decentralized health care systems, which provided multiple short-term targets (i.e., provinces) for the pro-access to make incremental gains across the country.

The national scope is the product of a series of three key early events that laid critical groundwork for the CDRC’s nationwide presence. First, many interviewed clinicians stated Canada’s multicultural identity and infrastructure to support immigrant and refugee healthcare played an important role in creating a network of providers who would act as a framework for the movement. However, Canada’s heavily decentralized, provincially-based healthcare system meant refugee providers often had no interaction across regional or provincial lines. Second, between 2005 and 2009, Prime Minister Harper’s federal Conservative government resettled 800 Karen refugees fleeing violence in Burma, who were relocated to major (e.g., Vancouver) and minor (e.g., Surrey) cities across the country (Marchbank et al., 2014). Burmese refugee populations are historically associated with higher rates of tuberculosis, which caused concern amongst refugee-serving physicians across Canada. In Toronto, Dr. Rashid recalled:

But, we were actually finding very low rates of latent TB. This didn’t make sense. And I remember a colleague of mine, I asked her if she could just find clinics across the country and contact them to see if they were seeing the same thing. And so she spent some time just blind calling; someone knew someone in Regina who sees refugees, we’d call them; we knew there was a clinic in BC; and so on. It was that rudimentary, our understanding of what was happening [in refugee clinics] across the country.⁹⁹

Questions around the health of Burmese government-assisted refugees spurred the creation of Canada’s first national communication of refugee-serving physicians, which quickly morphed into an email listserv where providers could pose questions and share resources, creating critical early connections that would be leveraged later by CDRC. Very shortly after, in 2011, Dr. Kevin Pottie of Ottawa also developed the *Evidence-Based Critical Guidelines for Immigrants and Refugees*, a set of guidelines for the assessment of immigrants and refugees that developed national and then international attention (Pottie et al., 2011)¹⁰⁰. These guidelines were released while the IFHP still offered full care and were discussed at healthcare events focusing on refugees and immigrants across the country. “Besides being a highly instructive project, one of the offshoots

⁹⁹ Dr. Meb Rashid (Founder, CDRC), interview by author, May 29, 2017.

¹⁰⁰ The guidelines were cited by several interviewed German physicians as instructive and widely-used.

was he put a number of people in the room from across the country. So, all of the sudden, we knew Nazaria in Montreal, and Duke in Newfoundland”, recalled Dr. Rashid¹⁰¹. Vanessa Wright, a Nurse Practitioner who works alongside Dr. Rashid in the Crossroads Clinic, similarly described the refugee healthcare guidelines as an important development in building the Canadian refugee community.

A third early event catalyzing a national refugee health network was the launch of the North American Refugee Health Conference by Dr. Anna Bannerji in 2009. As the first refugee healthcare-specific North American academic conference, the NARHC brought clinicians from across sectors and geographies together. “And, a large part of the conference was and is advocacy”, characterized Dr. Bannerji¹⁰². These events laid the groundwork for future connections. “We were quite lucky to have these networks in place”, stated Dr. Rashid; “without it, it would have been very laborious. [The CDRC] would have been a localized response”. Conceptually, the network linked people who were driven by common interests and had similar professional experiences, creating a community of providers. Tangibly, the listserv launched with the arrival of the Burmese refugees and expanded with the release of the health guidelines and the NARHC would serve as the springboard for the CDRC’s early messaging. “Ten years before 2012, when the cuts happened, we would never been able to mobilize people as we did. I think what had happened in those years was critical”, stated Dr. Rashid.¹⁰³

Support for the pro-access movement generally and for CDRC specifically also came from national health associations. These associations’ support was important for bolstering the movement’s national and leveraging their immense legitimacy, capital and strength. More than twenty esteemed organizations voiced their opposition to the healthcare cuts, including most prolifically the Canadian Medical Association, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, the Canadian Dental Association, the Canadian Nurses Association, the Canadian Pharmacists Association, the Canadian Pediatric Society, Canadian Association of Community Health Centres and the Canadian Psychiatric Association¹⁰⁴. Every interviewed Canadian identified support from their associations as critical

¹⁰¹ Dr. Meb Rashid (Founder, CDRC), interview by author, May 29, 2017.

¹⁰² Dr. Anna Bannerji (Physician, Founder NARHC), interview by author, February 28, 2017.

¹⁰³ Dr. Meb Rashid (Founder, CDRC), interview by author, May 29, 2017.

¹⁰⁴ Physicians and physicians’ organizations did opt out of supporting the pro-access movement. The College of Obstetrics and Gynecology stands out for their initial reluctance to support the movement but they too eventually voiced their support. Additional support came from healthcare organizations including the Canadian Association of

to the movement's ability to grow and to create impact. The early support from major influencers was seen as lending legitimacy to the movement while it was still in its infancy, lessening the perceived cost for physicians who considered adding their voice to the pro-access chorus. Dr. Neil Arya, a GAR-serving physician in Southern Ontario and longtime refugee advocate, suggested support from associations sent strong signals to the public that the pro-access position was rational and "good policy"¹⁰⁵.

Importantly, part of the value of the associations' support was its unprecedented nature. Politicized messaging from national health associations was surprising to practitioners as well as the general public. Like physicians, historically, major Canadian regulatory organizations such as the Canadian Medical Association (CMA) infrequently weigh in on public policy or political debates outside of those directly affecting their members. While arguably the IFHP reforms impacted the CMA's members directly, many were surprised. Dr. O'Shea expressed: "Yes, to be honest with you I was a bit surprised that people were willing to speak up at that level, they had more to lose I think than an individual physician did", though the associations' support lessened the risk to individuals. Organizations with regulatory powers or general societal clout can have important impacts on a movement's appeal as experts or highly visible organizations' lending their support is equivalent to lending legitimacy. Orsini & Smith (2010) argue that civic groups' involvement in social movements are "new forms of political agency", and that "the enhanced legitimacy of civic society organizations in policy fields such as the environment and human rights, have undermined the position of traditional state-based power-holders in the policy process" (Orsini & Smith, 2010: 2)¹⁰⁶.

Optometrists, Canadian Doctors for Medicare, Canadian Association for Midwives, Registered Nurses Association of Ontario, Canadian Federation of Nurses Union, Association of Medical Microbiology and Infectious Diseases Canada, Médecins du Monde, Public Physicians of Canada, Ontario's Council of Medical Officers of Health, Canadian Association of Occupational Therapists, Canadian Association of Emergency Physicians. Additional health organization supporters included the Catholic Health Alliance of Canada, Residents for Refugee Care. Medical and health faculties at Canadian universities include the University of Toronto and McGill University. Non-healthcare asylum seeker/refugee assisting-organizations include the Canadian Association of Social Workers, as well as a signed petition from more than 50 prominent Canadian writers and artists (Vu, 2013)

¹⁰⁵ Dr. Neil Arya (Physician), interviewed by author, February 16, 2017.

¹⁰⁶ Fascinatingly, the CDRC-led coalition stands in stark contrast to the last massive physician advocacy movement that emerged prior to the Canada Health Act (CHA) 1984, a policy Tuohy (1988) describes as "a striking example of the defeat of a powerful and concentrated interest groups – doctors- in favour of a diffuse consumer interest" (267). Provinces and physicians were similarly in agreement in their anti-CHA stance, and again, physicians exerted pressure on provinces, the program deliverers to signal their discontent with federal reform, the program funders. The nature of the protests was distinct; in the case of the CHA, physicians lobbied on their own behalf, representing their own interests as the federal government capped provincial user fees and spending by limiting transfers. But if

While campaigners politicized the white coat and the power of NHAs' standing and welcomed actionable partnerships with likeminded health and immigrant organizations, alignments with political parties were avoided. The CDRC maintained a strictly apolitical and unaligned position in order to direct focus to its singular messaging. Board members and strategist Chris Holcroft sought to present their positioning as non-ideological, apolitical, and neutral in its biases, factors identified by Orsini and Smith (2010) as impactful when leveraging expertise. Holcroft recalled requests from political parties and constituency offices who wished to align with the CDRC campaign but were refused. Remaining apolitical was perceived as important to ensure the door was open to working with the next federal government, and because many supporting physicians were Conservative voters. Dr. Berger stated that "Some of these were Conservative party, Red Tories; we would have never had that support". Dr. Meb Rashid agreed: "We strategically kept a bit of distance from colleagues and other groups who perhaps shared a lot of our concerns only because it allowed us to be autonomous", referencing again the CDRC's apolitical stance and lean, agile leadership as a strength¹⁰⁷. Canada's regionalized party affiliation was also an important consideration in maintaining an apolitical stance. Formal associations were similarly avoided with medical schools, refugee-serving nonmedical organizations, and the regulatory colleges such as the Canadian Medical Association, though their support was perceived as invaluable to the movement.

Campaign Messaging. Differentiating the Canadian campaign from other analyzed cases was the CDRC's decision and ability to hire a public relations coordinator. Chris Holcroft managed the CDRC's strategic messaging and media relations, providing a professional and image-conscious lens to the CDRC's public image. Holcroft's hired communications support speaks to the importance of financial resources in social movements; his paid services provided professional advocacy counselling to the movement, including advice on messaging content, channels (e.g., academic journals, social media, in-person protest) and support to streamline and target the movement's 'ask'. While much of what was communicated was decided by the largely flat structure of the CDRC, Holcroft's extensive advocacy communications experience and

the "CHA allowed governments to reassert the nationalizing role of the federal government in social policy at no financial costs", the IFHP suggested the opposite: a federal government seeking social policy elimination or fragmentation (across provinces, across the ability to pay for asylum seekers).

¹⁰⁷ Drs. Philip Berger and Meb Rashid (Founders, CDRC), interviews by author, February 22 and May 29, 2017.

professional relationship with CDRC members offered a strategic perspective to physicians' proposed actions.

Interviews with Holcroft and members demonstrated that CDRC messaging was consciously framed to leverage powerful messages around inclusion and deservingness. This framing reflects the movement's purpose but also a movement's intended audience. Reflecting on the campaign's uniqueness relative to other social issue campaigns he had led, Holcroft identified two factors as fostering the CDRC's success: first, the CDRC's laser-like messaging focus, and second, its decision to present itself as a physician-led campaign. On messaging, the campaign spoke strictly to restoring the IFHP to its pre-2012 format. This created a clear, decisive 'ask' to return to what was framed as a "clearly feasible, previously proven solution", which campaign framers perceived as relatable and comprehensible to the average Canadian citizen. It limited its 'ask' to supporting those who were previously supported; it did not include a request for IFHP expansion to groups such as undocumented persons, though many physicians personally supported this request. This approach avoided messaging dilution and limited opportunities for distraction or political compromise on secondary issues.

The CDRC's decision to focus solely on asylum seekers – persons who were in the country legally and who had made a refugee claim with the government – was referenced by all interviewed CDRC steering committee members as one of the most important reasons behind their success. Bernstein (2003) finds that advocates' strategies are tied to their understanding of "success"; those seeking policy change will thus make strategic decisions that will increase the likelihood of them achieving their goal, or in this case, conservatively tailoring their 'ask' to appeal to policymakers and the broadest public. By publicly demanding not an expansion of healthcare to non-status, illegalized persons whose presence was more contentious and more disputed, the CDRC was able to point to a population that was directly and measurably affected by the cuts; who were covered one day, and not covered the next. Their conception of success – a reinstated IFHP- mediated their strategy (Bernstein, 2003). The CDRC's frame leveraged the perceived difference in deservingness amongst precarious populations; while claimants were undoubtedly controversial, they were in Canada *legally*; they were not hiding, they were not accessing services they were not legally entitled to. This placed claimants higher on the social hierarchy than illegal, unworthy non-status persons, who acted in some ways as a foil to the legal asylum seeker claimant.

This far less contentious position allowed advocates to play on longstanding Canadian narratives towards refugees instead of forging new narratives around non-status persons and a borderless policy, though this was the personal stance of many physicians who advocated. Dr. Meb Rashid said about the strategy: “We were criticized for it, but I think it served us well. It allowed us to have that big tent and bring in people who traditionally would be harder to bring in.”¹⁰⁸

Further, this singular demand was situated in the larger agency-laden institution (Morris, 2000) of *multiculturalism*, a central component of the Canadian national narrative. Movements that are grounded in such institutions will have a built-in framework through which to access potential members and supporters because they include frames that will resonate with those who identify with the institution (Morris, 2000). The frame invites all those who align with its tenets to join the movement as a means of reiterating and bolstering the frame’s truthfulness. Similar to how Dr. King’s understanding that the church’s “transcendent belief system was the appropriate cultural material from which to frame the movement” (448), the pro-access movement strategically framed their messaging in core tenets of *Canadianness* vis-à-vis immigration, diversity, and inclusion. They regularly referenced Canada’s history as a refugee-receiving country including inspirational moments such as the historic arrivals of Vietnamese newcomers in the 1970s and 1980s.

The CDRC’s preferred message framing became ubiquitous with the movement’s overall messaging. Bernstein (2003) finds that movements supported by elites will typically defer to elites for message framing, but in doing so, advocates are more likely to be demobilized. Where “elite interests and movement interests coincide”, writes Bernstein (2003); “activists will likely cede the political terrain to elites and seize on other methods or political issues” (370). This was likely influential in the CDRC’s ability to gain widespread support from the onset, an early decision that amplified their reach amongst other elites (medical, legal, political) and increased advocate mobilization¹⁰⁹. These collective action frames, or strategic issue maps deployed by the CDRC

¹⁰⁸ Dr. Meb Rashid (Founder, CDRC); interview by author, May 29, 2017. Organizations demanding healthcare for all persons regardless of immigration status pre-date the IFHP movement, and include No One is Illegal and Canadian Doctors for Medicare.

¹⁰⁹ *Multiculturalism*, as an agency-laden institution also allowed Canadians to be indulgently reflective and invited those who supported this past to join the current movement to ensure its future. The movement also referenced how the multicultural, immigration-centric identity was of material use to Canada as refugees went on to achieve ‘great things’, including Governor General Michaëlle Jean. Physicians also strategically deployed this frame within their repertoire of actions; diverse physicians and healthcare providers, many of whom came from immigrant and refugee backgrounds spoke at National Days of Action and to the media in order to lessen the ‘distance’ between everyday

and their supporters were crafted to solicit a response from targeted audiences, which included both physicians and the public (Johnston & Noakes, 2005). Interviewees discussed the issue of health access as the core message when communicating with other physicians, but also the undemocratic exclusion of stakeholders from IFHP discussions. Interviewees stated email listservs served as an important tool for internal discussions and communications. Strong coordinated discourse whereby a movement solidifies the scope of its ‘ask’ and the principles on which it stands can help build movement strength before communicative discourse is deployed to connect to the greater public and disseminate messaging through external channels (e.g., Schmidt, 2008). Internally, information on upcoming events, referendums on specific actions, and updates on specific actions (e.g., data collection efforts, speech interruptions, etc.) were shared via the email listserv. Externally, CDRC used its website and connections with journalists to disseminate their message, including op-eds and featured articles (e.g., CDRC, 2015).

CDRC members also sought broad appeal by communicating through a variety of channels and targeting specific audiences. An exogenous factor shaping this strategy was timing; lasting from 2012-2016, the movement emerged squarely within the era of social media, broadening its messaging channels and potential to drive impact¹¹⁰. While social media was mentioned in passing by advocates, CDRC statements and activities were published on platforms such as Twitter, as well as in a diverse range of sectoral and public publications with targeted readers in mind. Discourse was both communicative and coordinative, seeking to influence its own physician and healthcare community and the general public. Holcroft explained:

It was a multi-track kind of audience. We did everything from street protests to attract the general media public attention, we wrote op-eds in some intellectual publications, including for mainstream media like the Globe and Mail...we tried to reach general Canadians through general media like social media. Then we tried to influence ‘informed opinion’, so thought leaders, people that like to debate issues, so you know, trying to get on the CBC Current and that kind of thing. But also specific audiences within the medical community and pitching the CMAJ, and specifically networking and conferences where doctors would go to talk, medical students, who provided a lot of foot soldier support, especially in the last two or three days of action; we also targeted politicians specifically with events we would do on Parliament Hill and in publications that would be read in government, like the Hill Times, Embassy Magazine

Canadians, the medical profession and immigrants/refugees. By presenting diverse Canadian doctors, these groups became one in the same, and supporting the pro-access movement became a means of supporting *being Canadian* and the Canadian healthcare movement having to identify specifically as “pro-refugee”.

¹¹⁰ See Gerbaudo, 2012 for a discussion on social media and activism.

for diplomats. We had a lot of interest in international press. And that was a great thing because that became a Canadian reputation issue...There also became constituencies within different communities who wanted to learn more so they could raise the profile of the issues within their communities, such as seniors' groups.¹¹¹

Regardless of venue, messaging centered on four core elements. First, the fairness of denying healthcare to persons who were legally in Canada. Evidently, physicians saw opportunity in situating their discourse within socially-acceptable parameters of *legal* asylum seekers (e.g., “The minister must know that refugee claimants are lawfully within our borders, follow the rules and so are perfectly “legal.”” [Rashid & Berger, 2014]; see also Caulford & D’Andrade, 2012), where legality was presented as relatively uncontentious proxy for deservingness. To deny legal residents healthcare was “not the Canadian way”, explained Holcroft. Second, the financial costs associated with providing emergency care over primary care were highlighted, and the IFHP cuts were framed as downloading expensive high emergency room bills onto provinces (Barnes, 2013; Evans et al., 2014). Third, the federal government’s refusal to speak to the CDRC or any other health provider-led organization was a focus of CDRC messaging, and CDRC speakers presented their exclusion from official dialogue as a bellwether for greater anti-democratic tendencies of the Harper government. Finally, as found by Beatson (2016), messaging highlighted the CDRC’s belief that the federal government was preying on a vulnerable, already marginalized group, which stood in contrast to an intruder frame used by the federal government (see also Philpott, 2014).

Micro (Individual) Level

Issue Champions and Movement Growth. Individual reform champions played a pivotal role in the IFHP reforms. As the CDRC’s social movement entrepreneurs, founders and unofficial spokespeople Dr. Meb Rashid and Dr. Philip Berger were the public face of the pro-access movement. Dr. Berger brought a career of health activism to the table, including as the founder of the Amnesty International Canadian Medical Network and co-founder of the Canadian Centre for Victims of Torture – a striking parallel to Dr. Torsten Lucas, a founder of the Berlin pro-access movement. Purposive and deliberate messaging was supported by the strategic choices of public relations expert Chris Holcroft, who imparted particularly effective discursive and public-facing

¹¹¹ Christopher Holcroft (PR, CDRC), interview by author, May 11, 2017.

strategies. The resulting CDRC messaging was not simply targeted, it was consistent and legible to the average Canadian. Drawing on Snow and Benford (1992), key characteristics of individuals in the pro-access movement were impactful on keeping the policy in the public eye and, according to a CDRC-led survey, bolstering support for IFHP reinstatement (CDRC, 2015): the movement entrepreneurs kept their messaging frame consistent, empirically-driven, and was promoted by individuals with great credibility and an ability to interlock their messaging with overarching Canadian narratives. Demonstrating their role as issue champions, Rashid and Berger wrote collective op-eds (Rashid & Berger, 2014) and made numerous public statements. Yet the movement still refrained from forming a cult around individual leaders. Indeed, the CDRC's model of open communications and membership encouraged any pro-access physician to speak to their constituent communities, geographic or in terms of specialties, leading to newspaper contributions, articles in medical journals and individual protest actions (e.g., interruptions) being taken by CDRC members and supporters.

Medical students were also key participants. They led and supported the National Days of Protest, engaged in scholarly research and data collection to support evidence-based argumentation, and engaged their medical schools in the asylum seeker healthcare debate. Major university medical schools including the University of Toronto and McGill University issued public statements in support of the Day of Action and released all students from their academic responsibilities for those who wished to attend the protest. Notably absent in their support was McMaster University, which took disciplinary action taken following a student's interruption of a federal Minister's speaking engagement on campus. Moreover, McMaster University did not provide medical students with release from their academic responsibilities in order to engage in protest, limiting their participation in the Hamilton Day of Action. Students' participation brought energy to sustain the movement, suggested Dr. Suzanne Kim¹¹²: "I think it's a little bit of a calculation of what do I have to lose by doing this?", she stated, denoting again the professional risk that physicians perceived themselves as taking in this movement, even alongside the support of the CMA and other colleges. However, she acknowledged students with unsupportive universities, such as McMaster, faced further limitations in participating.

¹¹² Name has been changed; interview by author, February 2017.

The CDRC's efforts created unintended consequences that extended the life of the movement. In particular, it delivered a more politicized body of physicians, including medical students, who were now connected to one another in a pragmatic and symbolic sense. The initial listserv that drove Dr. Rashid's first connections now included several hundred members, including physicians, provincial and federal bureaucrats, Members of Parliament and Members of Provincial Parliament, representing a potential resource to be leveraged in future politicized debates. While individuals played pivotal strategic roles, the IFHP also changed ministerial hands from Kenney to the less savvy Alexander. The new Minister took the role in July 2013, after the IFHP federal court ruling was returned. Alexander came to politics after serving 18 years as a diplomat and ambassador to Afghanistan. While Minister Alexander continued his predecessor's trajectory of declining meetings and debates with the CDRC and other pro-access organizations, his interactions were more adversarial. After Minister Alexander's appointment, "there was hope that the government might decide to change the discourse", said Janet Dench, director of the Canadian Council for Refugees in a published interview (Goar, 2014; n.p.). Instead, asylum seekers were further vilified as Minister Alexander doubled down on communicating the legitimacy of the reforms. However, Minister Alexander's approach diverged dramatically from his predecessor, Minister Kenney. His heavy-handed approach to engaging the media included hanging up on CBC radio host Carol Off (CBC, 2014), social media confrontations with individual health providers¹¹³ (Alexander, 2014), publicly sparring with Ontario minister of health, Deb Matthews (Mas, 2014) and a heavily critiqued "intemperate" debate with a journalist on his government's Syrian refugee policy following the death of Aylan Kurdi (Tolley, 2017: 108), a young Syrian boy whose application to travel to Canada was stalled by the Conservative government. Minister Alexander's approach to communications likely diminished the reform's credibility in the eyes of everyday Canadians. highly controversial asylum policies that were met with immediate public opposition, including his government's limited response to the Syrian crisis and the introduction of a tip line to oppose 'barbaric cultural practices', both of which became key election issues. He later characterized both policies as "mistakes" (MacDonald, 2017). The former, alongside Alexander's heavily-critiqued interview defending his party's position on the Syrian

¹¹³ Interestingly, social media frustrations stemmed from Tweets initially sent by the future Liberal Minister of Health, Dr. Jane Philpott (Alexander, 2014).

crisis, was described by Alexander in a published interview as costing the Conservative government the election (MacDonald, 2017).

In stark contrast to Kenney, Alexander was characterized as “one of the least impressive ministers in an increasingly weak government bench” (Wells, 2015), and “represent[ing] the Conservative party’s failures” (Gulli, 2015, n.p.) by journalists. While Minister Kenney openly glad-handed newcomer communities and developed strong relationships with mainstream and ethnic media, Minister Alexander was largely adversarial. Collectively, Minister Alexander’s actions as the “embattled minister of citizenship and immigration” were argued to “reverse some of the inroads made by Jason Kenney and others in recent years to attract the votes of new Canadians” (Gulli, 2015, n.p.). Without protection from Minister Kenney, the highly visible, media-friendly and de facto honorary member of every ethnic community minister, the Conservative government’s highly controversial immigration policies seemed cold, disconnected, and anti-Canadian. Minister Alexander’s appointment heightened the adversarial relationship between advocates and government and introduced new tensions between media and CIC on issues of immigration reform. Minister Alexander’s repeated gaffes related to the IFHP seemed to support the CDRC’s position: the federal government was ill-informed about their own policy, the policy was made on bad faith, and little evidence existed to support its proposed outcomes.

Interestingly, Minister Alexander characterized his position in IFHP reforms as “highly circumscribed” in an interview for this project. He perceived his experience as having inherited a fraught file, and with little choice but to continue to stay the course. When he became Minister of Immigration, the IFHP was “already a Cabinet decision, already in the courts. Nothing I could do about it; I had to defend it”¹¹⁴. Interestingly, he also described little involvement from Prime Minister Harper; reflecting on the IFHP and Harper, Minister Alexander stated:

I never talked to him about it. Because, it was before the courts, the policy had been set, the Cabinet decisions had happened. The only time I went back to Cabinet on this was after the court ruled against us and we had to react.

His individual political mishandling of the file, combined with macro-level factors and strategic choices by well-situated advocates, played heavily against the IFHP reforms, and signaled

¹¹⁴ Christopher Alexander (Minister of Citizenship and Immigration Canada), interview by author, June 13, 2017.

a strong public turn against the Conservative's stance on refugees, including the IFHP but also the Syrian crisis and immigration file more broadly. Speaking to the refugee file broadly, Dr. Rashid surmised:

Many people ... look back at those years as very mean-spirited. And I don't think that plays very well right now. And I think part of that was the reason they struggled in the next election. They seemed like a bitter, angry bunch of people. This is one example of many; there just wasn't any sense of compassion.¹¹⁵

Alexander reflected:

I think this narrative started on this issue and some other issues which sought to portray us as unwelcoming, cold-hearted, anti-refugee and eventually anti-Muslim and it's a total crock as far as I'm concerned. This was the start of a narrative that became very negative because we have the highest levels of Canadian immigration in Canadian history, most international students, and by comparison with our peers the most generous refugee approach to Iraq and Syria.¹¹⁶

Conclusion

Reinstatement of the IFHP has important symbolic value. It reiterates and reaffirms Canada's commitment to public, universal healthcare; to refugees and asylum seekers; and, to public debate. Canada's reform was politically motivated, however IFHP reform was made possible by key features of its political system, changes in the policy's institutional venue, and the political persuasiveness of its key champion. At the same time, resistance against the reform by powerful physicians was a necessary but insufficient factor influencing the policy's reinstatement, and several issues amplified their ability to ultimately succeed in a Charter challenge, including a tense relationship with federal politicians, longstanding norms around Canada's healthcare universality, the support of provinces, strategic CDRC campaign choices, and the efforts of individual health champions. Collectively, these factors helped shape public opinion of IFHP reforms and the nation's stance on refugee inclusion more broadly, a key factor in the 2015 election and ultimately, the IFHP's return following the success of the Liberal party at the polls.

¹¹⁵ Dr. Meb Rashid, interview by author, May 29, 2017.

¹¹⁶ Christopher Alexander (Minister of Citizenship and Immigration Canada), interview by author, June 13, 2017.

7. Germany

The word ‘Germany’ and ‘immigration’ stir up a complicated and sometimes contradictory set of images: the expulsions of the Holocaust, the arrival of millions of guest workers in the 1970s, the absorption of persons from former Communist nations in the 1990s, and the mass welcoming of Syrian asylum seekers starting in 2015, to name a few. Germany’s immigration history is vast and punctuated with innumerable points of contention. In this analysis, the Germany asylum seeker healthcare story spans twenty-two years, and is bookended by two critical junctures: first, the 1993 Asylum Seeker Compromise and second, the arrival of 1.4 million asylum seekers starting in 2015. This project’s two research questions are explored within the context of these events. Since its inception in 1993, the German pro-access movement has deployed unique strategies that bend to their institutional contexts, and faced a variety of constraints related to their complicated history as German physicians. Indeed, a comprehensive body of research has identified the normative, political and historical factors that underpinned and drove the Asylum Compromise (e.g., Klusmeyer, 1993; Schönwälder, 1999; Zetter et al., 2003). However, multiple factors that drove the Compromise would later serve to inspire advocates, and shape their reactions to the 2015 arrivals. These factors are less explored, though no less interesting to the question of understanding how Germany generally and Berlin specifically arrived at the current state of asylum seeker care delivery today.

This chapter first asks *how* Germany retrenched asylum seeker healthcare in 1993 by examining the conditions under which retrenchment occurred. It then examines the actions of the physician-led pro-asylum seeker health movement. Asylum seeker healthcare remains unchanged at the national level since 1993. The initial retrenchment could be viewed as expected in light of the passionate anti-refugee protest that sprawled across Germany in the 1990s; however, when viewed through the lens of the German constitution as a symbol of Germany’s post-WWII move towards asylum inclusion, it was unexpected. While it is federally unchanged, in the intervening years states including Berlin introduced administrative reforms such as electronic health cards that have improved claimants’ access. A faster and more robust state-level response in Berlin was expected however, if not immediately following the 1993 retrenchment, at a time earlier than the card’s 2015 implementation. Powerful physicians’ professional associations have long supported claimants’ access, and Germany’s two other city-states – Bremen and Hamburg –

relied on a business case for implementing electronic health cards and widened access in 2005 and 2012, respectively.

This chapter examines both of these questions in turn, but with a stronger focus in the second half on examining the assemblage of factors that shape German advocates' impact. It traces the Berlin asylum seeker healthcare story from 1993 to 2015, when Syrian and Central Asian asylum seekers arrived in large numbers and later, prompted changes to asylum seeker administrative processes. Findings are gleaned from 24 interviews with physicians, politicians, bureaucrats and refugee advocates operating in Berlin. The chapter begins with a review of relevant policy history, followed by a summary of factors that shaped the 1993 reform at each of the macro, meso, and micro level. It concludes with an ecological examination of factors that shaped the physician movement in Berlin.

To begin, the 1993 introduction of the *Asylbewerberleistungsgesetz* (Asylum Seekers' Benefits Act, herein *AsylbLG*) was a turning point in Germany's already-fraught relationship with asylum seekers. Before 1993, the German Constitution guaranteed an absolute right to claim asylum. Faced with mounting immigration pressures, however, the German legislature amended Article 16 of the Constitution in December 1992, severely restricting this previously unqualified right by implementing a 'safe third country rule'. This disqualified any persons who entered Germany from another 'safe' country from launching an asylum claim, effectively precluding land-border entrants from all surrounding countries. At the same time, the federal government introduced the *AsylbLG* to limit claimants' access to healthcare and social assistance. Both the constitutional amendment and the restrictions placed on social services were marked departures from the principles of the Basic Law, which was itself a deliberate break from Germany's Nazi past. By setting low minimum standards for health care, the central government institutionalized claimants' unworthiness to access the German social system and lessened their access to healthcare services. Moreover, excising asylum seekers from Germany's citizen-based benefits also changed how care was to be accessed. These process-related barriers served as additional federally-supported mechanisms for German *Länder* to limit claimants' access to care. While identifying the factors that limit claimants' access is not the focus of this study¹¹⁷,

¹¹⁷ See *Limitations (Chapter 1)*; important barriers outside the realm of policy include racism, language barriers, and cultural exclusion.

government-initiated procedural barriers are of note and thus, the most effective barrier is discussed here: the ‘green slip’.

From 1993-2015, claimants in Berlin accessed care through a *Krankenschein*, or ‘green slip’ – a green piece of paper identifying them as eligible for services. The green slip was distributed by civil servants working in municipal-level welfare agencies, such as Berlin’s *Landesamt für Gesundheit und Soziales* (State Office for Health and Social Affairs; herein the *LAGeSO*). Without medical training, bureaucrats were required to assess claimants’ health needs to determine if they met *AsylbLG* criteria; namely, if it were an emergency they were therefore entitled to care. Berlin’s green slip expired each quarter, requiring asylum seekers to re-apply for a slip every three months. The green slip also imposed burdens on physicians. While welfare claimants in Berlin would receive similar vouchers from the local welfare office (though these are given without a needs assessment), claimants received a voucher *application* which would need to be signed by their physician and returned to the welfare agency. If the procedure was approved by the agency as meeting *AsylbLG* requirements, the agency would *then* send the voucher back to the doctor, who would *then* use this to claim reimbursement from the same agency. This cumbersome and comically bureaucratic procedure was ostensibly designed to limit abuse (e.g., multiple claimants using a single voucher). In reality, it caused great delay for physician reimbursement, which in turn encouraged some doctors to refuse to treat asylum seekers and, in some cases, to demand payment in advance. It also encouraged a narrow reading of covered services, given the risk posed to doctors vis-à-vis reimbursement (Bozorgmehr & Razum, 2015; *Gesundheit-Geflüchtetete*, 2018: n.p). Indeed, as Pross (1998) argues, “the driving force behind this complicated bureaucracy is not to save money...but to make life for the recipient as difficult as possible” (49).

Paradoxically, the outcome of these processes is a decrease in state-supported healthcare and an increase in bureaucratic costs. First, claimants who were denied green slips by civil servants, denied healthcare by physicians or denied access by a nearly impenetrable bureaucratic system¹¹⁸ would either simply not receive care, or access care from non-government

¹¹⁸ Musing on this caricature of bureaucratic complexity, Pross (1998), the former head of the Berlin Centre for the Treatment of Torture Victims writes: “It is a part of German culture that public life is overregulated by laws, decrees, and orders. It follows that the legal framework for refugees and asylum seekers is so complicated, and in part so illogical, that it is hard for non-lawyers to understand, let alone an asylum seeker or non-native speaker” (49).

organizations. In Berlin and elsewhere, these include the MediBüro and Christian church-based providers, including the Order of Malta's *Malteser Migranten Medizin* clinic. These are examined further in *Meso-Organizational* level. Second, bureaucratic costs have increased. This is true in terms of processing asylum seekers' multi-step health claims, as well as in terms of healthcare payouts from the municipal welfare offices. Denied or delayed healthcare, as well as the *AsylbLG*'s explicit provision that claimants receive care in emergencies only, can worsen or aggravate health issues and lead to increased number of trips to the emergency room (Bozorgmehr & Razum, 2015; Pross; 1998), a phenomenon seen in Canada post-IFHP retrenchment. Critically, in 2015 Berlin joined its two fellow city-states by phasing out the 'green slip' in favour of an electronic health card, which streamlined processes and improved access for claimants. However, the 'green slip' inculcated an unwillingness to treat amongst many physicians, a legacy which persists today. As such, the origins of the 'green slip' and the factors that eased German lawmakers' ability to introduce the *AsylbLG* in 1993 are unpacked below.

As discussed in Chapter 2, the arrival of hundreds of thousands asylum seekers and 'return' of ethnic Germans, alongside the impermanent presence of over one million guestworkers are causally linked to the 1993 reform (Schönwälder, 1999). These arrivals were sparked by the fall of the Iron Curtain, German Reunification and regional instability, all of which triggered massive increases of new populations entering Germany. While a welcome mat was not necessarily rolled out for any of these groups, asylum seekers posed the biggest perceived threat to Germany's imagined homogenous nationhood: persons who required social support without a claim to membership based on contributions or ethnic nationhood. Thus, in light of public pandemonium surrounding the 'waves' of newcomers entering Germany's borders, excising claimants was perceived as the most fruitful, strategic choice for politicians. Examining existing research through the ecological model reveals key factors that influenced the pathways taken by the 1993 Asylum Compromise and *AsylbLG*. Later, many of these factors would also shape the strategies taken by the pro-access movement.

At the macro (societal) level, a controversial point in the pro-access movement's history is the left-leaning SPD party's support for the constitutional amendment and following, the *AsylbLG*. The SPD's support is a function of the German federal context and the rules of the game for amending the German constitution. Indeed, while Germany's corporatist arrangements,

coalition governments and joint-decision making federal structure indicate that reform should be incremental (Teutsch, 2001), in times of exogenous shock major shifts can occur. Importantly however, Germany's joint-decision making structure is designed to disperse power. This fundamentally shapes how central governments can instigate major reform – most notably, by precluding unilateral exit as in the Canadian case (Kropp, 2010, and Scharpf, 2009 in Broschek, 2011). Instead, Germany's constitutional amendment rules necessarily require the support of parties that might otherwise be in opposition to a proposal. Article 79 requires two conditions to amend to the Basic Law: an absolute 2/3 majority in the *Bundestag*, and a simple majority in the *Bundesrat*. Thus, all major federal and state level-parties had to agree to the new Article 16(a) before it could pass. While the CSU/CDP supported reform since the 1980s, SPD opposed the amendment on ideological grounds. While they were not represented in the grand coalition at the federal level, state-level SPD members were represented in the *Bundesrat* and their support was required for it to pass.

The SPD was initially deeply opposed. Article 16's symbolism as a departure from the National Socialist focus on ethnic homogeneity, as well as Germany's central role in creating the international refugee regime made "any attempt to amend Article 16" an "unacceptable departure from what they considered to be one of the Bonn – and Berlin – Republic's core values" (Green, 2001: 94; see also Halibronner, 1994). However, the confluence of arrivals and increase in violence amplified the CDU/CSU pressure on the SPD to support the amendment. In October 1991, general secretary of the CDU Volker R  he stated that if the SPD did not support the amendment, "every asylum seeker come Friday is an 'SPD asylum seeker'" (Young, 1995: 67). The Bavarian state-level CSU then published the name of SPD members who opposed the constitutional change in Munich newspapers, while Chancellor Helmut Kohl harkened back to Nazi-era politics by threatening to enact a state of emergency if a compromise was not reached¹¹⁹. After "a long and painful period of soul-searching", the SPD backed down (Green,

¹¹⁹ Young (2008) outlines a variety of factors that may also have pushed the SPD into compromise. For example, the SPD was concerned it was losing voters to right-wing radical parties that pushed asylum reform such as the *Republikaner*; this was seen in local elections in Hessen (1993), Bremen and Bremerhaven (1991) and Hamburg (1993). The Compromise is also seen as an attempt by the SPD to distance itself from its longstanding 'rootless cosmopolitan' stigma, a phrase rooted in anti-Semitic campaigns against Jewish intellectuals for their lack of allegiance. Finally, the move was strategic – by agreeing to the Compromise, the SPD was positioning itself as a legitimate partner for a grand coalition with the CDU in the upcoming 1994 election. Faist (1994) adds that the SPD faced internal concerns regarding the effects of asylum seekers on the labour market in Germany, which would potentially disrupt their traditionally labour-leaning base.

2001: 94). In exchange for otherwise leaving the Article intact, a condition was added to limit the right to asylum to claimants who were not from ‘safe’ countries and had not entered Germany through a ‘safe’ country. The decision to limit entrance through constitutional change not only implicated potential movement allies in the reform, but locked the reform into a difficult-to-reach constitutional space where future liberalizing reform would be challenging. While the *AsylbLG* was created as part of the compromise, it is not bound by the same change mechanisms as a constitutional amendment. However, the nature of the Article 16 reform limited the potential for alliances between the pro-access movement and the SPD, especially in the months immediately following the reform – a crucial time for movements’ acceleration and deepening (Morris, 2000).

At the meso (institutional) level, asylum seeker healthcare’s pre-amendment location – next to citizens’ healthcare – became a factor that urged the policy’s reform. Prior to the Asylum Compromise, asylum seekers’ benefits were outlined in § 120 Section 2 of the Federal Social Assistance Act (*Bundessozialhilfegesetz*, herein referred to as *BSHG*). As a component of the Social Code, a federal German codification of law that outlines entitlements of various forms of social insurance, the *BSHG* provides social assistance (housing, health and long-term care insurance) to persons who were unemployed or otherwise unable to work, the vast majority of whom are German citizens. German social citizenship is incongruent with this notion. Historically, the German corporatist welfare state model is tied to the concepts of interlocking ownership and dependency between the state, employers and the welfare system’s users (Liedtke, 2002). Without a history of employment-based contributions *or* claim ethnic ties to German nationhood, asylum seekers had little perceived claim to inclusion. Moreover, asylum seekers hold only a residence permit (*Aufenthaltrgrtattung*) and are prohibited from working for the first year, precluding the opportunity to perform deservingness by building a claim to the system as guestworkers did (Liedtke, 2002). That claimants drew on non-contributory benefits made their presence out of sync with German social citizenship norms, and their right to claim social welfare rights was questioned (i.e., healthcare, social welfare). Because ‘abusing the welfare system’ was made synonymous with ‘abuse of the right to asylum’, anti-asylum activists needed to simply claim that asylum seekers were drawing too heavily on the social assistance system to stoke fear of the Other (Faist, 1994). The 1993 Compromise and introduction of the *AsylbLG* further cemented asylum seekers’ position as recipients of German support but not members of the German polity by changing benefits to in-kind contributions or vouchers that

render them “systematically prevented from opportunities to establish any irreversible social foundations” (Liedtke, 2002: 494)

At the **micro (individual) level**, the power of individual actors in strategically leveraging their position and built-in audience is clear in the German case. Across levels of government and party lines, many politicians in support of the Asylum Compromise communicated its potential benefit to their constituents. Unlike in the Canadian case, where a singular minister took up the cause of asylum seeker reform, or in England, where reforms emanated almost entirely from anonymous civil servant organizations, examples of vocal, strong proponents are many. In most instances, politicians communicated their message through the agency-laden institution of German citizenship – that is, that which imagined a homogenous nationhood and focused on contribution and ethnic-based ties to claiming social rights. These include Bavarian minister Edmund Stoiber (who warned that Germany was on the cusp of becoming “a thoroughly racially mixed society”) and Berlin Senator Heinrich Lummer (who framed Germany’s future as a “multicriminal multiconflict society”) (Young, 1995: 65). Chancellor Helmut Kohl enacted this rhetoric by threatening a state of emergency if the Asylum Compromise was not successful. Kohl also signalled his politics through an absence of action when he refused to travel to Mölln following the arsonist murders of a Turkish family, stating he rejected any form of “condolence tourism” (*Beileidstourismus*) (Iken, 2012: n.p.).

Responding to Reform: A Fragmented, Localized Response led by Physicians

From 1993-2015, German protest waxed and waned across the national landscape generally and within Berlin specifically. It has varied in its intensity and composition but the movement to increase access to asylum seekers’ healthcare has persisted since the *AsylbLG* was introduced in 1993. While changes in complimentary policies at the state level have improved access to care for asylum seekers such as the introduction of the electronic health card, the *AsylbLG*’s healthcare provisions remain unchanged at the federal level. Like the Canadian and English cases, party politics play an important role in understanding asylum seeker reforms. At federal level, Germany’s centre-right Christian Democratic Union (CDU) and centre-left Social Democratic Party (SPD) typically share power, while a multitude of parties at the state level including the CDU and the SPD will coalesce to form governments. SPD members are typically associated with more inclusive, pro-immigrant and pro-refugee practices (Faist, 1994). However,

at the federal level two points are of note. First, SPD members in the *Bundesrat* supported the Asylum Compromise in 1993, permitting the governing CDU/CSU in the *Bundestag* to enact the constitutional reform that reimagined and significantly constrained the rights of refugees. While the SPD's agreement was a reaction to factors including SPD voters defecting to far-right radical groups that supported asylum controls (Young, 1995; see footnote 6), the SPD's support remains contentious. Moreover, the SPD was a member of the federal governing coalition from 1998-2009, and again since 2013, yet amending the *AsylbLG* has not been on the table¹²⁰. Instead, further amendments to limit claimants' access to citizen-equivalent medical provisions have been made while the SPD has shared power (see Table 4). Evidently, German political parties often act against expectation vis-à-vis immigration; after all, it was Angela Merkel, as Chancellor and member of the CDU who led her government to open Germany's doors to nearly 1.4 million asylum seekers from 2015-2017 (Craigie, 2018).

At the state level, political parties have acted in more predictable fashion, though still not without some surprises. It was under SPD-led governments that Bremen and Hamburg first introduced the electronic health card for asylum seekers in 2005 and 2012, respectively. SPD-led city-state Berlin followed suit with its own card in December 2015. However, this was four months after North Rhine Westphalia became the first federal state to introduce the card in September of the same year under an SPD-CDU coalition. The puzzle here is why Berlin was such a laggard on this file. Berlin has the 'right' political leadership, and – by virtue of also being the federal seat of government – had become the epicentre of a fairly sustained physician-led movement focusing on asylum seeker access for more than two decades. Evidently, neither party politics alone, nor the presence of pro-access movement can conclusively predict *Länder* or national government's action in the realm of asylum seeker entitlements¹²¹.

¹²⁰ Additional instances of the SPD party supporting or failing to oppose immigration restrictions including the SPD-led Berlin government supporting restrictions on migrants' ability to move freely within the city-state in the early 1970s and 1980s (Soenneken, 2014). Paralleling this, the SPD-led federal government increased restrictions on family sponsorship after the Berlin-supported restrictions proved popular amongst CDU-led states (ibid).

¹²¹ An important limitation to this study is the absence of a state comparator such as Bremen. This research initially began as an examination into the conditions under which physician-led groups achieve impact in improving asylum seeker healthcare access at the level of national government. However, interviews with key informants revealed a shift in strategy in Berlin in 2015 following the pro-access movement's failure to amend § 4 and 6 at the national level. Given its importance to this project's research questions, this line of inquiry was pursued. Further research could focus on a state-by-state comparison of EHC implementation that controls for governing parties/coalitions.

The German pro-access movement is comprised of people from a multitude of professional backgrounds. Unlike other cases however, a singular organization around which advocates can gather to advance their agenda has not emerged (e.g., as with the Canadian Doctors for Refugee Care). Physicians and their organizations are certainly leaders in this movement. This research indicates that while the movement is also populated by activists and advocates who do not have a medical background, physicians have consistently formed the largest professional group within the movement. Especially in recent years, the movement is supported vocally by major institutional healthcare players at the national level, including the *Bundesärztekammer* (German Medical Association) and the *Ärztekammer Berlin* (Berlin Physicians' Chambers or College of Physicians¹²²). It is also supported by national and local physicians' associations with strong political histories such as the *VdÄÄ* (Association of Democratic Doctors). As with the other studied cases, Germany has support from longstanding pro-refugee organizations including *Pro-Asyl* and *Flüchtlingsrat Berlin*, a national and local asylum seeker advocacy group, respectively. While highly politicized organizations such as the *MediBüro* and *MediNetz* have taken a lead in calls for reform over the years, a leading organization without previous agendas or institutional affiliations is not present in Germany at the state (i.e., Berlin) or national level as is the case in Canada with the CDRC.

The section below unpacks factors that have or continue to inform the Berlin-based German pro-access movement's composition, repertoire, and ultimately, its impact since 1993. The German case poses particular complications; advances vary enormously across federal states, and the impact of these causal and contextual factors is mediated heavily by time and extraordinary arrival of more than 1.4 million people who registered as asylum seekers from 2015-2016. With an eye to these intervening factors, this chapter seeks to understand the institutional story that underpins political party action. At the macro-societal level, I examine a multitude of factors that place downward pressure on advocates: Germany's controversial exit from postwar values at the *AsylbLG*'s creation; the impact of decentralized federal structure; the issue of problem definition and physician-buy-in; and, the role of anti-irregular migrant laws, Nazi doctors and German reunification in depoliticizing physicians. At the meso-institutional

¹²² This is the statutory professional/regulatory association of all licensed physicians practicing in Berlin, representing more than 31,000 doctors. Its role and function is similar to that of the College of Physicians and Surgeons in Ontario.

level, Germany's healthcare reimbursement system and the suitability of the German constitutional court are examined. Meso-organizationally, Germany's pro-access movement strategy is described. Finally, the role of prolific issue champions at the micro-institutional level is assessed.

Macro (Systems) Level

Federal Exit and the Anti-Violence and Pro-Asylum Movement(s). Like Canadian case, the manner in which Germany's asylum seeker reforms were enacted served as a driver for advocates in the pro-access movement. While Canadian discontent focuses on the government's clandestine approach, German frustration arises from the outward reason provided for the reform: to quell anti-foreigner violence. This reasoning and the symbolism imbued in the 1993 reforms were cited by interviewees as an important factor that fueled their resolve to reinstate full asylum seeker healthcare.

In the months preceding the 1993 Asylum Compromise, an unprecedented number of violent incidents were recorded against 'foreigners'. As the number of asylum seekers and ethnic Germans entered Germany increased, nationalists became concerned about Germany's changing ethnic composition and racialized 'foreigners' use of the social welfare system. Many enacted violence towards persons whose skin colour or accent signalled 'Other', and from 1990-1993 more than 2360 illegal acts and violence were taken against 'foreigners' (Schönwälder, 1999). These included crowds of up to 1000 people attacking asylum seekers' homes in Hoyersweda (1991) and Rostock (1992), as well arson attacks in Solingen, Lübeck, and Mölln that killed or injured dozens of Turkish residents (Willems, 1995). These attacks "raised the memory of the Kristallnacht, the anti-Jewish Nazi pogrom of 1938, and the events which followed and led to the Holocaust" (Schönwälder, 1999: 86). The violence was aimed at Turkish guestworkers and asylum seekers entering from Yugoslavia and other source countries. Discursively, the heightened violence and unrest across Germany was leveraged by pro-reform advocates as a means of achieving the desired reform: fewer asylum seekers would mean less discontent and less violence (Faist, 1994).

Predictably, anti-reform advocates found limiting the rights of refugee claimants to be a troubling way of quelling neo-Nazi violence. Still, despite thousands of Germans voicing

opposition to the violence and xenophobia, including an estimated 350,000 anti-violence protestors in Munich who marched under the slogan ‘Never again!’, the reform succeeded in 1993 (Klusmeyer, 1995; Schönwälder, 1999)¹²³. When the SPD eventually agreed to limit peoples’ right to claim asylum, it was accused of “giving in to the rhetoric warfare of the CDU/CSU” (Young, 1995: 68). For those in opposition to the violence and later, the Asylum Compromise, the decision to limit asylum seekers’ right to entry signaled a departure from postwar values and institutional constraints on power, and as a threat to Germany’s efforts to reconcile its past.

The 1993 reforms sent a troubling signal that Germany was lessening its resolve to institutionally guard itself against nationalist uprising and atone for its past. The events of 1993 were perceived as “major turning point[s] in post-war German history, as a departure from moral commitments arising from the Nazi past” (Habermas, 1993 in Schönwälder, 1999: 85). Referencing arson attack by neo-Nazi German citizens that killed Turkish residents in 1992-1993, Schönwälder (1999) found parallels between the attacks and the violence perpetrated against Jewish residents in the years prior. Habermas (1993) was deeply critical of the government’s suggestion that the problem underlying violence against asylum seekers was the presence of asylum seekers; he famously stated that the “problem with the hatred of foreigners is the foreigners themselves” (126). Moreover, Habermas (1993) and the pro-refugee movement raised concern that the Federal Chancellor and coalition expressed greater concern for the impacts of anti-violence protests than the impacts of the violence itself – namely, that such protests would foster identity discord in a recently reunified Germany (Schönwälder, 1999).

In 1993 and still today, the Asylum Compromise, the attacks against foreigners, and the use of Neo-Nazi violence as a means of justifying constitutional reform sparked anger amongst pro-refugee advocates and everyday Germans. Interviews indicate that many in the pro-access movement perceive the manner in which the 1993 reforms unfolded as still fueling their resolve to support asylum seekers. Mia Fischer¹²⁴, a refugee advocate and medical student stated: “It’s an embarrassment that people don’t have healthcare today because the government chose to stand with anti-immigrant protesters in 1993”¹²⁵. A desire to reverse the signal sent by the 1993

¹²³ Still, on December 3 1992, the day after the march in Munich, the Asylum Compromise was reached (Schönwälder, 1999).

¹²⁴ Name has been changed.

¹²⁵ Interview by author, August 2016.

reforms and to reframe Germany as a place where asylum seekers are welcome was identified as an underlying goal for several interviewees, particularly medical students. Moritz, along with interviewed members of the MediBüro indicated that they perceived the 2015 arrivals as an opportunity to showcase Germany's departure from its Nazi past but also from the 1993 reforms and were eager to signal that Germany was once again a welcoming place for refugees. Importantly however, in 1993 this frustration would not be enough to feed the full crystallization of the physicians' pro-asylum seeker movement; reasons for doctors' early disengagement are discussed in *(De)politicization of Doctors*.

Problem Definition and Physician Buy-In. An important factor shaping the German movement's limited impact is the movement's lack of a common identity. This is in part shaped by Germany's highly decentralized system, as discussed below, as well as by disagreement within local movement areas on what exactly *is* the 'problem' underpinning asylum seeker healthcare. In Berlin, this has historically stemmed from three factors. First, Berlin physicians disagree on the extent to which the *AsylbLG* creates barriers to access. Second, Germany lacks a strong history of training physicians in culturally-competent healthcare education. Third, there is limited data on asylum seeker healthcare outcomes in Germany, which inhibits collective learning of the *AsylbLG*'s overarching impacts. Collectively, these factors have encouraged an atomization of advocacy and limited the depth and scope of the pro-access movement over time.

First, the Berlin movement faces a problem definition issue. To begin, interviewed physicians were unclear on what the *AsylbLG* covers – several thought it was identical to citizen healthcare. Even amongst those who understood the *AsylbLG* was limited, many perceived this coverage as 'adequate' for refugees. Still others were unsure what was covered, but assumed it was inclusive because they had experienced few rejected *AsylbLG* reimbursement claims. Collectively, these factors amounted to great variation in the perceived scope and depth of the asylum seeker healthcare access problem amongst interviewed persons. For example, even 'pro-access' physicians had vastly different perspectives on what barriers refugee claimants faced in Berlin, if any. This was true across specialties, age ranges, and role in the Berlin professional community. Günther Jonitz, current President of *Ärztammer Berlin*, the Berlin physicians' college is widely respected amongst the pro-access movement as demanding better health conditions for Syrian arrivals. But on the topic of access to care, Dr. Jonitz stated he knew of the

AsylbLG's 'acute' provision but believed it did not pose real barriers: "There are discussions, also public discussions but in daily life you don't have any problems. So, issues are discussed? Yes, but in real life it's not a problem"¹²⁶. Dr. Emma Müller¹²⁷, a retired physician now supporting the Ärztekammer Berlin's Human Rights network agreed: "Asylum seekers have the same access to healthcare as German citizens. Everyone under the *AsylbLG* don't have restricted access anymore."¹²⁸

This is of course, not true¹²⁹. It may reflect a lack of awareness of current policy provisions, or a lack of recent experience "on the ground" with refugees and thus limited familiarity. A Berlin-based refugee academic stated: "One reason why doctors don't think there's a problem is they don't see a lot of [refugee] patients, or, those they see do not express their problems fully so they don't know that people are not getting serviced"¹³⁰. This was supported by a representative from MediBüro, who stated that a large but consistent group of physicians have historically delivered free care to asylum seekers: "We often have to call four or five doctors before one will say yes"¹³¹. This may signal that some physicians view the *AsylbLG* and the procedures required to attain care as appropriate for refugee claimants, who they may not view as deserving of full German social citizenship rights.

The *Deutscher Landkreistag* (National Association of Counties; herein *DLK*) plays an important role in the asylum seeker access debate as it promotes the interests of local government for Germany's 294 federal administrative districts, which support municipalities in their administration of the *AsylbLG*. *DLK* representative Jörg Freese stated: "Before you get a status, you shouldn't get the same healthcare offered to unemployed persons or refugees with the status...But in reality, they get everything they need...we don't leave anyone behind."¹³² Importantly however, perceptions that refugees 'get what they need' may also simply reflect these physicians' experiences. The *AsylbLG* is critiqued for its ambiguity (Eichenhofer, 2013); it

¹²⁶ Dr. Günter Jonitz (President, *Ärztekammer Berlin*), interviewed by author, August 4, 2016.

¹²⁷ Name has been changed.

¹²⁸ Dr. Emma Müller (name has been changed) interview by author, November 2016.

¹²⁹ Multiple organizations and academics have documented and reported the *AsylbLG*'s impacts on health, including Flüchtlingsrat Berlin (2016; 2012; 2004), medical students at the University of Berlin (Boettcher et al., 2003); Berlin Centre for Torture Victims (*bzfo*) (Weber, 1998; Birck, 2000; Graessner & Wenk-Ansohn, 2000) and Nazi medical historian and *bzfo* physician Pross (2002), amongst others.

¹³⁰ Dr. Daten (anonymous academic), interview by author, August 2016.

¹³¹ Dr. Anja Mayer (name has been changed) physician (*MediBüro*), interview by author, August 2016.

¹³² Jörg Freese (Advisor, German County Association [DLT]), interview by author, November 1, 2016.

does not codify what is covered, nor does it expressly outline what an ‘emergency’ or ‘acute pain’ is. However, this vagueness is also an important tool in the pro-refugee physicians’ toolkit. Interviewed doctors stated that because “no one is quite sure what is covered”, everything is up for interpretation and debate. Interviewed doctors described the responsibility of discretion as difficult, but that they usually ended up providing care. Dr. Ayse Linder mused: “But what is an emergency? Would you tell me that? I would say that if a patient comes here and has pain or something, that’s an emergency, isn’t it? So, what is it?”¹³³

Dr. Renate Schüssler, a Berlin-based physician who has served asylum seekers in Berlin for thirty years and now consults on Syrian refugee healthcare issues described the *AsylbLG* reimbursement system as “like a lottery”, but one which can be won through persistence:

With the green slip, you can insist. If you insist, especially for children, you will get everything you need. Of course, you have to insist – you have to write, you have to engage them on this. At first, they will say no, it’s not possible but you must keep pushing and then you’ll get it.¹³⁴

Indeed, that the *AsylbLG* remuneration process is an inexact science was highlighted by Bozorgmehr and Razum (2015), who found that the *AsylbLG* reimbursement system erred by refusing valid needs but also by approving unnecessary services, which inflates costs for the municipality. The *AsylbLG*’s room for interpretation may support individual-level persistence but it stifles systemic change. Siloed providers persist, with some claims reimbursed and others rejected, all the while lacking a wide-angle view of the overall problem. The ability to “muddle through” the *AsylbLG* process and arrive at an acceptable resolution disincentivizes physicians from investing energies into advocacy to reform the *AsylbLG* reimbursement system. For example, despite evidence that the electronic health card (EHC; a card with a magnetic information strip) streamlined and simplified processes for providers (e.g., Kreykenbohm, 2016) many interviewed private physicians did not actively lobby for its implementation. The green slip posed problems, but they had become used to the system, indicating a path dependency had formed around the less-efficient ‘green slip’.

¹³³ Dr. Ayse Linder (physician), interview by author, August 11, 2016.

¹³⁴ Dr. Renate Schüssler (physician), interviewed by author, August 11, 2016.

This is in part because there is no data on how often claims are refused and service is denied, or how often physicians refuse to offer care in the first place *because* the *AsylbLG* process is cumbersome. This issue of *AsylbLG* ambiguity was highlighted as a challenge by an expert in the field of asylum seeker healthcare data (herein: “Dr. Daten”), who stated:

There are a number of physicians who know how to play the system; they know of paragraph 6 [of the *AsylbLG*] well and can to get what they need. Then why on earth do we need paragraph 4 and 6 if already the assumption is being made that docs find a way to circumvent barriers? If so, might as well remove them.¹³⁵

Indeed, data collection plays a role in problem definition issues. National-level and state-level data collection or studies that examine the long-term effects of limiting healthcare entitlements as a result of the *AsylbLG* are virtually absent. This is confirmed by English publications that cite a surprising lack of study into asylum seekers’ healthcare needs and experiences in Germany (Bozorgmehr & Razum, 2015; Schneider, Joos & Bozorgmehr, 2015). An interview with Dr. Daten, a research expert on this topic found that “there is an obvious lack of data and it is a problem”. While Dr. Daten did note that efforts to improve data collection to inform policy and practice had been undertaken since the arrival of Syrian newcomers, he argued that efforts were long overdue and as a result, the *AsylbLG* was failing: “Physicians who see patients don’t see those who don’t come because of access barriers. Without a solid database, it is impossible to see negative effects.”

Second, a dearth of cultural competence influences Germany’s problem definition issue. In the Canadian case, norms around culturally-competent and inclusive care widened the network of potential physician advocates to include those who did not treat asylum seekers directly. In Germany, the effects of a longstanding repression of its multicultural identity extends into its healthcare institutions, where the notion of “asylum seeker healthcare” was, until recently not recognized as a discrete area of healthcare provision. Interviews suggest that this dearth is important because it limits the profession’s consciousness of asylum seekers’ particular healthcare needs, which can include mental health support and treatment of atypical healthcare problems. This diminishes the perceived need for advocacy to expand asylum seekers’ healthcare coverage; the *AsylbLG* is perceived to be sufficient for anyone’s short-term healthcare needs.

¹³⁵ Dr. Daten (anonymous academic), interviewed by author, August 2016.

Moreover, a lack of awareness of claimants' social-cultural healthcare needs also moderates the perceived need for physicians to become advocates for claimants' access, vis-à-vis the *AsylbLG* but also beyond entitlement barriers. Claimants' healthcare needs can exceed those of typical German citizens because claimants face a variety of access-related barriers and require resources such as interpreters and longer appointments with physicians. However, the notion of culturally-competent care or considerations for the social needs of refugees coming from traumatic situations were rarely considered, especially before the arrival of claimants in 2015 (e.g., Bozorgmehr, Schneider & Joos, 2015; Wollina et al., 2016). 'Cultural distance' between provider and asylum seeker is associated with negative health outcomes in EU countries including Germany, where enhanced professional sensitivity training was recommended (Detollenaere et al., 2018). Dr. Bernhard Gibis, a senior leader at the *Kassenärztlichen Vereinigungen* (National Association of Statutory Health Insurance Physicians; herein the *KBV*) found German physicians' understanding of the cultural nuances associated with asylum seeker healthcare to be lacking:

Doctors don't want to make any difference between the different patient groups [*to treat everyone equally*] but they're also not so cultural sensitive very often. They always want to treat everyone as the same. I feel more in that area, we have lots of work to do to provide cultural sensitive services. Treating women from Arab countries, even if there is a young man who is not shaking hands with a female doctor might not be cultural competent but to some extent understandable.¹³⁶

While it came to a head in 2015, this issue long predates the arrival of Syrian newcomers, noted Dr. Torsten Lucas. While he found the Berlin Centre for Torture Victims (*bzfo*) attuned to claimants' cultural and health needs, the everyday hospital was not. Referencing the particularly homogenous hospital culture of East Berlin, he recalls:

In 1993, in East Berlin our reality was very different. We had our first Vietnamese patient. Nurses and doctors were very stressed because there was no common language and they weren't used to communicating. So I found very basic racist tendencies in the hospital.¹³⁷

¹³⁶ Dr. Bernhard Gibis (Director, Dept. of Medical Services, National Association of Statutory Health Insurance Physicians Berlin [KBV]), interviewed by author, November 3, 2016.

¹³⁷ Dr. Torsten Lucas (physician), interview by author, November 2, 2016.

An academic researcher working in the field agreed that historically, German physicians largely did not believe that their practices needed be adapted for patients' cultural or religious needs. Physicians viewed their role as entirely scientific and not one that should interfere with individual preferences. Interestingly, parallels arise here as physicians seek the 'ideal patient' – a person who is upfront, open, and straightforward – as countries seek the 'ideal' or 'good' refugee – one who does not ask too much of a country and is willing to adapt practices to suit their new country's preferences (e.g., Pozniak, 2009).

Dr. Gibis stated his association was working with physicians in countries with strong histories of cultural competency training to develop a training program but this was not yet available. Similarly, a representative of Pro-Asyl perceived opportunities for international learning on this issue as limited. Interviewed persons could not reference cultural courses in their medical training, though younger interviewees expressed hope this would change in Berlin in light of Syrian arrivals. However, without a systematic approach to instilling cultural competence into German medical teaching, clashes between physicians' expectations and patient requirements may have a chilling effect on the practice's willingness to build inclusive healthcare. Dr. Klaus Burghard, a retired prominent surgeon Berlin recalled attending to Syrian refugee women a trying act: "Sometimes they demand a women doctor, but you cannot demand this when you are in a reception area with hundreds of people waiting"¹³⁸. This comment was reflected in other interviews. Recognizing physicians' frustration, Dr. Gibis' (KBV) still found the refusal to adapt healthcare to patients' religious or cultural needs to harken back to a darker era: "There is all this discussion going on in this area as to how far one should be tolerant", he stated. At the same time, "Not so long ago. 30 or 40 years, there were similar circumstances."

Importantly, this is not to say that most physicians do not support claimants accessing the German healthcare system. To the contrary, it was agreed amongst interviewees that physicians in Germany supported the principles of universal healthcare and supported claimants' right to care. Castañeda (2013) found that physicians' everyday acts of resistance were viewed as fairly unremarkable for most providers, as simply "an extension of their professional duties" (237). However, many of these same physicians also perceive claimants as simply additional patients that can be folded in quietly to their physician practice. That is, "asylum seeker healthcare" is

¹³⁸ Dr. Klaus Burghard (physician), interviewed by author, November 1, 2016.

just healthcare for asylum seekers whose needs can be met under the current *AsylbLG*. Claimants are not perceived as going ‘without’, and there is little support amongst everyday physicians that asylum seeker healthcare requires additional healthcare resources including additional time and supplementary services such as translators and social workers, none of which are supported under the current *AsylbLG*. This perception in turn makes it difficult to create a rallying force behind the issue of access.

A secondary outcome of Germany’s lack of highly visible culturally-competent care networks¹³⁹ is its effect on networks and network building. Individual refugee-serving physicians serve claimants as they would any other patient, and indicated they had few opportunities to connect with others to discuss their experiences as providers. An interviewed Berlin-based family physician stated that they often provide care to patients regardless of legal status, but just viewed this as part of her daily practice and physician duties: “I can’t really tell you about others, and I don’t really care. I would think most doctors don’t really care about the legal things.” In Canada, events like the creation of the *Evidence-Based Critical Guidelines for Immigrants and Refugees* and the annual North American Refugee Health Conference provide concrete activities for the pro-access movement to regroup and grow. It provides easy entry points for medical students and non-physician healthcare providers to join the movement. In Germany broadly and Berlin specifically, refugee-serving physicians have fewer options for connecting and network-building. Prior to the arrival of Syrian newcomers, there were few opportunities for providers to exchange experiences and ideas on these topics. Meetings remained siloed amongst organizations such as the *VdÄÄ*. While new members were welcomed, recruiting fresh perspectives is challenging. Physicians who do not treat refugees directly have little perceived need and few leveraged opportunities to learn about these issues. As a result, they have little reference point as to why a pro-asylum seeker healthcare movement is even necessary.

Collectively, these factors shape a limited awareness of asylum seeker healthcare issues amongst physicians and contribute to the atomization of advocacy. A limited consciousness amongst even physicians who provide ad hoc refugee care were not always aware of the pro-access movement or its purpose. Interviewed physicians agreed they were part of the pro-refugee movement, and perceived their work as political; they were also aware of major asylum seeker-

¹³⁹ This statement refers to the state of affairs pre-2015; this likely evolved following asylum seekers’ 2015 arrivals.

serving organizations such as MediBüro, which often referred patients to them. Mostly however, individual physicians saw individual asylum seekers as patients, and engaged in limited other forms of collective advocacy. Absent from the Berlin scene was a broader conversation that sought to connect the movement's multiple parts, effectively recruit new members, and agree on the issue at hand. These factors diminish the potential of the asylum seeker healthcare movement in terms of size, strength, and the ability to make an impact.

Systems Shaping Action: Federalism, Autonomy and Decentralization. German federalism is characterized by its joint-decision-making structure that requires federal and state-level governments to cooperate in issues such as constitutional reform. Postwar Germany mitigated executive power by dispersing it to Germany's federal states and municipalities. As a result, states and local municipalities have considerable autonomy in implementing and administering issues related to social welfare. For example, while the federal government sets minimum standards, municipalities, often working with state governments, will execute a policy's delivery, such as in the case of asylum seeker healthcare. While this decentralization aims to check executive power, this study suggests it also disperses advocacy power across multiple groups, levels of government, and geographic areas. The multiplicity of potential targets forces advocates to hedge their bets and results in highly localized efforts that target shorter-term gains. This can alleviate healthcare barriers in areas where advocacy is successful but frustrates the ability to foster a national movement. Such trade-offs made by pro-access movements across Germany are partly responsible for the disjointed patchwork of entitlements that constitute the German asylum seeker healthcare system.

As Laubenthal (2011) notes, while national or subnational units are oft analyzed independently, *federalism* is largely under-examined in migration studies, though some have analyzed the impact of Germany's unique power distribution. Katzenstein (1987) found Germany's distribution of power across states and the central government created limited political opportunity for policy change. Green (2006) found Germany's institutional configuration not only stunted policy change opportunities but fostered strong path dependency amongst Germany's migration policies. Thränhardt (2001) found that while this institutional configuration disperses power, it still provides for the federal government to create most overarching policy frameworks within migration policy – specifically, those governing

immigration entrance policies. Subnational units will in turn have considerable autonomy in integration policies, yet still the study of states, cities and municipalities are also understudied (Soennecken, 2014).

This autonomy has led to variation in entitlements and experiences between and within federal states, especially with regards to state-centric policies such as those concerning integration and asylum seekers' social service access. Derrida (2001) notes that tensions between the interests of the state, levels of government, organizations and individuals can create new possibilities for imagined forms of inclusion and “novel horizontal solidarities” (in Holmes & Castañeda, 2016: 13). Germany's states can become “diverging actors” in forging new paths for inclusive immigration policies. German state-level policy innovations been examined as a vector to improve irregular migrants' education rights (Laubenthal, 2011: 1365) and in shaping integration policy (Henkes, 2008) it has not been examined with an eye to healthcare entitlements for asylum seekers.

In the case of asylum seeker healthcare, German municipal authorities are the central body in social service delivery for non-citizens. It is at this level where crucial decisions on process-oriented policies are made, such as how to issue ‘green slips’ and how translators will be made available. These policies can open access and reduce frictions for claimants seeking healthcare. By reducing barriers to care, municipal governments can increase access far above the minimum standards set by the central state via the *AsylbLG* without instigating a constitutional amendment. This makes municipalities strong targets for advocates, as such governments, alongside their district and state-level counterparts can produce quicker gains for advocates and asylum seekers seeking to improve access to care. Ranier Neef, a non-physician *StopAsylbLG.Org* member commented that Germany's highly decentralized framework encourages advocates to “target their Land because it's easier to find success there.”¹⁴⁰

Electronic health cards (EHCs) are the quintessential example of state-level reforms that can improve access for claimants without changing legal entitlement. In 2015, Berlin joined city-states Bremen and Hamburg to eliminate ‘green slips’ and introduce EHCs for asylum seekers. Bremen (2005) and Hamburg (2012) first introduced the cards in an effort to streamline administrative processes and ease barriers to asylum seekers, and reports its effects as positive: it

¹⁴⁰ Ranier Neef (*MediBüro, StopAsylbLG.Org*), interviewed by author, August 17, 2016.

lowered administrative costs and has not resulted in higher spending per asylum seeker (Kreykenbohm, 2016). Hamburg and Bremen report that downloading healthcare administrative responsibilities to an insurer led to reduced bureaucracy and improved efficiency at refugee reception centres, simplified reimbursement for physicians and provided better delivery of care for asylum seekers (Tenew, 2012). By no longer administering ‘green slips’ on a quarterly basis or analyzing entitlement claims and appeals, the costs to the city are lower. North-Rhine Westphalia permitted its municipalities to introduce EHCs just prior to Berlin, in September 2015. As of February 2016, 18/236 of the state’s municipalities had entered into an agreement with an insurer. North-Rhine Westphalia’s fractioned take-up of the EHC shows the different experiences of city-states versus federal states. Berlin, Bremen, and Hamburg could enter into a single agreement with an existing sickness fund to administer the card as one municipal authority covers the state’s population. However, federal states permit their constituent municipalities to enter into individual contracts because it is at the municipal level where responsibility for asylum seeker reimbursement lays, creating multiple contracts with multiple insurers.

The net effect of the health card is positive: asylum seekers face fewer barriers to accessing care, and local authorities save on administrative costs (Bozorgmehr & Razum, 2015). However, this research shows that EHCs produce two unintended effects that actually diminish the movement’s power: first, it creates confusion amongst providers, and second, it fosters the disjointed patchwork of entitlement across states and limits the potential for a truly national movement. First, the EHCs create confusion amongst providers regarding entitlement. Dr. Anna Kühne of MediBüro lauded its rollout but found it caused confusion as many physicians took the card to mean that asylum claimants were now enrolled in statutory health insurance (see *Meso Institutional: Healthcare System* for a full discussion), which amplifies the issue with problem definition outlined above. Certainly, the EHC’s timing may have compounded this issue. The card arrived shortly after the large number of asylum seekers in 2015, which overall, interviewed physicians viewed as positive: new arrivals would theoretically encounter fewer barriers to care. However, interviewees including Dr. Kühne were concerned that the card masked important entitlement issues by making the reimbursement process easier, especially as many physicians began treating claimants for the first time.

Indeed, for claimants who received the card starting in January 2016, the reimbursement process was undifferentiated from other patients, which interviewees perceived as limiting

physicians' awareness of the *AsylbLG*. Providers may *become* aware of the legislation's limitations if their reimbursement claims were denied, however also interviewees reported that their experience submitting claims had been easier (i.e., more likely to be approved) in late 2015/early 2016 given the political pressures at the time¹⁴¹. For physicians who were treating claimants for the first time and/or whose practice would not include claimants long-term (as arrivals slowed down, as claimants became enrolled in standard health insurance (SHI) providers, etc.), respondents feared the Berlin card sent the wrong message by concealing inequalities caused by the federal-level *AsylbLG*. This potentially masked the entitlement deficit created by *AsylbLG* § 4 and 6 at a moment where the system was ripe for critique by physicians. This, feared interviewees, limited physicians' understanding of the *AsylbLG*'s negative effects, diminished the movement's ability to build additional support and represented a missed political opportunity overall. A hospital-based Berlin GP active in Syrian healthcare stated: "Doctors think that now that they have the card, they have full access, but the card didn't change the policy, just how accessible their existing provisions are"¹⁴².

Second, the asylum seeker health card created different realities across states, which reduced incentives for strong collective action. Advocates in many areas, including Berlin, felt that focusing on state-level changes such as the EHC was the most strategic action and would lead to the most attainable gains in the shortest timeline. The creation of stable, piecemeal alternatives at the city level such as the EHC redirects resources from *AsylbLG* reform and disperses pressure across Germany's 11,000 municipalities, thirteen federal states and three city-states. This reality "creates a very loosely tied together network of people needing somewhat similar things" and limits a feeling of solidarity, argued *StopAsylbLG.Org* member Ranier Neef. Instead of lobbying for national change under the *AsylbLG*, advocates could focus on local representatives to make smaller, incremental change. This led to success in some areas and failure in others, and created a highly disjointed patchwork of entitlements and realities on the ground. For example, advocates in Bavaria face different pressures than those in EHC municipalities like Berlin or participating North Rhine Westphalia cities. Enlisting the support of advocates from other municipalities can be difficult; after long EHC campaigns, advocates in Berlin sought to capitalize off their success and channeled their resources to additional 'quick

¹⁴¹ This perception was gleaned from interviews but could not be verified.

¹⁴² Drs. Christine Kurmeyer and Ingar Abels (physicians), interviewed by author, August 11, 2016.

gain’ state-level wins, such as advocating for an additional, anonymous EHC for use by undocumented persons (*Gesundheit-Gefluechetete*, 2018: n.p.). The result is city-level advocacy campaigns that are small and duplicative, and exert less pressure on more government targets. Ranier Neef of *StopAsylbLG.Org* argued that this duplication of advocacy efforts makes it “too easy” for the state and federal-level governments to dismiss advocate demands: “When they [advocates] write a letter to the Federal or even Land government, the whole thing is just perceived as too unlikely plus too politically un-savvy so they [the government official] just ‘pass the buck’ and say, ‘not our jurisdiction’.”¹⁴³

For asylum seekers, this entitlement disjointedness has created confusion – in some municipalities, they access care through a temporary slip or voucher; in others, they use a municipality-bound EHC; in other towns or cities, yet another EHC is required. Germany offering location-bound levels of healthcare access is particularly problematic for claimants as they are assigned to German municipalities through an algorithm. As more cities enter into contracts with insurance providers and invest in necessary infrastructures to implement municipal-level changes, the path away from national-level advocacy and change becomes entrenched and self-reinforcing (e.g., Capoccia & Kelemen, 2007).

Germany’s localization of advocacy is also linked to the absence of a nationally-focused organizational ‘issue champion’, as is seen in the Canadian example. Indeed, in Germany, even national advocacy organizations tend to invest in local-level outposts (e.g., MediBüros). This creates coordination issues between multiple levels and locations, each of which must strategically enact trade-offs and decide which issues to pursue locally (e.g., EHC introduction) and which resources to earmark for national lobbying. As a result, the reality on the ground for each organization differs, and advocates’ collective ‘ask’ is diluted. A legal representative from nationally-based general advocacy organization, Pro-Asyl stated collaboration in Germany’s multi-level system can be cumbersome, and may result in more effort than potential return:

We don’t have a lot of direct contact with medical organizations because these medical organizations are operating in a local level or [the nature of their work is] providing direct aid for asylum seekers. We, as a federal organization, an NGO that is operating at a whole Germany level isn’t really working in direct action.¹⁴⁴

¹⁴³ Ranier Neef (Volunteer, *StopAsylbLG.Org*), interviewed by author, August 17, 2016.

¹⁴⁴ Dieter Lange (name has been changed) member (Pro-Asyl), interviewed by author, August 2016.

Moritz Pfeiffer, a medical student, member of MediBüro Berlin and organizing member of *StopAsylbLG.Org* finds Germany's decentralization to be both a help and a hindrance to pro-access groups:

For MediBüro, we always have this on different levels. We have a lot of groups working on the city or regional level talking to their direct city administrator, getting some successes done on this very small level. We still try to, which is difficult for us because we're such a loose network, we make it that we want a solution for everyone, not only in single counties. We try to talk to this on a federal level as well. Working with such small entities all the time is just time-consuming. People have to try to visit every single city and at some point, we lose focus for the bigger goal which his not only the [electronic health] card but to get rid of the restrictive paragraphs in the *AsylbLG*.¹⁴⁵

Dr. Kühne of MediBüro agreed; the multiple access points for advocates can be helpful but also leads to duplication of efforts: "It's always difficult because we do not have one association that can say this is our program now, we can come together, and these are all our demands because we don't know if all the MediBüros want to share that."¹⁴⁶

In these ways, Germany's postwar division of powers shapes advocacy strategies and influences advocates' ability to make long-term national reforms, both by incentivizing short-term state-level targets and compounding problem definition issues. Over time, state-based, inward-looking reform strategies amongst advocates have become normalized, and coordination across organizations or places is fairly limited (see also Castañeda, 2013). Collectively, these factors hamper the possibility of national-level *AsylbLG* reform. German federalism is typically characterized by a high degree of unanimity and harmonious joint decision making (Soennecken, 2014); the instance of asylum seeker healthcare supports this, insofar as states have agreed to not collectively challenge the federal law. However, this research also suggests that advocates will urge states to act as divergent actors by implementing state-level laws when advocates perceive their ability to create federal unanimity as low.

¹⁴⁵ Moritz Pfeiffer (medical student, *MediBüro*, *StopAsylbLG.Org*), interviewed by author, August 3, 2016.

¹⁴⁶ Dr. Anna Kühne (physician – *MediBüro*, *StopAsylbLG.Org*), interviewed by author, November 3, 2016.

Policy and the (De)politicization of Physicians. Analysis of the German pro-access movement shows that in social movement formation, early events and early conditions matter. In the German case, the 1993 Asylum Compromise and *AsylbLG* reform triggered a strong reaction from the pro-asylum community. Protests by everyday citizens and physicians demanded Germany reinstate full asylum seeker healthcare; when the reform still passed, many healthcare workers continued to treat claimants without billing for services. However, two factors shaped the movement's ability to exist visibly immediately following the reform: the German Residence Act and German doctors' relationship with political action. Together, these factors erased physician-led pro-access advocacy from the social landscape in the 1990s, which limited its potential growth amongst providers and everyday citizens and ultimately contributing to the delayed success of the pro-access movements.

The German Residence Act was implemented in 1993, and continues to have a negative impact on the pro-access movement by muddying the waters on what doctors are legally permitted to do in order to serve 'foreign' patients in Germany. To begin, irregular migrants face exceptional challenges accessing services in Germany, especially when compared to other European Union countries. A strict policy regime works to deter undocumented persons' arrival and make life difficult once inside Germany's borders. For example, residing in Germany without a valid permit is a felony, not simply an administrative violation (Castañeda, 2012: 836). While irregular migrants are also insured under the *AsylbLG* and are entitled levels of support similar to that of asylum seekers, provisions in the German Residence Act require social service providers to alert federal authorities if an irregular migrant accesses services. Paragraph 87.2 of the Residence Act reads: "All public institutions, schools, and hospitals are obliged to inform the Foreigner's Office about the presence of an irregular migrant". Paragraph 96 further states that those who assist 'illegal' persons face imprisonment of up to five years. This includes for medical purposes, depending on how the paragraph is interpreted (Castañeda, 2012; Kühne, Huschke & Bullinger, 2015). Indeed, despite the Ministry of the Interior stating in 2007 that medical providers were not obliged to report patients without status (Gross, 2009 in Castañeda, 2012) it remains codified in § 87, para. 2 of the Act. Moreover, limited efforts to communicate the clarification in mainstream media or physicians' circles has led to little or delayed change on the ground in physicians' willingness to treat all patients (multiple interviews, 2016; Castañeda, 2012). Limited communication around such reforms is perhaps expected, given the regulation's

intended deterrent effect. As a result, the stipulation causes confusion amongst providers and creates de facto barriers to accessing healthcare for irregular migrants (*Gesundheit-Gefluechetete*, 2018: n.p.).

Ambiguity surrounding the Residence Act was heightened during the 1993 reforms and created spillover effects for asylum seekers and the pro-access movement. Interviewees who practiced in the early 1990s recalled that many providers could not or would not differentiate between undocumented persons or asylum seekers under the new *AsylbLG* system. Undocumented persons were sometimes rejected asylum seekers, while asylum seekers would sometimes lose or be given incorrect documentation. The task of determining who was covered, what services were covered, whether the patient was to be reported and whether the doctor would be liable for *not* reporting was perceived as simply too complicated for many physicians to unpack. At the same time, the healthcare system was in great flux, having undergone major healthcare reform that substantially altered the statutory health insurance system for citizens in 1992, as well as handling the administrative tasks associated with reunification (Coleman & Bhatia, 2003; interviews, Drs. Lucas, Kühne, & Jonitz). Limited resources and political willpower from major healthcare institutions (see: *Meso (Organizational) Level*) made clarification difficult and compounded confusion amongst medical providers, ultimately creating a freezing effect on some physicians' willingness to serve claimants or become politically activated on issues of access.

The Residence Act also erased physicians' visible presence from the pro-access movement's protests. Interviewees described a fear amongst physicians of being identified or flagged as 'pro-refugee' if they participated outwardly in the anti-*AsylbLG* movement activities in the early 1990s, when ambiguity around the Residence Act was particularly high. Physicians feared raids on their practices that could compromise the security of patients being served under the *AsylbLG*. Thus, many physicians' activism was invisible or was enacted through individual acts of resistance, such as by serving persons with uncertain residency status without claiming *AsylbLG* reimbursement. A MediBüro member stated: "This law meant that healthcare providers couldn't put on their white coat and make themselves visible in the same way. The law prevented them from making their position clear."¹⁴⁷ Evidence of the Act's erasure of advocacy from the

¹⁴⁷ Dr. Anna Kühne (physician – *MediBüro*, *StopAsylbLG.Org*), interviewed by author, November 3, 2016.

public eye is also seen in the launch of the MediBüro, a clandestine assemblage of physicians willing to serve the uninsured in Hamburg, 1993. In response to the *AsylbLG*'s restrictions and the punishing effects of the Residence Act, concerned physicians created the MediBüro as a decentralized network of offices across German states that connected undocumented persons with supportive physicians. Patients remained anonymous, and doctors did not claim expenses through the *AsylbLG*. The Berlin office was the second location, and opened in 1996.

Second, the German medical profession's historic role executing the National Socialist agenda further contextualizes physicians' (de)activism around the time of the *AsylbLG*'s launch. Germany's historic Nazi past is deeply intertwined with its medical sector; more than 7% of all German doctors were members of the National Socialist Party during the Second World War, compared with less than 1% of broader German society (Colaiani, 2012). Physicians conferred scientific legitimacy to Nazi-era policies and experiments; the power afforded by the physicians' white coat was central to the execution of National Socialist aims including eugenics and the use of forced medical subjects. Support from organizations including the *Bundesärztekammer* further legitimized doctors' involvement, as well as initiated and financed research on medicine during the Second World War (Roelcke, 2014).

Nazi-associated physicians remained in positions of public prominence long after the war ended. Well-known physicians held elected positions in bodies including the national Psychiatric Association and academic positions in German universities (Roelcke, 2014). Indeed, it was the shocking privilege and power afforded to Nazi doctors that prompted the 1986 launch of the *VdÄÄ* (Association of Democratic Doctors). Through this organization, physicians worked to expose Nazi-affiliated physicians who still practiced, as well as to infiltrate voting processes of major organizations in order to limit Nazi doctors' influence on professional associations' policy. Still, despite Germany making relatively strong efforts to recognize and address their problematic past, the German medical practice generally and the *Bundesärztekammer* specifically has been reluctant to address the profession's role during the National Socialist era (Roelcke, 2014). Indeed, it was not until 2012 that this national-level medical assembly recognized physicians' role by passing the "Nuremberg Declaration", a move that was actually initiated externally from members of the International Physicians for the Prevention of Nuclear War (IPPNW) (Livingston, 2012).

Long-term, this complicated professional past and limited protest traditions cut both ways in shaping the physician pro-access movement (Morris, 2000). While it was cited as a reason for several physicians' involvement in human rights issues, interviewees also suggested that Nazi involvement had a freezing effect on German physicians' politicization. While broadly, most physicians supported healthcare for all persons at the time of the *AsylbLG* reforms, there was limited appetite to outwardly lobby for policy change or express strongly political views because political involvement had a negative, National Socialist-era connotation for many physicians. Physicians sought to distance themselves from political activity as individuals and through their professional organizations, which remained largely apolitical following the Second World War. Professional organizations' involvement in Nazi war crimes and later, quiet support for former Nazi party members may have elicited feedback effects that fostered this depoliticization. Formally, these organizations had Nazi physician members and leaders, who may have supported resolutions that further quieted professional associations' political activities; informally, a want to 'fly under the radar' as a result of their Nazi past (or current members) may have similarly depoliticized professional organizations' cultures. Indeed, the *Ärztammer Berlin* was described as largely apolitical and reluctant to take contentious stances for many of the decades following WWII, even on issues of human rights. Early pro-access movement leader Dr. Torsten Lucas recalled: "There were always people afraid of taking sides, in the sense that the College being seen as a non-political body".

While these historical legacies informed some physicians' unwillingness to protest when the *AsylbLG* was passed, at the same time a sea change was occurring within the profession. The road to politicizing doctors through core organizations such as the *Ärztammer Berlin* was slow but fruitful. It started with the election of Dr. Ellis Huber, a well-respected advocate of social healthcare in 1991. It was at this time that Dr. Lucas became active in the Berlin arena, where his personal experience with advocacy played a key role in shaping him as a future pro-access leader (Morris, 2000). Under Dr. Huber, Dr. Lucas co-founded the *Ärztammer's* first Human Rights Working Group in 1992 in an effort to encourage Berlin providers to take a wider view to their role in human rights and advocacy. He later repeated these efforts at the federal level. Efforts by Dr. Lucas to grow the Berlin network of human rights-oriented physicians were strategic. He focused first on drawing attention to professional and personal violations against fellow

physicians around the world, an issue that was tangible and legible to his target audience¹⁴⁸. This strategy of highlighting the impacts of physicians' struggles and how these struggles impacted patients was then extended to Berlin. For example, as Dr. Lucas described, in the early 1990s Berlin physicians were enlisted by the Berlin Senate to issue statements clearing asylum seekers of mental health issues such as PTSD, such that they might be deported. Many felt these physicians, who worked for the Berlin police department, had insufficient training to issue these assessments. Activist physicians challenged this practice in the media and in professional gatherings, suggesting that physicians' independence was compromised, and their expertise was being inappropriately leveraged for deportation. The Senate ultimately relieved the police medical service from the practice of reviewing medical certificates, a result he perceived as boosting the physician human rights movement in Berlin. Alongside individual leaders, the *Ärztchamber* slowly took up more political stances to support asylum seekers, while others took up a wide spectrum of individual resistance practices (see *Micro (Individual) Level*). Slowly, through individual acts of resistance, the Berlin pro-access movement grew:

The movement got bigger and bigger as more and more people realized what the system had done to a certain group of patients and what the system was doing about doctors who were serious about wanting to supply equal healthcare to their patients according to needs and not according to status... People got better information, started to question certain things. On this path, they became more political. Not party-oriented, but they felt they wanted to be able to treat their patients according to their convictions.¹⁴⁹

¹⁴⁸ Dr. Lucas, an early pioneer in Berlin's physician-led human rights movement, described his perspective on the politicization of Berlin physicians; these experiences informed his future role as a pro-access movement leader (Morris, 2000). This perspective cannot be triangulated through other documentation or interviews, but it provides important insight into early events that grew the Berlin network of human rights-driven physicians. Dr. Lucas recalled that in the early 1990s the movement was linked to involvement in international human rights organizations such as Amnesty International and the International Physicians for the Prevention of Nuclear War (IPPNW), two organizations also cited by Canadian doctors as influencing early political involvement. Dr. Lucas explained that through these organizations, Berlin-based physicians joined an international delegation that sent them to Anatolia as official observers at the trial of physicians who were unwillingly implicated in government-directed torture. He recalled relaying the delegation's observations to other physicians through radio broadcasts, articles in medical trade journals, actions he felt slowly awakened the medical community to the human rights issues facing their own profession abroad. He also argued that the conversation around human rights and the medical profession also had spillover effects to peoples' awareness of issues within Germany, as an increasingly aware physician population encouraged the Berlin Physicians' College and indirectly, *Bundesärztekammer* to release statements and positions on human rights issues such as torture. This, he felt, primed the Berlin medical community to act when Berlin physicians were being similarly implicated in human rights violations.

¹⁴⁹ Dr. Torsten Lucas (physician), interview by author, November 2, 2016.

A final macro-societal, historically-based factor contextualizes German physicians' slow-to-start pro-access movement: German reunification. In 1990, the Federal Republic of Germany and the German Democratic Republic rejoined, with newly reunited Berlin as its capital. This created extraordinary financial and organizational strain as West Berlin absorbed the East Berlin medical system and with it, East Berlin medical providers. East German physicians had largely matured in a professional environment that was even further divorced from political action than their West Berlin counterparts. While there are certainly divergent examples (Roberts, 1991), residents of East Germany were systematically discouraged from questioning authority or challenging policies; even at present, "Many eastern Germans perceive all criticism of the system as a personal attack" (Schroeder in Bonstein, 2009: n.p.; see Deutz-Schroeder & Schroeder, 2008). Dr. Lucas argued that this depoliticization bled into the physicians' professional life, and further limited the potential for a Berlin-wide, physician-driven anti-*AsylbLG* campaign in 1993:

There was tremendous difference between Western Germany and Eastern Germany, on many, many issues. And of course, human rights, political freedoms, being politically active outside of the official party frame was completely new and had been threatening in the past for people of East Germany. If you had a political opinion and voiced it, your life, existence and professional career and so on could be threatened...Some wanted to get involved in human rights issues. But many others had the experience that it's always dangerous to get involved in these issues and had a personal biography or their parents did of cooperation with at least one dictatorial system that would be threatening to their identity.¹⁵⁰

As a result, the absorption of East German physicians into the West German system did not expand the realm of potential pro-access physicians. Rather, it created conditions that were further primed for low activist participation following the *AsylbLG*'s launch in 1993. Fascinatingly, Dr. Lucas recalled that after reunification, medical journals associated with East German medical associations began to respond to the overall movement's growth by reprinting articles that focused on Berlin organizations' human rights-oriented missions (see footnote 158). Reprinted in journals including *Brandenburgisches Ärzteblatt* and *Ärzteblatt Mecklenburg-Vorpommern*, these articles transmitted key learnings, history, framing and perceptions of West

¹⁵⁰ Ibid.

Berlin to their new East Berlin colleagues and supported the politicization of the medical profession in former Communist Germany.

Meso (Institutional) Level

Healthcare Systems Shaping Access. As in Canada and England, the German healthcare infrastructure plays a role in shaping how advocates navigate asylum seekers' access to care. Like England, Germany's healthcare payment system is the factor shaping asylum seeker access, though here, it is a contextual factor. The German system does not necessarily shape *advocacy*, nor does it directly open or close opportunities for advocates to push for change. Rather, the system intersects with existing practices around billing, as well as with the newly-implemented EHC to decrease barriers for refugee claimants. Interestingly however, while the health system explains claimants' fairly continuous but precarious access to care, it does not necessarily speak to either the government's choice to retrench the *AsylbLG* or the impact of physician groups. However, because the health system presents opportunity for physicians to leverage in order to expand access, it is worth exploration here.

To begin, Berlin's physician billing system has normalized providing free care for German patients, which may be a factor that encourages some physicians to provide care for asylum seekers even when there is little possibility reimbursement. Like Canada and England, the German system is premised on the principle of access for all permanent residents, regardless of income. It achieves this through the pioneering German Bismarck model's compulsory health insurance model ('sickness funds') that are funded by employer and state contributions. If a person is unemployed, they are enrolled in public insurance funded by their municipal government - in Berlin, through the *LAGeSO*. This system previously covered asylum seekers before the 1993 *AsylbLG* introduction. The *LAGeSO* still funds care at present, but through the more restrictive *AsylbLG* framework.

German general practitioners (GPs) operate as entrepreneurs in a similar way to Canadian family physicians. German GPs are divided into groups by region, which negotiate with insurance representatives to create annual budgets that are to be shared amongst the group. The annual budget is divided into quarters, such that the quarterly budget represents all spending that can occur by physicians within a three-month period. Physician group members submit their

patient billings to the sickness funds, which reimburse covered expenses but only until the quarterly budget is reached. Once the budget is exhausted for the quarter, physicians are no longer reimbursed¹⁵¹. At that point, some physicians will close doors to publicly insured patients while continuing to serve privately-insured patients, who are not subject to the quarterly cap (Knight, 2018). However, many physicians remain open and continue to serve their patients. This potentially creates a form of normative inertia around service, billing, and expectations in Germany's universal healthcare system.

Asylum seekers' claims are paid directly by municipalities and are not actually a component of the quarterly budget. Providing refugee care should not then factor into budgeting, as it will not financially displace citizens. However, it is the *practice* of serving people without expectation to be paid that is inculcated (begrudgingly) into many German physicians (Knox, 2008). This, argued interviewees, might be responsible for priming physicians to at least occasionally provide care to asylum seekers. As Dr. Ayse Linder, a German GP interviewed for this research stated: "I don't get paid for a lot of my patients, so how is this different?" While race-to-the-bottom social policy frameworks are problematic, the argument is that an institutional context primed for a given outcome (e.g., not being paid for all services) is more conducive to supporting additional instances of that outcome (e.g., not being paid for a rejected *AsylbLG* billing claim). Dr. Jonitz, *Ärztammer Berlin* President agreed that this reality works in asylum seekers' favour; he stated:

A good part of doctors' work, they won't get paid for. But this is normal. If you're working in a GP, every three months you get paid for two. So, one month is for nothing is normal anyhow, even to the ordinary German patients. So, when the relation between doctor and patient is okay they normally find a way.¹⁵²

While concern about reimbursement is a frequently cited reason for physicians to turn away persons covered under the *AsylbLG*, a lack of reimbursement is also par for the course for German doctors. Still, other factors could contribute to physicians' reluctance to serve asylum seekers, such as higher-complexity cases, or perceiving claimants as not entitled or deserving of

¹⁵¹ This top-level description of the German healthcare and billing system is suitable for this analysis but only scratches the surface of Germany's healthcare complexities, which as *Bundesärztekammer* member stated, "no one really understands". For a comprehensive overview, see Institute for Quality and Efficiency in Health Care (2018).

¹⁵² Dr. Günter Jonitz (President, *Ärztammer Berlin*), interviewed by author, August 4, 2016.

benefits or concern that their actions may not be covered under physicians' liability insurance (e.g., Jacklin, 2015). On the other hand, this assumption that care would be provided without cost might discourage even supportive physicians from treating asylum seekers, on the grounds that the state's burden of responsibility should not be shifted to compassionate doctors. This stance is in line with MediBüro's campaign (see: *Meso Organizational Level*)

A second feature of Berlin's healthcare system is also supportive of the pro-access movements' demands: the EHC. Beyond simply improving access by folding claimants into normal payment processes, the card also privatized back-end claim processing. Statutory health insurers are contracted to issue the cards and process claims using existing infrastructure. Municipalities then pay a per-claimant fee for processing, either as set amount (e.g., Berlin pays 10 Euro per month per claimant) or as a percentage of overall claims (e.g., as does North Rhine Westphalia) (*Gesundheit-Geflüchtetete*, 2018: n.p.). However, insurers are not equipped or, for financial reasons, not willing to assess what is an 'emergency' or what is 'acute or painful' as per the *AsylbLG*'s restrictions. Recall that this restriction requires interpretation; there is no fee schedule or list of restricted services. Insurers, already potentially reluctant to provide this service, do not employ or train persons to assess a claim's validity; the experience of interviewed persons was that most often, if a claim is made, a claim is reimbursed. Financial incentives trump political or rhetorical incentives associated with the state's performative restrictions on care. As a hospital-based Berlin physician noted, "Until it is cheaper to start sorting through what is covered and what is not, the insurer will just pay. It's a company at the end of the day".¹⁵³ Interestingly, this was the recommendation from Bozorgmehr and Razum (2015), in their cost-benefit analysis on the restrictions of the *AsylbLG*. They found that reimbursing the majority of claims would produce more positive economic outcomes than assessing claims and re-assessing appeals.

Importantly, while this system provides an informal continuity of access to care, these provisions are fraught and insecure. Interviewed persons raised concern that municipalities may impose new restrictions to limit access. The system also positions doctors as the true gatekeepers to care – for as long as they agree to provide care (whether reimbursed or not), asylum seekers will have access. However, aside from financial barriers, questions of quality of care related to

¹⁵³ Dr. Anja Mayer (name has been changed) physician (*MediBüro*), interview by author, August 2016.

cultural competence of doctors still loom large. Without targeted efforts to address those issues (as noted above, this includes cultural competence training, anti-racism training), the likelihood of this informal system of asylum-seeker healthcare provision translating into a more secure systems change is uncertain. Advocates thus perceived the EHC as a gap-fill, and that legislative reform was needed. At present however, it can be said that in a rather unexpected turn, privatization has improved services and access to persons of precarious status, with potential for continued impact on claimants' health access¹⁵⁴.

Meso (Organizational) Level

Wide-Breadth Strategy and Disparate Impact. Germany differs from Canada and England in two core features of the pro-access campaign: who is lobbying for change, and the approach these advocates are taking. The Canadian movement, and to a lesser extent the English movement are defined by the actions of a newly formed, purpose-driven organization that set the protest agenda and repertoire within a short, defined period of time. The longstanding German movement has consisted of many organizations and individual actors that focus on various pieces of the *AsylbLG* puzzle, deploy various frames to communicate their message, and target various actors and levels of government in an attempt to make change. Longstanding pro-access organizations including MediBüro and the *VdÄÄ* have driven the movement but likely limited its ability to shape policy because of their lack of frame resonance and weak societal position (Morris, 2000). This section focuses on the movement's overall disposition with particular attention paid to the major players involved in the movement since its 1993 inception; where attributable evidence is available, links to their particular impacts are made.

The German pro-access movement, like that of Canada and England, supports Morris' (2000) assertion that there is a reciprocal relationship between ability to mobilize on the one hand, and political opportunities that create potential for impact on the other. That is to say, collective action can create political opportunity and vice versa; which comes first is a function of "empirical grounds rather than on *a priori theorizing*" (Morris, 2000: 447). In the German

¹⁵⁴ However, while the card reduced some of the tactile barriers associated with the 'green slip' system (removing the requirement that claimants renew their 'green slip' quarterly, that requests for medical care be assessed by a bureaucrat), many cards, including that in Berlin indicate that the claimant's care is limited to that described in § 4 and 6 of the *AsylbLG*.

case, reform sparked collective action; however, the action's biggest impact came after it strategically reorganized as *StopAsylbLG.Org* following an opening in the system.

Movement Composition and Framing: Pro-Access Actors, Organizations and Messaging.

Physicians, medical students, and nonprofit refugee aid groups play integral roles to advocating for increased care, while larger international groups (e.g., German Red Cross) also support the agenda (Laubenthal, 2011). The settlement sector, an area devolved largely to municipalities is present but plays an arguably less activist role than the longstanding Canadian settlement sector. Unique to Germany is the core role of churches and Christian-based religious organizations in supporting asylum seekers. This support primarily comes through the church asylum movement (*Kirchenasyl*), which supports churches providing sanctuary to people facing deportation. As a Christian-majority nation with Christian-oriented parties elected to power, the strength of this sector is perhaps not surprising. Faith-based organizations have long supported asylum seekers' needs, including delivering healthcare in Berlin, such as the *Malteser Migranten Medizin*. These organizations demonstrate the variable forms 'advocacy' can take. Like many pro-access physicians in Berlin, the major church organizations are political in their provision of care. However, while faith-based organizations such as *Diakonie Deutschland* and *Asyl in der Kirche* supported the *StopAsylbLG.Org* campaign, such organizations have played a limited role in the pro-access movement's positive activism, such as by lobbying government or calling for change to the *AsylbLG*.

Interviews supported similar findings by Castañeda (2012): activists and faith-based organizations approached the question of asylum seeker support through different lenses. While advocacy organizations like the MediBüro take more 'radical' approaches to disturb the policy landscape, Germany's church-driven religious movement prioritizes service over disruption. While radical Berlin organizations also provide asylum seeker care, church-based initiatives have institutionalized the process. For example, church clinics have historically kept records of patients, and for all intents and purposes are comfortable acting in the government's stead. The advocacy work of faith-based organizations is important, humanitarian and impactful, but remains largely localized at the individual level such as providing individual claimants with support. This work is political in that it signals the deservingness of asylum seekers to receive care, and resists state-level urging for institutions and practitioners to exclude claimants.

However, faith-based organizations are not activist in a positive sense, and there are limited efforts to insert faith organizations into policy discussions or to change asylum seekers' legislated entitlements.

Campaigns and demands from the non-faith-based, more radical pro-access movement, especially that which grew around the MediBüro, are punctuated with calls for abolishing federal legislation, dismantling broader systems of oppression, and providing healthcare for anyone in need, regardless of status. The MediBüro does provide necessary services for free, but they do so anonymously to limit patients' exposure to government interference. Moreover, volunteers critically reflect on the effects their free labour may have on perpetuating claimants' exclusion from the healthcare system. They perceive their service as necessary but describe this work as “dishonourable”¹⁵⁵. This and the provision of care by faith-based organizations are critical but create unintended consequences for the pro-access movement. Dr. Kühne argued that when non-government healthcare provision becomes informally institutionalized, this lessens pressure on the federal and *Länder* governments to enact any change:

It could be a very convenient way for politics to direct the problem to someone else. If you find an NGO that is good enough to provide healthcare, the political pressure gets much lower. This is what happened after Malteser, an NGO...they actually got one of the highest honours of the state, given to you by the Chancellor. It's in a way cynical to provide someone the highest state honour for providing healthcare for people the state should provide healthcare for.¹⁵⁶

MediBüro was formed in 1994 in Hamburg in response to the *AsylbLG* and in Berlin in 1996, and now has twelve locations across Germany. Driven primarily by medical students and those in the anti-racist movement, MediBüro provided care to those who were no longer covered for all services or who faced deportation threat for accessing services. Since its founding, MediBüro's main focus has been serving undocumented persons, but their campaigns focus around abolishing the *AsylbLG* to open healthcare for all. They run annual and ongoing campaigns directed at government, including *Solidarity City – Stadt für Alle* and *Against Foreclosure and Illegalization - gegen Abschottung und Illegalisierung*. These campaigns are

¹⁵⁵ Dr. Anna Kühne, interviewed by author, November 3, 2017. See also MediBüro (2016); the 20th anniversary of MediBüro publication, “Controversy over voluntary work in times of refugee failure”.

¹⁵⁶ Dr. Anna Kühne (physician – *MediBüro, StopAsylbLG.Org*), interviewed by author, November 3, 2016.

indicative of the organization's approach to improving access to care: social rights, including the right to remain in Germany are intertwined by healthcare rights. To this end, additional campaigns are directed at informing asylum seekers and providers of claimants' rights and steps to access care, such as the *Gesundheit-Gefluechetete* website portal. Their approach and list of demands is wide and indiscriminate towards residency status: they call for full, undifferentiated healthcare access for asylum seekers, irregular migrants, tolerated persons and anyone else not covered by Germany's statutory insurance system. Coupled with their anarchist stance, left-leaning disposition and calls for radical state transformations, MediBüro is a critical voice in the pro-access movement. However, given their anti-state position and 'radical' inclusion agenda, organizers and supporters rarely see eye-to-eye nor have meaningful conversations with state representatives on issues of healthcare access.

This encompassing 'healthcare-for-all' approach is held by most members of the Berlin pro-access movement, and indeed the German movement more broadly. Along with MediBüro, other 'radical' organizations that have historically driven the call for *AsylbLG* change include the *VdÄÄ* (Democratic Doctors) and Pro-Asyl, a national organization founded in 1986 to improve asylum seekers' livelihood in Germany. Other organizations working in the space support these organizations' advocacy but focus on more immediate, local mandates. For example, *Ärzte der Welt* (Doctors of the World Germany), an organization that plays a critical role in England's lobby provides care to people in need via the Berlin *Ärzte der Welt* clinic. Like the MediBüro, the clinic is anonymous however unlike the MediBüro, it does not engage in activist campaigns in Germany. However, an interview with representative Johanne Offe suggests that *AdW* is increasingly becoming more 'outwardly' political by taking policy stances on issues like the *AsylbLG* (e.g., *Ärzte der Welt*, 2015) in an attempt to elevate *Ärzte der Welt*'s impact from the organizational level to supporting systems change.

This broad approach likely limits the movement's short-term impact. Unlike other analyzed cases, German advocates are historically unsuccessful at identifying their movement within a broader agency-laden institution that resonated with the greater German public or with government officials. The encompassing demand of *healthcare for all* was incongruent with current political fears around high numbers of 'Other' entering Germany. It also reminded citizens of the limits of German healthcare universality. German social citizenship is linked to employment-based contributions and ethnic ties. As asylum seekers and irregular migrants, the

two groups merged together under the movement's frame, have claims to neither it was not controversial for citizens to reject the movement's demands. A more strategic institution through which to ground the movement may be through an anti-Nazi era agenda, whereby the 1993 Asylum Compromise and *AsylbLG* are continually and visually linked in the pro-access movement messaging. While these reforms were packaged, the movement focuses mainly calling for the *AsylbLG*'s abolishment. Decontextualized from the 1993 Compromise – and its perceived pandering to neo-Nazi violence, its reform of the postwar Basic Law principle of asylum, and its nods to 'keeping Germany German' – abolishing the *AsylbLG* may not resonate as relevant with everyday Germans. This is also true for the highly institutionalized and respected organizations involved in the German movement, such as the *Ärztammer Berlin* (Chamber or College of Physicians). Despite longstanding ties to the community as well as symbolic and real power, the College did not hook their message to a greater German institution other than, 'this is the right thing to do'. While this was arguably an important tool to gain German physician members, it did little to invite everyday Germans to join the conversation.

More mainstream major organizations also exert considerable pressure in Berlin and at a national level, including Amnesty International, the German Red Cross, and faith-based international organizations including Caritas, a Catholic charity organization, and Diakonie, a Protestant charity organization (Zetter et al., 2003; Hailbronner & Peek, 2006). The Berlin Centre for Torture Victims (*bzfo*) is a strong voice on the issue and has also played an important role in the training and politicization of advocate doctors, including Dr. Torsten Lucas who was interviewed for this project. Individual physicians undertake everyday acts of resistance (Isin, 2008) by serving patients in their own practice, volunteering with organizations like *Malteser* and *MediBüro*, and publishing articles on asylum seeker access from a variety of frames. These include from a human rights and international law perspective (Eichenhofer, 2013); with regards to political opportunity created by court challenges (Janda, 2013); and think-pieces in professional outlets such as the *Ärztammer Berlin*'s journal *Berliner Ärzte* (e.g., Bobbert, 2015; Franz, 2010; Wein, 2015).

Despite their collective resistance, individual doctors and organizations' resources are stressed. Combined with Germany's decentralization and high level of variation in organizations' and cities' needs, this limits their ability for coordination and top-level strategic planning. Instead, organizations are siloed, deploying different messages, different 'asks' of government,

and speaking to different audiences. A summary of key actions by major organizations can be found in Table 8. This table represents information gleaned from interviews, publications, and online repositories and is not exhaustive

Table 7: Select Examples of Germany's Pro-Access Repertoire

Organization	Description
MediBüro	<ul style="list-style-type: none"> • 33 locations across Germany • Connects persons without coverage to volunteer physicians <p>Repertoire: Direct service provision</p>
VdÄÄ	<ul style="list-style-type: none"> • Late 1960s: Started as strategy group to eliminate Nazi physicians from high-ranking positions in German medical establishment, including the <i>Bundesärztekammer</i> and <i>Ärztekammer Berlin</i>; now, chapters across Germany lobby physicians' organizations to pass resolutions on access to care for persons regardless of residency status <p>Repertoire: Direct service provision</p>
Ärzte der Welt	<ul style="list-style-type: none"> • 2 locations across Germany; clinics for undocumented persons/persons without coverage <p>Repertoire: Direct service provision and policy reports</p>
Pro-Asyl	<ul style="list-style-type: none"> • Works on all issues relating to asylum seeker acceptance and settlement in Germany and the European Union <p>Repertoire:</p> <ul style="list-style-type: none"> • Public relations and campaigns • 2008-2009: Campaign with postcards and direct action (e.g., petitions) at Bundesrat • Press releases reiterating stance
Malteser Hilfsdienst	<p>Repertoire: Free clinic for uninsured persons (opened 2001)</p>
<i>StopAsylbLG.Org</i>	<p>Repertoire:</p> <ul style="list-style-type: none"> • Lobby municipal and federal politicians to communicate demands • Public awareness campaign including press releases and accessible website
Individual physicians	<p>Repertoire:</p> <ul style="list-style-type: none"> • Provide help within own private practice • Volunteer for free clinics • Publish articles in trade and academic journals (e.g., <i>Berliner Ärzte</i>)

Institutional Actors and Legitimacy. In addition to the role played by social movement organizations and individual physicians, institutional actors have also had a political presence since the 1993 *AsylbLG* reform. The *Ärztekammer Berlin* (“the College”), a regulatory college

akin to the College of Physicians and Surgeons of Ontario, partnered with local refugee-rights organization Flüchtlingsrat Berlin and nationally-based Pro-Asyl in 1998 to produce *Medicine in Handcuffs*. The publication includes stories of claimants who were denied rights and the struggles faced by doctors as a result of the *AsylbLG*. This is in addition to leaflets and information for physicians informing them of their rights in the past two decades. The Berlin College supported the call for all patients to have full health access by issuing statements and called for stronger advocacy at the national level by initiating or supporting annual resolutions in the *Bundesärztekammer*. As noted previously, the Berlin College also cooperated with groups such as the *VdÄÄ* and the Berlin Centre for Torture Victims (*bzfo*) on issues such as asylum seeker deportations, a success Dr. Torsten Lucas attributed in part to their coordination with different refugee groups and physician media outlets like *Deutsches Ärzteblatt*. However, like other organizations, the College are also constrained by resources and a wide mandate to advocate on behalf of their members and all German residents on issues of health. Political support within the College is indicated since 1993 but advocacy fatigue, combined with the aforementioned factors that suppressed their political expression (see *Macro Level Societal*) worked in concert to stem impact.

Conversely, the Berlin Centre for Victims of Torture (*bzfo*) is a strong voice on the issue and has also played an important role in the training and politicization of advocate doctors since its inception, as well as fact-sharing publications (Pross, 2002; Graessner & Wenk-Ansohn, 2000). Recently, under the auspices of advocate Dr. Frank Montgomery (see *Micro [Individual] Level: Social Capital as Resource*) and following the 2015 arrivals, the *Bundesärztekammer* has ramped its campaign support considerably. This support was less visible in the 1990s when organizations were averse to politicization, leading Pross (1998) to assert that “[p]rofessional organizations must use their lobbying power to support these efforts and counteract further erosion of the access these individuals have to the health care system” (50).

Courts as a Venue for (Indirect) Change. Following the analysis above, discussion of *the courts* would typically be located at the institutional level. However, because here, advocates did not launch a judicial challenge, it becomes a question of German tactics. German advocates’ court aversion is the culmination of strategic decisions and resource depletion. It’s not because the German movement is less litigious, or that courts are inaccessible for advocates of asylum seeker

benefits. Indeed, lower-level courts are very active venues for individual persons to challenge the refusal of their entitlement to program benefits under the *AsylbLG*; between 1993 and 2015, more than 3000 decisions were recorded on the *AsylbLG*, SGB 11 & X11, work permits, child benefits, and other social entitlement decisions (Classen, 2015). However, unlike their Canadian and English counterparts, German physicians have yet to challenge asylum seeker healthcare's constitutionality. Interviews with advocates, including those involved in court challenges suggest that advocates do not view the court as an appropriate venue in which to involve medically-precarious asylum seekers and moreover, do not perceive the move as strategic or likely to find in their favour. This is surprising given the difficulties many physicians reported experiencing when attempting to be reimbursed for providing care.

While constitutional challenges are ultimately decided in the Federal Constitutional Court (*BVerfG*), there are three routes through which to launch a challenge. First, a Land government can demand the Federal court review legislation, a politically unlikely scenario vis-à-vis the *AsylbLG*. While Land-level SPD-led coalitions may express support for the pro-access movement's efforts and a desire to reform the *AsylbLG* as in Bremen and Hamburg, it faces barriers translating this to impact at the federal level, as their federal SPD counterparts have limited social capital in the coalition government and will likely prefer to focus on reforms with more universal public appeal, or at least those supported by the main governing party such as the CDU¹⁵⁷. Second, 25% of Bundesrat could agree to demand a review, though for the reasons outlined above, this is also unlikely especially in light of the 2015 asylum seeker arrivals. Land governments and their subunits will continue to resist supporting asylum seekers' social welfare, argued DLK representative Jörg Freese, as a means of appearing to assert power and protect the interests of their citizens¹⁵⁸. Finally, an individual(s) can also launch a constitutional challenge. On its face, this appears to be the most accessible route for advocates in Germany; this was the route taken in Canada and in England. Indeed, it was the route taken by Pro-Asyl in 2012 when it successfully challenged § 3 of the *AsylbLG*, which governs cash benefits paid as part of

¹⁵⁷ Future research could further examine the restraints placed on *Land* governments' ability to push more contentious immigration agendas at the federal level as a result of the restrictions created by coalition politics.

¹⁵⁸Freese suggested that German governments began using asylum seeker healthcare as an opportunity to signal their political clout to voters in the asylum seeker debate. By not implementing the asylum seeker health card or supporting any call for reform, states asserted their sovereignty in the greater German refugee debate. Vocal calls from states to not expand healthcare services made clear to voters that state-level autonomy was still central even if asylum seekers were arrived in their borders without their consent.

social assistance; critically, Pro Asyl did not attempt to challenge § 4 and 6, which govern health. Pro-Asyl successfully argued that § 3's benefits were below subsistence levels as they had not changed since the legislation's introduction in 1993. On the basis of Article 1.1 of the Basic Law, in conjunction with the principle of the social welfare state in Article 20.1, it found that differentiating cash payments on the basis of residency status was discriminatory, and that current levels prohibited asylum claimants from enjoying a dignified minimum existence (*BVerfG, 2012*).

The Act to Amend the Asylum Seekers' Benefits Act and the Social Court Act reflected revised § 3 benefit levels, and took effect on March 1, 2015. It reduced the wait time for claimants to be mainstreamed into mainstream social benefits (including healthcare, housing, and financial support) from 48 months to 15 months. This meant that claimants would only be covered by the *AsylbLG* for 15 months or until their claim was accepted, after which they would receive the same healthcare coverage as German citizens. The 2014 Act also amended the *AsylbLG* to list the preference for in-kind benefits over cash benefits as applying for only the claimant's stay at an initial reception centre (BAMF, 2015).

A court challenge was not supported by any interviewees as an appropriate or strategic response to amending the *AsylbLG's* § 4 and 6 health provisions, however. First, advocates expressed concern around the ethics and practicalities of recruiting an individual(s) to act as the challenge's applicant. The § 3 challenge took several years to complete (2010-2012), an extended and time-consuming commitment for the affected person to endure. Said person must also be willing to be named or potentially identified in this case and be comfortable challenging the German government on this issue; this was described by the Pro-Asyl legal representative as "difficult to find". Advocates also perceived it inappropriate to 'ask' claimants to stand trial, given the social and personal strains this may cause especially for a person seeking protection from Germany: "The interest of asylum seekers may be different than those of Pro-Asyl. As a refugee rights organization, we must respect the interests for the refugee and not Pro-Asyl's strategic interests."¹⁵⁹

Finally, finding the ideal person to test the case poses pragmatic difficulties. The recruited person must meet a set of characteristics or circumstances that make them an ideal

¹⁵⁹ Dieter Lange (name has been changed) member (Pro-Asyl), interviewed by author, August 2016.

plaintiff for the case, as the applicant's experience will be used to judge the acceptability of the *AsylbLG*'s medical provisions. If the applicant's experience is not able to withstand judicial scrutiny and the court disagrees with the challenge, this can lead to a verdict that is *more* restrictive and *more* constraining than the status quo. Recruiting plaintiffs for the *AsylbLG* § 3 challenge was described as extremely difficult¹⁶⁰, and the task of finding the 'right' person who met objective medical needs and were subjectivity deserving of the court's sympathy is a high order – in fact, both the Canadian case and the *AsylbLG* § 3 case strategically included children to encourage an empathetic read of the applicants. Indeed, each claimant interviewed expressed concern that the *AsylbLG*'s interpretability and discretion may be restricted if a court challenge is unsuccessful, creating further hardship and limitations than at present. This again highlights the legislation's ambivalent wording as mechanism of both inclusion and exclusion. *Ärztammer Berlin* President Dr. Jonitz stated:

To try and argue to get the *AsylbLG* defined properly might be problematic as, same as in the situation of the court case, they may be told a very narrow definition and once that is decided or responded to, and is done so as 'narrow', they are in a real bind. At least now they can pivot and maneuver with the vague definition.¹⁶¹

Difficulties identifying the 'right' applicant is in part linked to organizations' limited resources, including time and money. This is in part linked to their highly dispersed movement, which duplicates efforts and strains resources (see *Macro (Societal) Level: Federalism, Autonomy and Decentralization*). While similar difficulties were likely present for the § 3 challenge, the claim – that claimants received below-subsistence levels of funding – was easier to measure as it was backed by clearer-cut data, which was not available for health-related issues. It was thus less vulnerable to these issues that would potentially compromise the claim.

The Courts and Political Opportunity. While the pro-access movement did not perceive a direct challenge as tenable, opportunity for change arose during two court-driven openings of the political system: the 2012 amendment of § 3 of the *AsylbLG*, and the 2015 deadline to implement

¹⁶⁰ Two plaintiffs were recruited: Plaintiff 1 was born in 1977 and arrived in Germany 2003. They applied and were rejected for asylum and now live as a tolerated person in a communal shelter. Plaintiff 2 was born in 2000 and living in Germany as a foreign national in a private rental apartment.

¹⁶¹ Dr. Günter Jonitz (President, *Ärztammer Berlin*), interviewed by author, August 4, 2016.

EU Directive 2013/33. These political opportunities refer to “dimensions of the political environment” that incentivized German advocates “to undertake collective action by affecting their expectation for success or failure” (Tarrow, 1994:85). Court decisions forced the opening of German legislative institutions and created new access points for the pro-access movement and gave rise to hope that the pro-access movement had improved chances to reform the *AsylbLG* § 4 and 6.

Following the successful 2012 challenge, legislators were given a defined period to rewrite § 3 to comply with the Court’s ruling that it violated Article 1 of the Basic Law. This amendment provided a defined window where the *AsylbLG*’s healthcare provisions might credibly be reconsidered alongside § 3, while also providing a rights-based discourse for advocates to challenge the healthcare provisions. Advocates identified this as a political opportunity to reform the *AsylbLG* without the risks posed by a direct court challenge, and thus advocates sought to leverage the court’s ruling to challenge the remainder of the legislation. This opportunity sparked the launch of *StopAsylbLG.Org* in 2012, a coordinated, physician and medical student-led organization driven by MediBüro volunteers. While *StopAsylbLG.Org* was connected to MediBüro and the *VdÄÄ*, it represented a strong departure in strategy and efforts of volunteers thus far (see: *Meso Level [Organizations]* for a description of strategy).

Most importantly, *StopAsylbLG.Org*’s mission was singular and focused: to target identified federal politicians and civil servants who were positioned to support their goal of applying the Federal Constitutional Court’s findings to §§ 4 and 6 of the *AsylbLG*. However, the political climate at the time, alongside little historic push from Länder governments to mandate higher minimum standards, created little political will to open healthcare offerings further at a time of unprecedented asylum seeker arrivals amidst a highly skeptical German public (*Gesundheit-Gefluechetete*, 2018: n.p.; interviews, *StopAsylbLG.Org* members). Still, an important change was included in the *AsylbLG* amendment. On December 10, 2014, the federal parliament implemented the Act to Amend the Asylum Seekers’ Benefits Act and the Social Court Act amended the *AsylbLG* to list preference for in-kind benefits over cash benefits as applying for only the claimant’s stay at an initial reception centre, as was intended by the Pro-Asyl-supported challenge. However, the amendment also reduced the length of time asylum seekers must wait before being mainstreamed into healthcare from 48 months to 15 months (BAMF, 2015). This did not change the *AsylbLG*’s restrictions on access, but it did shorten the

time claimants were *subject* to restrictions. These changes took effect on March 1, 2015, just as the number of asylum seekers arriving in Germany began to increase.

Interviewed advocates were hesitant to call this a ‘success’. A success to the most ardent members of the pro-access movement would be abolition of the legislation’s restrictions. However, the group re-launched their campaign when another opportunity opened following the passing of the European Union Directive 2013/33. The EU Directive (notably, passed prior to the 2015 arrivals) required member states to provide benefits that allow for an “adequate” standard of living “that guarantees their subsistence and protects their physical and mental health” (EU Directive, 2013). *StopAsylbLG.Org* argued that in order to fulfil the EU Directive and provide adequate care to vulnerable groups, a sweeping reform was necessary in order to be able to even first *identify* these vulnerable groups – that is, regular access to care was needed to first identify and reach those who would need additional care as a ‘vulnerable group’. However, despite the Directive exerting downward pressure on German institutions from the supranational level and the movement exerting upward pressure from the grassroots, efforts did not translate to eliminating restrictions on care at the federal level.

Interviewees likened the lack of political will to that expressed earlier that year under the *AsylbLG* revision; the risk of pushback from voters and from states who would be required to implement changes would be high. While some states had signaled pro-asylum seeker stances such as Bremen and Hamburg, others (e.g., Bavaria) had supported earlier extensions of the *AsylbLG*’s timeline mandate (see Table 4) and were expressly anti-expansion. In addition to the limited foreseen political benefit, the EU’s June 2015 implementation deadline dovetailed with the arrival of the first wave of asylum seekers to Germany, creating particularly limited political appetite amongst states and voters.

However, so too did this opportunity elicit a secondary consequence. The pro-access movement, alongside the 2015 asylum seeker arrivals likely prompted Berlin’s adoption of the EHC in December 2015. In part because Berlin is the seat of the federal government, many of the *StopAsylbLG.Org* members were based in Berlin, and during efforts to support the EU Directive, the movement simultaneously focused on delivering Berlin’s parliamentarians information on the ‘Bremen Model’ to encourage EHC adoption. The arrivals of nearly 80,000 asylum seekers in Berlin in 2015 placed unprecedented pressures on the local *LAGeSO* and

associated ministries¹⁶² as well as local physicians. This implored organizations including the *Ärztammer Berlin* (2015b, 2015c) and the greater pro-access movement to lobby for streamlined processes and the EHC's introduction. The card's introduction is framed by a MediBüro-run website, *Gesundheit-Gefluechetete* as a “compromise” with advocates in response to their more extreme demands of eliminating the *AsylbLG* earlier that year (*Gesundheit-Gefluechetete*, 2018: n.p.).

StopAsylbLG.Org: New Direction in the Berlin Pro-Access Movement. The support of professional organizations was most recently seen in the launch of the *StopAsylbLG.Org* campaign¹⁶³, a collaborative effort by the MediBüro, *VdÄÄ* and medico international, a government-supported humanitarian relief organization. The movement sought to leverage two institutional openings prompted by the 2012 Federal Constitutional Court ruling and the 2015 European Union Directive 2013/33 (*see: Meso [Institutional] Level: Courts*). The German case shows that new political opportunities can also discipline existing groups to take on new organizational forms that reflect the new venues in which they are operating, as in the Canadian case. Yet groups may incentivize a strategic trade-off of frames and goals, if the opportunity appears fruitful enough to be warranted.

We can see an example of strategic frame-changing in two new campaigns that were launched in response to two openings in the German political system, both of which were marked departures from advocacy efforts thus far. First, the campaign had a singular and sole target: to influence members of the *Bundestag* as they implemented the 2012 constitutional amendment and considered the 2015 EU directive implementation deadline. Gathering around a singular message allowed the organization to spend their resources and energy wisely and create a cohesive messaging strategy free of contradicting demands. Second, the campaign's target was narrow and positioned itself within existing legislative frameworks. Instead of demanding the

¹⁶² Berlin-specific data pre-2015 is not available. However, to contextualize this in recent German asylum history, Berlin's 80,000 arrivals is compared to 173,100 for all of Germany in 2014, 109,600 in 2013 and 64,500 in 2012 (UNHCR 2014, 2015, 2016). This indicates the lack of institutional preparedness in Berlin for the 2015-2018 Syrian and surrounding states' asylum seeker arrivals.

¹⁶³ The *StopAsylbLG* campaign was supported by Doctors of the World, the German Bar Association, Republican Lawyers and Lawyers Association, the National Association of Psychosocial Centres for Refugees and Torture Victims, Diakonia Germany, Refugee Council Berlin, Ecumenical Federal Association of Asylum in the Church, Pro-Asyl, Parity Welfare Association, International Physicians for the Prevention of Nuclear War (IPPNW) and their student groups.

AsylbLG's abolition, advocates called on targeted actors to include revising §§ 4 and 6 in its court-mandated revision of § 1. Third, the campaign strategically leveraged images of deservingness and inclusion. Understanding that irregular and tolerated migrants were politically incompatible with the political scope, the campaign focused on the inclusion of legally-registered asylum seekers. Dr. Kühne stated:

For the first time the focus shifted from undocumented migrants to asylum seekers very specifically. We realized we couldn't argue for this law to say it's also bad for undocumented migrants – I mean, it's bad for them anyway because they can't use it – but it was the first time there was a decision in light of knowing there's no common ground getting better access for undocumented migrants, there have been many different initiatives in different cities with varying success. But no, we didn't have the feeling we could on a national political level gain any ground for say abolishing article 89 that says undocumented migrants need to be notified to official institutions. We decided for very pragmatic reasons we said that we won't get through them.

Regarding strategy, Dr. Kühne continued:

So, on very pragmatic grounds, we decided we would try for the first time to do campaigning... We very systematically addressed all those candidates – I think we left out the CSU, because we thought there was no common ground to find – but we directed all our efforts to members of the Green Party and SPD thinking that the Left would be on our side anyway... We found out who exactly were the people who are in these groups that first discuss everything in the Bundestag. We sent them letters, talked to them on the phone, and tried to meet a couple of them and had really extensive work from a lot of people to get in direct contact.¹⁶⁴

Commenting on the *StopAsylbLG.Org*'s branding Dr. Ben Wachtler stated that the *StopAsylbLG.Org* website contained messaging that would be palatable for the average physician, an important secondary audience to the campaign:

In terms of 'health for all' traditional activist messages, and also very comprehensive information on every little detail you'd need to know as a doctor or as a region to provide care. The website doesn't look like a MediBüro website, it looks more like a health insurance website.¹⁶⁵

¹⁶⁴ Dr. Anna Kühne (physician – *MediBüro, StopAsylbLG.Org*), interviewed by author, November 3, 2016.

¹⁶⁵ Dr. Ben Wachtler (physician – *VdÄÄ*), interviewed by author, November 3, 2016.

Two campaign members referenced the importance of cross-sectoral collaboration, including outward support from by the *Ärzttekammer Berlin* and *Bundesärztekammer*, a purposive strategy that lent legitimacy to advocates oft-characterized as ‘radical’ and leftist:

Some MediBüros had existed since the 1990s, and some people had been doing this since the 1990s. And there were people who weren’t active for so long but had backgrounds in law, social work and are also in contact with many different organizations. So in a way it’s a very effective network to work with other NGOs on such topics. Just to have this network was just once person but many different people who knew people who could help to find expertise.¹⁶⁶

We’d been doing a lot of lobbying by saying ‘Hey look, even the Ärztekammer – not a radical left-wing organization’. You find some common ground by saying, even the Ärztekammer thinks it a problem...It helps a lot for the political argument to have these things and that’s a lot of what the *VdÄÄ* does.¹⁶⁷

Despite taking an approach more consistent with Canadian Doctors for Refugee Care (CDRC), one factor differentiating *StopAsylbLG.Org* from the CDRC was resources. The CDRC, though self-funded, was able to secure the support of a hired public relationships professional and was led by several senior physicians with hospital-based job security. In contrast, the *StopAsylbLG.Org* movement was run by physicians who were largely self-employed GPs. The movement was also driven in large part of medical students. Perhaps importantly, German physicians are typically paid less than the average Canadian or British physician (Knox, 2008).

Micro (Individual) Level

Social Capital as Resource. The German case shows that social movement leaders with organized followings are an important means of mobilizing resistance, but the social power and positioning of these followers is paramount. While the majority of movement’s leaders have experience leading organizations, and these organizations are agency-laden these are institutions with limited societal resonance (i.e., they are self-described as anarchist and anti-racist). Even

¹⁶⁶ Moritz Pfeiffer (medical student, *MediBüro*, *StopAsylbLG.Org*), interviewed by author, August 3, 2016.

¹⁶⁷ Dr. Ben Wachtler (physician – *VdÄÄ*), interviewed by author, November 3, 2016.

leaders who can successfully assemble and mobilize their institutional members will be stunted if the core movement frame does not resonate with everyday citizens. Arguably this differs at the national level under the current *Bundesärztekammer* president. However, Dr. Montgomery's relatively resonating and digestible calls to action are lost in the cacophony of voices, fears, calls to action and uncertainty surrounding Germany's responsibility to the 2015 arrivals.

Indeed, many acts of resistance and protest are undertaken daily at the individual level. Dr. Lucas recalled the importance of micro-level defiance in the early years of the pro-access movement:

Many people got involved with individuals, either in their medical practice or their hospital or in their private community... They would invite someone to breakfast or issue a [stay on deportation] certificate, or find a doctor that would be willing to treat them without payment. Very useful but far less political than the stuff we're talking about now. So many different ways of trying to support us as we co-exist.¹⁶⁸

However, as noted the atomization of advocacy also has damaging effects as doctors may serve claimants and navigate the *AsylbLG* reimbursement schemes quietly, outside the broader networks of supports. This is positive for patients, who receive necessary medical treatment. However, individual acts of resistance can be less than the sum of their parts. An interview with Renate Schüssler, a retired Berlin-based pediatrician with strong advocacy roots found that especially before the 2015 arrivals, physicians who do not serve a high volume of refugee patients remain disconnected from resources and networks that would benefit their practice. This is in part because many doctors view helping asylum seeker patients as simply a component of their job. The result is feelings of isolation, burnout, and delivering care in difficult environments without necessary institutional supports, such as translators. Conversely, joining networks of other physicians was seen as amplifying efforts and creating cascading effects as the cause and the cause's main supporters – white coat wearing physicians – become more visible.

Interviewees also noted two key figures as instrumental in shaping the current pro-access movement: Dr. Ellis Huber and Dr. Frank Montgomery, former and current Presidents of the *Ärztekammer Berlin* and *Bundesärztekammer*, respectively. Interviews with physicians involved since the 1990s as well as current medical students described both as pioneering leaders in the

¹⁶⁸ Dr. Torsten Lucas (physician), interview by author, November 2, 2016.

refugee health movement. Dr. Huber's early professional alignments and interactions with key institutions such as the *bzfo*, and Dr. Montgomery's leadership during times of professional openness (i.e., the 2015 arrivals) proved instrumental in the asylum seeker healthcare movement and demonstrate the importance of critical actors in agenda-setting and determining the direction of a well-established organization.

2015: Changing Germany's Relationship with Refugee Claimants. At the tail end of this project's analyzed period is the unprecedented arrival of over a million asylum seekers to Germany, starting in 2015. Critically, these arrivals did *not* prompt changes in the *AsylbLG*'s health provisions¹⁶⁹. States and municipalities felt increased financial pressure to provide the legislated minimum standards, let alone the health services needed by claimants arriving with previously unseen medical and mental health conditions¹⁷⁰. However, these arrivals drove awareness and engagement within the German healthcare profession, and likely catalyzed the introduction of the EHC in Berlin in 2015.

Before this, the Syrian humanitarian crisis began in 2011 and has resulted in the deaths of an estimated 465,000 people (Al Jazeera, 2018). Countries in the European Union and North America initially responded in a limited fashion, voluntarily repatriating a small number of refugees or processing the claims of asylum seekers who reached their borders and were permitted to apply for protection. However, the vast majority of people were hosted by countries immediately surrounding Syria, including Lebanon, Jordan, Turkey and Egypt, where by 2016 more than 4.8 million Syrians resided (Arar, Hintz & Norman, 2016). By 2015 violence in Syria reached unprecedented heights, while life in surrounding countries became untenable for many. Thousands of people began the journey to Europe with the hopes of being granted protection. Quickly, media and politicians began framing the events as the 'European refugee crisis'. While many individuals crossed the Mediterranean or Southeast Europe without a set destination in mind, agreements within the European Union (EU) as well as bi- and multilateral agreements between the EU member states shaped asylum seekers' routes. Most prominently this included

¹⁶⁹ The Act on the Acceleration of Asylum Procedures entered into force on October 24, 2015. This accelerated the asylum application process and also permitted *AsylbLG* benefits to be provided as cash, not just in-kind, in order to lessen the burden on German reception centres. It did not affect health entitlements.

¹⁷⁰ This, even despite an agreement to transfer €670 per claimant each month for the duration of each asylum claim (Gesley, 2016).

Dublin Regulation of 1990, which requires people to register a claim for asylum in the first ‘safe’ (i.e., European Union member state) country they enter. Because of asylum seekers’ geographic route, this placed many claimants in border countries such as Greece and Hungary, and limited people from making admissible claims in inland countries such as Germany. This meant that most of the nearly 45,000 people who made a claim in Germany from January-June 2015 would face expulsion orders and be inadmissible (Hall & Lichfield, 2015).

However, in August 2015 Chancellor Angela Merkel announced Germany would suspend the Dublin Protocol and overlook agreements stipulating safe third country provisions, including that written into its Basic Law under the 1993 Asylum Compromise. This announcement sent the message that any asylum seeker who could arrive at Germany’s borders could make a claim without being immediately disqualified. Accordingly, thousands of Syrians entered Germany in 2015. Claimants also arrived, in descending order from Afghanistan, Iraq, Iran, Eritrea and Albania, among others. In total, nearly 1.4 million people would launch an asylum claim from 2015-2017 (Craigie, 2018)¹⁷¹.

In the years since, Germany has made great efforts but struggled to support asylum seekers’ needs. Federal states, each responsible for integration of newcomers as well as providing social services under the *AsylbLG*, faced challenges ramping up institutional supports, such as German integration classes (e.g., language and cultural classes) and creating housing to accommodate people after they left initial reception centres. Berlin has faced intense criticism for its handling of asylum seeker arrivals. Thousands of arrivals waited weeks to register with the *Landesamt für Gesundheit und Soziales* (State Office for Health and Social Affairs; herein the *LAGeSO*), with many camping in its adjacent yards overnight for days. The first weeks of Berlin’s welcoming efforts “ranged from chaotic to downright dangerous” as a state-level government attempted to process thousands of people in need of social support in numbers that had not been seen since the early 1990s (Eddy & Johannsen, 2015: n.p.). All of Germany struggled, but Berlin – where the state’s official marking slogan is ‘Berlin: Poor, but Sexy’ – struggled visibly on the global stage. The city-state had experienced significant cuts to its social

¹⁷¹ Acceptance rates for asylum claimants vary by country, though Syrian claimants have the highest rate of acceptance – for example, of the 268,866 claims made in 2016, 57.6% of processed claims were granted refugee status, 42.0% were granted subsidiary (tolerated) status, and 0.1% were rejected (BAMF, 2016).

budgets and municipal workforce since reunification 1990, making the provision of basic supports including healthcare challenging (ibid).

From a healthcare perspective, interviewed physicians described the conditions at the *LAGeSO* as alarming and insufficient for the number of persons arriving, let alone for their often-urgent healthcare needs. “We were performing barefoot medicine”, stated Dr. Ayse Linder, referring to the ad hoc provision of care in the *LAGeSo*’s side yard (see also: Coggin, 2015; Fuchs, 2015; Surana & Beauty, 2015)¹⁷². *Ärztammer Berlin* President Dr. Gunther Jonitz, who multiple interviewees described as playing a critical role in streamlining immediate healthcare processes and demanding action from the Berlin government in 2015, described the scene at the *LAGeSO* as near-chaos. While the experience was amplified in Berlin, it resonated across the country. Two decades of neoliberalism and anti-immigrant sentiment prompted the dismantling of refugee-serving infrastructure such as reception centres, “thus contributing to the experience of crisis” (Holmes & Castañeda, 2016: 15). Despite material deficiencies, each person interviewed noted that innumerable physicians volunteered their time and resources to provide care to individuals in need. Volunteer care was provided at initial reception centres, indoors or outdoors at the *LAGeSO* tents, or in their office:

I heard about it and it was shocking, so of course I got involved. It was shocking to see that our Berlin Senate just did not work. Of course, Berlin is supposed to be very poor and they’re trying not to spend money anywhere.¹⁷³

The response from the medical community to support claimants in 2015 was immediate. Interviewees noted the efforts made by physicians were a testament to the importance of individuals’ commitment to the oaths they take to provide care to everyone, regardless of circumstance or need. Drs. Christine Kurmeyer and Ingar Abels, two hospital-based physicians described the events as having important effects on doctors’ perceptions of their role as healthcare providers as well as their relationship to asylum seekers. For many, the months immediately following August 2015’s Dublin suspension were the first time they treated people from diverse backgrounds and with complex needs associated with a precarious status. For many, this experience marked their first-time handling reimbursement claims under the *AsylbLG*.

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¹⁷³ Dr. Ayse Linder (physician), interview by author, August 11, 2016.

Individual physicians and prominent organizations including the *Ärztammer Berlin* expressed frustrations and disappointment with the challenges physicians faced trying to provide care to newly arrived asylum seekers in the face of hardship (*Ärztammer Berlin*, 2015a; 2015b). However, interviewees also suggested the ‘honeymoon phase’ of physicians’ volunteerism, like those of many sectors, had winded down and many physicians had returned to expressly or implicitly preferring to serve non-*AsylbLG* patients. Reasons for this ranged from refugees’ healthcare complexity to frustrations related to cultural considerations and the *AsylbLG* process, including reimbursement issues and restraints on what healthcare could be provided. While anecdotal, this evidence provides insight for understanding how individual behavioural changes (i.e., providing care to new populations) can be short-lived when not accompanied by the institutional (e.g., expansion of care entitlement) and systemic supports (e.g., culturally-competent care training).

The arrival of over a million people to Germany and thousands of people to Berlin since 2015 is a critical juncture in the German and Berlin asylum seeker healthcare narrative. It signalled a new direction in national and local refugee politics and spurred countless physicians to support claimants’ healthcare needs as part of the national ‘welcoming culture’ that flourished in 2015 (e.g., Hasselbach, 2015). The 2015 arrivals are also the single most important factor shaping the Germany’s political contexts at the end of this study’s time period. The bolstered pro-access movement was driven by newcomers’ needs but also the state’s failure to provide adequate services (Fuchs, 2015). This spurred strong institutional responses from German professional medical associations including the Berlin and national-level physicians’ colleges. Refugee claimant arrivals placed new pressures on municipal services and resources and prompted reforms to core German immigration laws. Reforms were drafted with an eye to streamlining processes, increasing security, and positioning accepted claimants to integrate into Germany long-term. While many critiqued Germany’s responses as insufficient and others voiced concern for the country’s social and financial prosperity, these changes still represented a seismic shift in German immigration policy¹⁷⁴. While 2015 arrivals did not prompt changes in

¹⁷⁴ The full impact of asylum seeker arrivals from countries including Syria, Kosovo, Albania and Afghanistan in 2015 on German migration legislation and processes are fascinating but outside the scope of this analysis. A helpful play-by-play of relevant procedural and admissions changes was created by Jenny Gesley, Foreign Law Specialist at the American Law Library of Congress (2016); additional academic work by Holmes and Castañeda (2016) provides excellent into this important topic.

the *AsylbLG*'s health provisions, these events prompted new actions and growth within the movement which in turn placed upward pressure on governments to enact change. Still, without amendments to the legislation governing entitlement, the *AsylbLG*, these changes are precarious.

Conclusion

The German asylum seeker pro-access movement began slowly in the early 1990s, but is punctuated by notable initiatives by major asylum-seeker serving organizations and marked by a sustained, ongoing effort by German professional associations. Yet, despite strategic campaigns by informed practitioners and vocal support from leaders of influential organizations, the *AsylbLG*'s medical provisions remain unchanged. However, these movements are not without tangible impact. Direct lobbying is connected to a reduction in how long claimants are subject to the *AsylbLG*'s timeline in 2014, and the introduction of EHCs in 2015. These partial and pragmatic victories have not existed in a vacuum; they are the outcome of the broader contextual arenas in which movements such as the Berlin pro-access are sustained.

The German pro-advocacy movement highlights the importance of factors at the macro-level: primarily, how history can shape behaviour and constrain options. The Second World War bore influence on Germany's highly decentralized federal system, which dispersed advocates' power and duplicated efforts across governments and states. Physicians' particular history with the Nazi party exerted a freezing effect on advocacy, as did normative remnants such as an imagined ethnically homogenous homeland. Later, German reunification influenced how the movement took shape at a critical early time in the pro-access action. These findings suggest that historical legacies will shape collective action, similar to how individuals' protest histories will influence a leader's strategy (Morris, 2000). My analysis also shows that openings in the political system can arise as secondary events that come as a result of clear, obvious instances of political opportunity. These opportunities can spark action, and in combination with time as a factor (i.e., how long collective action has been sustained), such opportunities can trigger new strategies amongst established groups. Healthcare systems also shape access indirectly by disciplining physician behaviour – in this case, by normalizing free labour. The German case also highlights the importance of early events in setting protest trajectories. For example, Germany's Residence Act erased the pro-access movement from public display and ultimately, limited the movement's ability to gain traction in the public eye or amongst physicians in the critical early years of

collective action (e.g., Morris, 2000). The feedback effects included prolonging the movement's 'ramp up' as doctors who were initially deterred from joining the movement fail to also recruit new members and potentially communicate their reasons for not joining to others.

This chapter has also emphasized key findings about the strategies of movement organizers. Namely, building a movement out of what Morris (2002) describes as an agency-laden institution – pre-existing, deep-rooted normative institutions that resonate with audiences – is critical. The German movement's decision to approach health care access from a 'radical' perspective created barriers to driving policy impact as radicalness did not resonate with their intended audience. Messaging that resonates with everyday citizens, and thus government, is paramount to building momentum. Relatedly, while longstanding organizations lend legitimacy and resources, they also bring baggage concerning members' expectations and organizational mandates. Fresh organizations led by well-established leaders may produce stronger advocacy outcomes. Moreover, the German case shows that social movement leaders can play an important role in mobilizing resistance, however their impact depends vitally on the structure, social power and positioning of their organizations and movement membership. Finally, the German case shows that organizational ability and opportunity are linked strongly to structure but in turn, these are impacted heavily by external, exogenous shocks that may expedite a movement's advocacy or exert distinct pressure for change – in this instance, the Syrian humanitarian crisis.

8. England

The NHS should be free at the point of service.
They think that in order to protect this, we must exclude outsiders.

(Lizzie Moore, Public Health Specialist¹⁷⁵)

Responding to Reform: A Proactive, Sustained Resistance from Diverse Actors

Of the three analyzed cases, the *persistence* of asylum seekers' access to healthcare in England is the most puzzling. When compared to Canada or Germany, the British press has most maligned asylum seekers, while policy places a particular focus on problematizing their access to other social services, and multiple social service-based reforms have been enacted since the 1990s with the express intention of making asylum seekers' life difficult (e.g., Capdevila & Callaghan, 2008; Gabrielatos & Baker, 2008; KhosraviNik, 2009, 2010; Mulvey, 2010). At the time of proposed asylum seeker healthcare reforms in the 1990s and early 2000s, media scrutiny of non-UK nationals was harsh generally, but especially so with regards to asylum seekers; in the year 2000, notorious anti-migrant publication *The Daily Mail* ran 200 negative asylum seeker stories, acting as both a vehicle for government rhetoric and shaper of public perception (Mulvey, 2010). Yet, despite strong resistance against foreigners' use of the NHS system, asylum seekers have full access to all care, equivalent to that of citizens. There are restrictions in place that do confer negative consequences: some rejected asylum seekers awaiting deportation are charged for secondary care. But relative to what would be expected, access is fairly open; no one is charged for NHS primary care, and asylum seekers have full access, equivalent to that of citizens. Rejected asylum seekers may be charged for secondary care, provided they do not fall under an excepted group; still, NHS hospital trusts have the discretion to provide secondary care without cost.

Why is this the case? The answer is certainly not political. While individual MPs will align themselves with a pro-immigrant agenda, policies restricting immigrants' and asylum seekers' social entitlements are supported by the two primary parties, Labour and the

¹⁷⁵ Interview by author, October 6, 2017.

Conservatives. Charges on primary were first proposed under a Labour government, while consultations to revisit the issue have continued since David Cameron’s Conservative win in 2010. Charges to NHS secondary care as well as increased collaboration with the Home Office, restrictions on housing, welfare entitlement, and asylum admissions have similarly been enacted under both Labour and Conservative governments. Anna Miller, a member of Doctors of the World summarized the major parties’ nearly interchangeable positions on asylum¹⁷⁶:

Mainstream parties are falling over each other to be the toughest on immigration...even if you convinced the Department of Health and the Home Office that it made no policy sense at all to ever charge these groups, I don’t think they’d have the confidence and guts to face the public backlash that would be about forgiving free healthcare to these groups....Charges in healthcare is part of this wider process to make life more difficult for people under the completely misconceived idea that if you make life difficult people will just go home and back where they came from.¹⁷⁷

Indeed, support for immigration and asylum is a historically unpopular stance amongst British parliamentarians, especially outside of London (Blinder, 2015). These restrictive views are echoed and shaped by the British press, wherein the anti-asylum seeker rhetoric story traces a similar path to that in England and Germany. Within policy rhetoric and media, the presumption that asylum seekers were *bogus* was normalized in the late 1990s, where it found particular success amongst the British public (Mulvey, 2010: 434; see also Phillips & Hardy, 1997; Schmidt, 2000). This language shift was critical, argues Mulvey (2010), because language “is closely linked to perceptions that the public have as a result of framing, and is of particular relevance to immigration” (444). As in the other cases, UK discourse reframed and reproduced migrants as “presenting a risk to many aspects of British life – to employment, welfare and security, and to national values and identity”, effectively priming UK residents for the incoming refugee policy reformation (Sales, 2007: 6). Rhetoric surrounding the ‘queue jumper’ and ‘illegitimate refugee’ appeared in news media (e.g., Gale, 2004) and general popular discourse (e.g., Kennedy, 2013; Goodhart, 2004). Yet, despite construction of claimants as “*bogus* and therefore undeserving of entry to Britain and of social support” (Sales, 2002: 456) and popular

¹⁷⁶ However, the modern Conservative party does take a more hardline anti-immigrant approach, as evidenced in the successful ‘Brexit’ vote, which was opposed by the Labour party.

¹⁷⁷ Anna Miller (Policy & Advocacy Manager, Doctors of the World UK), interviewed by author, August 17, 2016.

framing of refugees as ‘medical tourists’ (e.g., Goodhart, 2004; Taylor, 2009), care is relatively accessible.

While the disadvantages of an underlying consequence of excluding asylum seekers—reforming the NHS – are perceived as outweighing the potential political value, England’s parties still recognize the rhetorical benefit that accompanies *proposing* restrictions. Indeed, political capital is the most important factor in driving NHS England’s ongoing parade of charging consultations. It is not likely driven by a genuine economic concern, as the financial benefit to be realized from implementing charges is nearly inconsequential. Rejected asylum seekers’ primary NHS care totals just 3.1% of costs from legal European Economic Area (EEA) visitors (Prederi, 2013).¹⁷⁸ For reasons unpacked below, the costs of billing, charging, and collecting claimants’ bills would outpace the costs recovered. In an interview, the former Director-General of Finance and Investment for the Department of Health (DH) (2000-2015) Richard Douglas plainly stated:

You’d never go up to this thing from a financial point-of-view because actually the numbers, the money you would lose in the rounding, it wouldn’t even appear anywhere. So, although it was a big political issue... the policy would never be financially-driven.¹⁷⁹

Despite relatively liberal access to the NHS, asylum seekers still face a myriad of barriers accessing care. Within primary care, these centre on challenges relating to registering with a GP. Despite GPs being prohibited from refusing to accept a patient because they lack proof of address, identification, or immigration status is not grounds to reject applicants, research by Doctors of the World UK found that claimants are often turned away for these reasons, alongside others with precarious migration status. Importantly, GP practice administrators are the primary barrier in this regard; despite asylum seekers and undocumented persons being eligible, 13% were turned away because of their immigration status in 2016 (Doctors of the World UK, 2016). In these ways, administrators’ role as gatekeeper to the GP is most important, and it is at this step that claimants are most often turned away, not at the time of a health appointment with a

¹⁷⁸ The 2013 Prederi report was funded by the NHS, and notes these numbers are estimates as there is limited effort to count and/or track rejected claimants in England. Supporting this, an interview with former Director-General of Finance and Investment of the Department of Health suggest assertions of high costs to be recouped are likely inaccurate due to limited data collection efforts and capabilities (interview, Richard Douglas 2016).

¹⁷⁹ Richard Douglas (Director-General, Finance and Investment, Department of Health), interviewed by author, October 27, 2016.

physician. This signals that practice administrators may lack clarity on entitlement regulations, but also that proxies for ‘migrant’, including race and accent are being used as justification to demand additional documentation before one can register or see a doctor. In response, the BMA has issued multiple guidelines reiterating entitlement, and the Royal College of General Practitioners (RCGP) has suggested administrators receive targeted training (Gale, 2016).

Indeed, a powerful force limiting claimants’ access to care is confusion amongst both asylum seekers and healthcare providers (e.g., Joels, 2008). Rayah Feldman, an academic and member of Maternity Action felt that complexity around entitlements is a way of imposing limitations without imposing regulatory reforms. This is acknowledged by the Department of Health (DH), though interviewed persons felt the Department fosters this confusion as a means of encouraging asylum seekers’ exclusion. For example, the Department formally published guidelines on who is entitled for the first time in 2012, after engaging in several grounds of consultations to probe amending entitlements; these guidelines were initially published online only. Until 2012 when the DH published updated guidelines on serving asylum seekers, GPs relied on third parties for communication. To clarify, associations such as the BMA (2008; Lloyd, 2015; GHAP, 2009), RCGP (2015; England, 2017; GHAP, 2009), and Doctors of the World (2015; 2016) continually issue guidelines on registering practice, but face barriers to reaching all physicians. Moreover, the DH’s information sharing agreement with the Home Office is a de facto barrier for many rejected asylum seekers, as a debt exceeding £500 can be reported and compromise future residency prospects.

One salient factor that has been present since the initial 2003 consultation are the voices of providers who oppose removal of healthcare for asylum seekers. As with Canada and Germany, England’s pro-access movement is supported strongly by all major Royal Colleges, including the Royal College of General Practitioners (RCGP) and Royal College of Surgeons. It is also supported strongly by medical students, as well as general asylum seeker-serving organizations (e.g., Refugee Council UK, Refugee Action) and targeted medical supports that are both local (e.g., Maternity Action) and local branches of international organizations (e.g., Doctors of the World UK, Medact UK). The movement is also populated by practitioner supporters, including general practitioners (GPs) and specialists. While physicians play a core leadership role in this movement, this coalition is also guided by public health specialists, nurses, and non-profit healthcare advocates. However, notably absent as a factor easing open the doors

to England's NHS is the role of the 2015 asylum seeker arrivals to Europe. Compared to Germany's 587,346 claimants in 2015, England received just 38,500, and granted asylum to just 45% of cases (British Red Cross, 2016). Despite pressure from Germany, organizations such as Amnesty International and UK-based NGO Refugee Council, the United Kingdom continued to observe and reinforce the Dublin Protocol throughout the Syrian humanitarian crisis (Werber, 2015).

As in Germany, advocates are hesitant to declare their work a success. Still, features were identified as successful outcomes from the pro-access movement. First, in 2012 the NHS (Charges to Overseas Visitors) Regulations made HIV treatment and all maternity-related care no longer chargeable to any overseas visitor, regardless of status. While the NHS regulations do not state these changes are the result of advocacy, these two areas were core areas where the movement demanded change. Moyra Rushby, a former member of Medact and core organizer in the 2000s stated: "Access to HIV care and maternity care. Those were two big wins." Moreover, primary care remains free for all persons at the point of access – including asylum seekers and rejected asylum seekers, but also irregular migrants – despite movement by multiple governments to implement charges.

This chapter draws on interviews with nineteen physicians, nurses, civil servants, and non-profit workers to understand why asylum seekers maintain access to the NHS, and relatedly, how the pro-access advocacy coalition has operated since its inception in 2003. Because the question of primary interest here is why healthcare has *persisted* in England, both research questions are addressed in a singular analysis of factors shaping access at the macro, meso, and micro levels. Identified factors follow those analyzed in the German and Canadian chapters, in addition to factors which are specific to the British movement. At the macro level, the role of categorizing as a tool to restrict and liberate access is examined, alongside norms and system of government. At the meso-institutional level, courts and the effects of Britain's unique free-at-the-point of service healthcare system are examined, followed by an overview of England's unique pro-advocacy coalition and its strategies. Finally, the impact of agentic policy and advocacy entrepreneurs are unpacked at the micro-individual level.

Macro (Systems) Level

Policy Consultations and Media Constructions. The Department of Health’s cavalcade of consultations suggests that there is political capital to be gained by continually prodding the public to discuss the merits of charging asylum seekers. Indeed, constantly shifting legal frameworks around a subject constructed as illegitimate can be an important tool in fostering a sense of crisis around asylum seekers (Mulvey, 2010)¹⁸⁰. For example, in 2004, the Department of Health canvassed stakeholders on charging failed asylum seekers for secondary care. In 2005, the DH inquired about charging for primary care, and in 2010, on refusing entry to persons indebted to the NHS; further consultations followed and continue to be launched. Such consultations and pronouncements create “policy momentum” through which “further restriction and hostility became the default option” writes Mulvey (2010); in early-2000s England, “this was particularly pronounced for asylum seekers and refugees as the most ‘unwanted group’” (449). Nationalist fears are projected onto the targeted group, and the waters are tested to determine if the environment is conducive to wide scale policy change.

In an interview, Rosemary Sales, an academic-turned-Hackney, London councillor articulated the goal of charging reforms: “It’s about differentiating between people who don’t deserve it. It’s not about economics.” A public servant working in the NHS similarly described the public focus as shifting to different groups over time, but the underlying issue remains the same – separating who is ‘in’, and who is excluded:

The failed asylum seeker was quite a big thing in the mid-2000s. it then seems to have become, more again linked to the EU stuff, more about Eastern European people, and now more refugee thing from the Middle East. Who the target of it is...seems to change all the time and its more about non-resident people.¹⁸¹

¹⁸⁰ However, while asylum seekers are often the ‘face’ of proposed charges, the category of persons under charging consideration is typically the much larger category of persons who are not ‘ordinarily resident’ in the United Kingdom (UK). In the UK, ‘ordinarily resident’ typically means a person who is lawfully living in the UK for a settled purpose; after a 2008 judicial review, this concept was clarified to *include* rejected asylum seekers, though on appeal it was found to *exclude* failed claimants in 2009. In other areas of government such as income taxation, the term is applied differently still. Interviewed practitioners say this category is steeped in confusion amongst healthcare providers and most importantly, their administrators and a major barrier for asylum seekers attempting to access care.

¹⁸¹ Rosemary Sales (Councillor, Hackney), interviewed by author, October 24, 2016.

Fear of non-contributors exploiting NHS resources is housed most broadly under concerns of ‘health tourism’. In the early 2000s, health tourism fears reached a fever pitch (e.g., Borman, 2004; Ingram, 2008; Thomas et al., 2010). Health Secretary John Reid announced a crackdown in 2003 in an effort to recoup a purported £200 million annually; this number included ‘abuse’ by business travelers and visa over-stayers, but prompted action only towards rejected asylum seekers, those perceived as least deserving of shared resident resources. Fascinatingly, British legislators need only look to the rest of the UK to see that free, open healthcare for all asylum seekers is simply not a draw for asylum seekers or failed asylum seekers to enter or remain in the UK. Scotland, Wales and Northern Ireland offer full care for all claimants, yet have not experienced the ‘flood’ of asylum seekers expected by the health tourism perspective. When asked if advocates leveraged this clear, compelling comparison, Anna Miller, UK Policy Advisor and Manager at Doctors of the World UK stated that the argument gains little traction:

[Policymakers and politicians] don’t particularly respond to it. It’s a really good argument for exempting refused asylum seekers and to also show them they’re not suddenly inundated with huge amounts of healthcare bills from these people it’s not a floodgate issue.¹⁸²

Without presenting evidence of its effects, ‘health tourism’ was cited as a main driver behind the need to limit claimants’ healthcare entitlements in the 2004 consultation (Department of Health, 2003). Media focused on failed claimants-as-health-tourists, though interviewees noted that many or most ‘health tourists’ were actually tourists, businesspeople, or white, British passport-holding individuals returning for healthcare. Indeed, a 2013 NHS-commissioned study found that lawful visitors from the EEA cost the NHS £261 million annually; non-EEA persons in the UK primarily for work or study cost £1,075 million, and British expats, £94 million annually. In comparison, failed asylum seekers cost the NHS just £8 million annually (Prederi, 2013). Still, claimants and rejected claimants in particular were highlighted as a drain needing to be excised by the media and politicians, prompting 2004 proposals to exclude rejected claimants from secondary care. Asylum seekers were framed as waves of people attempting to access the NHS without contributing, diluting the resource pool for British citizens, who were already

¹⁸² Anna Miller (Policy & Advocacy Manager, Doctors of the World UK), interviewed by author, August 17, 2016.

contending with a financially-strapped and underfunded system (e.g., Gabrielatos & Baker, 2008).

This problematizing of asylum seekers' health access aligns with what Mulvey (2010) describes as the “symbiotic relationship” between policy, the immigration-rejecting public, and an overtly hostile media in Britain (449; see also Bercerro, 2004). Richard Douglas, former Director-General of Finance and Investment of the DH summarized:

It tends to get muddled in the public mind with things like health tourism and bigger issues about migration. This is a tiny little pin drop about something that is slightly bigger than that. And a lot of the pressure then comes from a public – by the media and particular newspapers... The political issue is more driven more I'd say by the wider issue of migration, frankly probably more about the Home Office agenda in England... The thing about main fencing, protecting the NHS and the money was symbolically important to politicians but again I'll come back to the sums of money involved were absolutely small – well, actually we didn't even know the number of asylum seekers who would be involved, we knew it was small, but we didn't know what it was.¹⁸³

Tactically, the DH framed Others as threats to the continuance of publicly funded healthcare, constructing a policy need without actually publishing any predicted cost savings associated. Instead of masking exclusion through empirics, as their Canadian counterparts routinely did, British political actors found that public focus and fear is normatively-driven, and suggestive discourse of the threat of the bogus claimant was effective in stirring discontent amongst the British public.

The dearth of material evidence signals that the DH's overall thrust is ideational, not material (e.g., Bleich, 2002) as it exploits fears around security threats to resources and symbols of British nationhood (e.g., Clarke & Newman, 2012). In a critical parallel to discourse deployed to justify Germany's Asylum Compromise in 1993, John Reid and Labour politicians argued that in order to quell racist discontent amongst Britons, action to limit NHS access for asylum seekers was needed (Mulvey, 2010: 452). Anna Miller of Doctors of the World summarized this fear:

Accessing the NHS is probably the most controversial area of immigration at all because we take the NHS so, so seriously and we protect it and it is part of our national identity, so when we're told this very simple situation that migrants are coming here, taking too

¹⁸³ Richard Douglas (Director-General, Finance and Investment, Department of Health), interviewed by author, October 27, 2016.

much pressure on it and threatening the future of the NHS; nothing makes people more concerned than that.¹⁸⁴

Asylum seeker healthcare reform is driven strongly by political benefit, which can be gained even if regulations do not pass. Multiple consultations and continually keeping the topic of charging top of mind in stakeholder circles has the effect of creating confusion amongst providers, and eroding some advocates' hope of their ability to stave off change: early movement supporter Dr. Michael Andrews¹⁸⁵ stated, "I wouldn't be surprised if we lost primary care eventually"¹⁸⁶. Consultations executed by the DH but supported by the Home Office are further symptomatic of the Home Office's influence in British asylum policy (see Chapter 2).

Normative and Programmatic Inertia. As a symbol of Britons, Britain, and British nationalism, the NHS is beloved by most people in England. This reality spells good news for asylum seekers, who are covered under the NHS, as its dismantlement and thus, the shirking of its founding principles – even to excise a group maligned by media, politics and the public – is generally not supported. Indeed, an Ipsos-Mori poll asked what institution made people proudest to be British, the NHS ranked first, even above the monarchy; this was true for white and racialized respondents, across social classes, and across all age groups except the oldest respondent bracket (British Future, 2013). One need not look further than the 2012 London Olympics opening ceremonies to appreciate the vaulted position of the NHS in the minds of Britons. Former MP Nigel Lawson described the NHS as "the closest thing the British have to a religion" (Appleby, 2011: 342). Indeed, while approximately 11% of England opts in to private coverage, the NHS still remains one of the country's most valued symbols of British values and culture; moreover, these persons still retain access to the NHS (Rice-Oxley, 2016: n.p.). Suffice to say, NHS England is highly valued amongst its adherents, and that asylum seekers are covered under its provisions is an important feature that shields claimants from entitlement retrenchment.

This is important because the NHS is anchored by three principle values that insulate asylum seekers from reform. The NHS is mandated to meet all persons' needs, to be free at the point of access, and be based on medical need, not financial capacity (Rafighi et al., 2016). Its

¹⁸⁴ Anna Miller (Policy & Advocacy Manager, Doctors of the World UK), interviewed by author, August 17, 2016.

¹⁸⁵ Name has been changed.

¹⁸⁶ Dr. Michael Andrews (Member, Medsin-UK), interviewed by author, August 19, 2016.

roots run deep; the 1911 National Insurance Act was among the first national health policies to offer physician and sickness benefits to a substantial component of the population, and reflected “the British public’s acceptance of, and demand for, state involvement in the delivery and finance of medical care” (Hacker, 1998: 92; see also Hall, 2006). This support for state-involvement culminated with the implementation of the NHS in 1948, guaranteeing free and universal medical care to all its citizens. Post-WWII, it expanded along a policy development pathway that foregrounded healthcare as a tool for societal development “based on the idea that society has an obligation to look after the health of its people” (Light, 2003: 27). Subsequent post-WWII NHS expansion followed a policy development pathway that foregrounded health care as a tool for societal development with equal access on the basis of need, foundational principles that further defined the NHS as an institutional venue (Light, 2003; Taylor, 2009). In these ways, British and more broadly, UK health care can be understood as a form of ‘welfare citizenship’ that transcends nationalist citizen vs. non-citizen divisions, a “culturally specific institutional expression of a commitment to collective social justice” whereby “inclusion and autonomy flow in part from access to a comprehensive system of health care” (Milewa et al. 1999: 460).

While the Home Office reframed secondary care an instrument of immigration control, primary health care for claimants is still simply an extension of the NHS. Instead of ‘asylum seeker healthcare’, in England, asylum seekers access care that is undifferentiated from citizens. This creates barriers for those who try to limit individuals access to the NHS – differentiating access by user group or creating parallel healthcare systems is politically not feasible because it would lessen care for some but because later, it might lessen care for *citizens*. The NHS’ frame as a symbol of the UK creates a layer of normative protection or “an intellectual path dependency in policymaking” around asylum seekers’ health access in England by acting as an ideational constraint (Blyth, 2001:4; see also Bleich, 2002)¹⁸⁷. Kris Harris of Medical Justice

¹⁸⁷ However, nationwide exuberance regarding universal health care began to wane under Margaret Thatcher’s New Public Management (NPM) reforms (Bevan and Robinson, 2005). NHS’ ability to withstand the endogenously delivered shock of the ‘bogus refugee’ rhetoric is understood here through the notions of sequencing and path dependency. Under Thatcher, 1990s NPM reforms initiated a decentralization of health care from the central national government to more localized administration. This shift was informed by a broader individualist health care that framed health care users not as patients but consumers, and positioned medical professionals to compete for funding in order to respond to market-based needs (Bevan and Robinson, 2005). Critically however, by 1996, consensus emerged that competition-based management was ineffectual for providing ‘population-based’ health care (Light, 2003), and the Blair administration “abandoned the rhetoric of competition” (Bevan and Robinson, 2005: 55). The

summarized the fear of many at the idea of charging rejected asylum seekers for care: “Now they put these big mechanisms in place, you’ve got the Department of Charging – why not charging people for more things?”¹⁸⁸ This, argued interviewed persons, limits public appetite for charging refugees.

This situation differs from Canada, which shifted its already-distinct asylum seeker healthcare policy to the reform-conducive Citizenship and Immigration Canada ministerial venue in 1996, as well as Germany, which introduced asylum seeker-only legislation when it underwent reforms in 1993, instead of amending legislation that included citizens. In both instances, separating asylum seekers from greater healthcare schemes was a form of venue-shifting that increased political appetite as well as opportunity to implement reforms, given the concurrent rise in bogus asylum seeker discourse and shifting trust in asylum systems. As Schneider and Ingram (1993) argue, political actors create or reproduce particular constructions of populations and identities to fit ideological and pragmatic policy aims. These constructions are reproduced in media and political discourse, creating or reinforcing societal positions and potentially shaping “both the policy agenda and the actual design of policy” (334).

The importance of venues as transmitters of norms and the influence of constituent actors in England is clear when healthcare administration is compared to housing and welfare, the other two major other social assistance programs. Refugee welfare and housing reforms are administered by the centralized National Asylum Support System (NASS), whose establishment in 2000 “involved the creation of a different culture” (Sales, 2007: 167). In an interview, Rosemary Sales argued that the excising of asylum seekers from all non-health related social supports was the biggest barrier facing asylum seekers. Bracketing off the population increased their vulnerability; amending entitlements to this distinct population is conceptually and politically less problematic than amending entitlement structures that fundamentally reform access to the NHS. NASS explicitly seeks to separate its asylum welfare administration “from the ethos of professionals like social work and health care and the cultures of local authorities

strengthening of funding afforded to the NHS emboldened its place within the British welfare state and reasserted the NHS as an indivisible entity (Bevan and Robinson, 2005). Resultantly, despite government rhetoric framing claimants as social service abusers, removal of specific populations from NHS coverage would be politically un-savvy (Stevens, 2010), and government ability to again digress from its institutional path of universality by bisecting health’s recipient population may counter UK citizens’ adaptive expectations regarding universal, unitary health care systems closely linked to notions of social citizenship, and thus prove politically costly (Béland & Waddan, 2011).

¹⁸⁸ Kris Harris (Research & Policy Worker, Medical Justice), interviewed by author, October 25, 2016.

and the NHS” (Jordan & Duvell, 2003: 325, emphasis added). Unlike the NHS, actors working under the NASS or more broadly, the Home Office work to maintain an institutional image as national gatekeeper, working to limit abuse of UK social generosity by operating “on the presumption that the majority of asylum seekers are ‘bogus’” (Sales, 2002: 464). This stands in contrast to the policy actors associated with the NHS, as well as the impact the conceptual and practical recentralization of universal, population-based health care had on the NHS’ public image. These have insulated the NHS’s relationship with refugees from the onset of neoliberalized refugee reform.

Just as in Canada and Germany, interviewees also expressly stated that the norm of serving persons based on clinical need not immigration status is inculcated in British doctors. Interviewed practitioners routinely stated that they did not want to be implicated in Home Office mandates, or become tools of immigration control. “The culture and ethos of the NHS is important to them”, stated Anna Miller of Doctors of the World. Moyra Rushby of Medact elaborated:

Part of the thing that made it easy for us was that doctors just never had to deal with deciding who they could and couldn’t treat. That was the big cry that we used to use – because we have this one system that everyone accesses, and now trying to decide who gets to access... [doctors] didn’t know how to make sense of it so their reaction was just ‘no’.¹⁸⁹

A representative from the Royal College of General Practitioners as well as a sympathetic former DH executive agreed:

Unlike hospitals, we [GPs] do not have a responsibility to the government to screen out people who are not entitled to NHS... So essentially, it’s because we believe we should offer a service to everybody and not be involved in making decisions about peoples’ need.¹⁹⁰

NHS physicians in particular their office staff, their view was that was not their job. ‘We’re not immigration officers, this is not our job’. We haven’t got an identity card system in the country, there isn’t a way of testing these things easily, our job is to treat

¹⁸⁹ Moyra Rushby (Medact), interviewed by author, August 16, 2016.

¹⁹⁰ Dr. Ruby Conway (name has been changed), physician working with the Royal College of General Practitioners, interviewed by author, August 2016.

people as they present, not to worry about where they come from. So, there was quite a feeling within the NHS generally that they didn't want a role as immigration officers.¹⁹¹

These findings echo those from Canada and Germany: for the most part, physicians prefer to provide care based on clinical need, not immigration status. This limits central governments' ability to impose reforms, as it restricts what physicians feel is their professional duty and moral obligation¹⁹².

Systems Shaping Central Government Action. Structural-institutional factors also shape the feasibility of restricting care for asylum seekers, as in the case of Canada and Germany. This is seen in two ways: first, England lacks supporting subnational infrastructure including free health clinics, which prevents downloading. This imposes pragmatic reforms on England's ability to impose change. Second, England's use of regulatory reform to amend the NHS should support its ability to exit unilaterally and shielded from parliamentary debate, similar to the case of Canada's use of the Order-in-Council. However, opposition from providers who refuse to implement restrictions on care requires reformers to attempt to build support through consultations, which frustrate their ability to impose change. These two features limit the government's ability to impose restrictions on asylum seeker healthcare and shape the pro-access movement by emboldening their resolve, paralleling the experience of advocates in Canada and Germany.

To the first point, rather predictably, England's unitary government complicates the potential for federal downloading. While federal systems facilitate downloading, unitary governments lack this option when the policy at hand is complex, expensive, and involving multiple stakeholders, such as with health care, as municipal or regional governments are likely to lack the resource capacity to undertake the implementation and administration of such policy. Unlike Germany, England's municipalities are not empowered with the ability to tax citizens or tailor the implementation of national-level policies. Unlike Canada, there exists no highly

¹⁹¹ Richard Douglas (Director-General, Finance and Investment, Department of Health), interviewed by author, October 27, 2016.

¹⁹² The NHS responded to this oft-repeated stance in an instructional video made for all NHS clinicians. The video encourages hesitant doctors to support Overseas Visitors Managers (OVMs), and states urgently: "We are not asking clinicians to be border guards" (ELH, 2018). This role can be avoided, it suggests, by engaging actively with local OVMs to determine when refused asylum seekers should be referred to secondary care.

institutionalized healthcare delivery system at a lower level of government; England's subnational institutions lack the political power or capacity to deliver asylum seeker healthcare services. Indeed, England's experiment with downloading refugee housing responsibilities to urban municipal authorities led to bureaucratic strain, inefficiencies, and overburdened administration that forced the re-'uploading' of housing to central government via the Home Office's NASS in 1999 (Sales, 2002).

Further, while the NHS' universal system has historically worked to widen access for asylum seekers, it also provides very few safeguards when the system fails. The NHS' founding principles committed to providing healthcare for all were first shook in 2005 when secondary charges were implemented. While an access-for-all approach to primary and secondary care has historically been beneficial to users, it also meant that at the time of the reforms, there were no parallel non-profit system to serve the uninsured. Unlike Canada and Germany, England lacked a developed secondary sector provider of healthcare at the time of reform¹⁹³. This effects of this were felt by current and refused asylum seekers even as they attempted to access primary care, as GPs shut their doors amidst confusion around the consultation and changing regulations.

Advocacy organizations such as Doctors of the World UK (England's outpost of *Médecins du Monde*) eventually stepped in with programs designed to connect refused patients to GPs. This advocacy includes accompanying people to GP practices and insisting persons be registered as patients. This, and similar work by other organizations places pressure on the system to operate as it is legally obliged. This reality also encourages pro-advocacy organizations to target their efforts towards training GP practices to accept and register asylum seekers and failed asylum seekers, among others with precarious status. Yet, despite being entitled to care some claimants are still refused¹⁹⁴, and so in 2006 Doctors of the World UK opened London's only free clinic for people who are refused service. The clinic is run by volunteer GPs and nurses, and faces high demand. This clinic was the first of its kind in London; movement founder Moyra Rushby recalled the situation in the early 2000s at the time of reform:

¹⁹³ Canada has longstanding clinics to serve the uninsured, including the Canadian Centre for Refugee and Immigrant Healthcare, that predate the 2012 IFHP cuts. Germany's main provider for the uninsured was formed in response to the cuts (MediBüro in 1993) but other providers, including *Malterser Migranten Medizin* predate the 1993 *AsylbLG* implementation.

¹⁹⁴ Doctors of the World connected 1906 patients to GPs in 2016; how many were not connected despite being entitled is not available.

We had to point out that we have a National Health Service and because it's national, and because it's free at the point of entry, we don't have charitable hospitals. We don't have free clinics – because we don't need them... You could say church groups or medical students could pick up what fell through the cracks but there was none of that... anybody who can't access the NHS has no access to healthcare at all. There is nothing else. *Medcins du Monde* now does but it's really just finding people within the NHS.¹⁹⁵

To the second point, reformers pursued regulatory changes as the vehicle of asylum seeker healthcare restrictions. Much like the Order-in-Council mechanism used in Canada, this shielded reformers from debate. This raised much ire amongst advocates. An interviewed family GP stated: “We aren't kept abreast of what is happening. When there are changes, they are regulatory so there is no mandated debate period. The debate is all done on paper through consultation submissions, but when there are consultations, we don't hear the results.” Indeed, secrecy around the initial regulatory change consultation is arguably what invigorated the pro-access movement after the secondary charging reforms were enacted in 2005 (see Chapter 3 for an overview of the Global Health Advocacy Project's Freedom of Information request).

Still, England's unitary system defies expectations vis-à-vis its ability to enact reform. With fewer veto points, unitary systems theoretically have a better capacity to enact large-scale reforms (Coleman & Bhatia, 2003), and are also capable of implementing social policy change more swiftly (King, 1999). This analysis suggests this assertion of unitary states' policymaking power is problematized when the policy venue is laden with emotional, nationalist sentiment, and requires the buy-in of practitioners in order for the unitary government to execute. Thus, unlike Canada, England's system of government limits policy reformers' ability to restrict care to asylum seekers. But like Canada and Germany, the manner in which the reform was attempted triggered a reaction from the pro-advocacy community, and ultimately contributed to the pro-access movement's consolidation.

Meso (Institutional) Level

Healthcare Payment Systems. The NHS' ideational institutions are foundational to the healthcare system and inform key features of NHS healthcare payment processes. Ideas can be

¹⁹⁵ Moyra Rushby (Medact), interviewed by author, August 16, 2016.

similar to path dependency; once programmatic beliefs are institutionalized, parties “find it difficult and costly to abandon [or] contradict (Berman, 1998: 4). Relevant here is the NHS’ practice of *not* requiring identification from patients in order to receive services. Identification and proof-of-address can be requested at time of initial registration with a GP, but a lack of identification cannot be used as a means of excluding people, though as discussed at the top of this chapter, this practice still occurs. Anna Miller of Doctors of the World stated:

[GP practices] are allowed to turn away people not inside their catchment area so they can ask for it. But, they aren’t allowed to stop a patient from registering or having an appointment because they can’t provide identification – circular but that’s it.¹⁹⁶

In modern-day GP practices, patients register for their appointment upon arrival by entering key pieces of information like name and address into a computer, or provide their name to a receptionist. The only time this information would be verified is at the time of registration; confirmatory identification is not required to see one’s GP. This is in part a reflection of the NHS primary care system: every person is entitled to access care, which is paid through the national service, not insurers. Thus, health cards – such as those used in Canada’s single-payer insurance service and Germany’s multi-payer service to identify who is entitled– are not necessary¹⁹⁷. This feature of the UK healthcare system – free on access, with no expectation to surrender identification or a health card – ensures the pathway to accessing NHS primary care is wide. This notion is perplexing for many Canadians and Germans, who expect to surrender a provincial health card or swipe their sickness fund card at each visit to the physician, but is a defining feature of NHS’ institutionalized open access approach.

To this end, ‘free-at-the-point-of-service’ in primary healthcare is a major roadblock to charging asylum seekers for care. Because GPs do not need payment systems, receipting procedures, or billing mechanisms to provide healthcare, these features do not appear in the offices of England’s GPs. In contrast, such systems appear in Canadian and German doctors’ offices, where they are used primarily to bill provinces (Canada) and sick funds (Germany). Thus, in order to charge asylum seekers for primary services as was first proposed in 2004, GPs

¹⁹⁶ Anna Miller (Policy & Advocacy Manager, Doctors of the World UK), interviewed by author, August 17, 2016.

¹⁹⁷ GPs are self-employed, and are paid annually by the DH approximately £146 per patient on their ‘patient list’ (Buttar, 2017).

would have to implement expensive billing systems. The costs recovered would pale in comparison to the cost of installing and maintaining the systems, a cost which would be borne by doctors. This differs from hospitals, where multiple charging systems are in effect, and secondary charging was implemented with relative ease. However, even in hospitals, secondary care costs are recouped from just 13% of patients; an interviewed Overseas Visitors Manager argued this was because of regulations requiring patients to be billed retrospectively, as opposed to prior to receiving treatment.

In effect, feedback effects from initial NHS decisions to provide care free at the point of service has imbued values in practitioners, precluded investment in complimentary machinery or charging mechanisms, and ultimately made difficult the want to charge asylums seekers for care. A London-based physician stated:

GPs don't want to do it. They're not used to doing it, they don't do it, there's no system in place to do it. To set it up for someone whose probably not even able to pay is just a complete waste of everybody's time.¹⁹⁸

If this barrier to implementing charges for asylum seekers seems rather predictable, it was. The 2004 DH consultation on secondary charges acknowledged this risk:

Such charges would be NHS charges and would need to be accounted for by practices as NHS income. For most practices, the income would be marginal, but each practice would need to have in place systems to account for this new NHS income. This could prove bureaucratic (7).

The proposal suggested that conversely, GP practices could treat asylum seekers as private patients, which would allow GPs to devise their own system of charging and cost recovery. This too, would be extremely bureaucratic. At current, GPs can opt in to providing private care by becoming employed by a private provider, which provides charging systems. EEA patients hold a European Health Insurance Card (EHIC), which GPs record and report to NHS trusts for charging. However, neither patient group provides the bureaucratic machinery that would be necessary to support the charging claimants.

¹⁹⁸ Dr. David McDonald (name has been changed), physician, interviewed by author, November 2016.

The cost such systems would impose on physicians matters also because it widened the network of stakeholders who opposed charging reforms. Requiring GPs to bill asylum seekers is tantamount to requiring GPs to purchase and implement payment systems, a burden the British Medical Association (BMA) deemed counter to the professional interests of doctors. “Requiring GPs to implement charging systems represents an undue financial burden and is opposed by the BMA”, explained a BMA representative¹⁹⁹. While the BMA Medical Ethics Unit, a sub-unit of the greater Association had released statements opposing refugee charges on human rights, cost-effectiveness and ethical grounds (Lloyd, 2015), framing charging as a professional issue implicated the Association writ-large. The BMA is a well-regarded and powerful trade union for all physicians in the United Kingdom, and their joining of the pro- asylum seeker access movement was regarded by interviewed physicians as critical to building their credibility. The BMA’s voice represented a new dimension and logic to the pro-access debate: this was not just a matter of fairness to asylum seekers, but fairness to doctors.

Underpinning the NHS’ dearth of health cards is a national aversion to surrendering identification. This too works in favour of the pro-access movement, which leaned on Britain’s aversion to identification-based surveillance to oppose identifying – and then charging – asylum seekers. Former DH Director-General of Finance and Investment Richard Douglas stated:

There’s a lot of historical stuff in England about not having identification. The whole thing we went through for 10 years about identity cards – you don’t expect to have to present to any government official who you are. So very deep-rooted. It’s built into your DNA in some way.²⁰⁰

Indeed, the UK’s attempt to implement national identity cards is emblematic of the country’s disdain for identity-based tracking. In 2002, the Home Office began a two-year consultation on the creation of a national identity management infrastructure that would create an ‘entitlements card’ as a standard electronic identifier for British residents. This card, an attempt “to relate the rights and entitlements of citizenship in the UK with a standard electronic identifier” was to be used to prove a person’s legal residency (i.e., ordinarily resident status) as well as identification. Together, these would be used to gain access to public services, such as

¹⁹⁹ Anonymous BMA representative, interviewed by author, August 2016.

²⁰⁰ Richard Douglas (Director-General, Finance and Investment, Department of Health), interviewed by author, October 27, 2016.

the NHS (Beynon-Davies, 2007: 245). This, argued government officials would be a powerful weapon in fighting illegal immigration and entitlement fraud. The timing of this card is important. It responded to heightened national fears following 9/11. It also immediately predated the consultation on imposing secondary and primary charges, the card primed the citizenry to begin questioning how one can prove entitlement, and how such evidence can be used to halt abuse from undeserving persons.

The card was resolutely rejected by British residents. Dubbed a ‘modern horror’ (Agar, 2001), civil society groups voiced opposition²⁰¹ based on data management and security concerns, cost, the card’s likelihood to disproportionately impact racialized persons, and the card’s biometric features as a component of state surveillance. As a form of everyday bordering, national identity cards are critiqued as tools of surveillance and as particularly harmful to already-subjugated populations, such that a “nation’s others are, as has too often been the case, most at risk” (Lyon, 2005: 68). Resultantly, the card’s implementation was delayed several times. A pilot group of non-EU persons received the first identity cards in 2008, and an initial rollout to British citizens followed in 2009. However, strong opposition to the cards continued and the program was ultimately cancelled following 2010 election, with the accompanying National Identity Register was destroyed.

Given the UK’s title as one of the most surveilled states in the world (as a result of its unparalleled use of CCTV in public spaces), this opposition to national identity cards might seem confusing. Kris Harris, Research and Policy Worker at Medical Justice argued as such: “It’s ironic because have the most surveilled people in the world. So it’s quiet an odd mix.” However, the card’s failure does signal an important message: British citizens do not wish to be required to identify themselves as British citizens in order to facilitate control of people or access to services. This aversion to identification ultimately widens pathways to accessing healthcare. Kris Harris argued that to charge migrants for primary care, you would have to first identify who would be subject to charging. To do so systematically, all persons’ identity would need to be checked:

²⁰¹ And interestingly, inspired the anti-state surveillance, anti-national ID anthem, “Kiss Ya Lips (No I.D.)” by British singer Ian Brown.

If you start charging migrants, now you're going to have to demonstrate that you're not chargeable, if you're not. How are you going to do that? You're going to need a mechanism to demonstrate you're not chargeable. It would be unlawful to just ask some people – you have to ask everyone. You can't just ask brown people.²⁰²

Critically, identity is still demanded from many persons who 'present' as an 'outsider – even without cards, sociodemographic characteristics are used as heuristics for 'entitlement' (see *Introduction*).

Court Systems as Venue. England's pro-access movement also challenged asylum seeker healthcare reforms in court. Before arriving in the courtroom however, the threat of legal action was frequently deployed by advocates seeking to connect refused claimants to secondary care. Moyra Rushby of Medact recalled:

We saw people being refused over and over again but when you'd threaten to take them to court, the NHS Trust would back down and provide healthcare for that one person. Not long later, something else would come and the process would start again.²⁰³

Threatening legal action prodded change at the individual level but did not move the dial on opening access for all refused claimants. Thus in 2006, an advocacy coalition led by Medact and the Global Health Advocacy Project (GHAP, a medical student-driven organization) sought judicial review of the NHS (Charges to Overseas Visitors) Regulations 2004 with the goal of reversing the changes imposed on refused claimants. The coalition's tactics foreshadowed those used by the Canadians in 2013. Experienced refugee-serving lawyers²⁰⁴ contacted physician-led group Medact, as well as the National Aids Trust and the Terrence Higgins Trust, two relevant, established organizations that expanded the issue's scope of supporters. The applicants drew on data collected by physicians and Refugee Council UK to substantiate their case. *R(YA) v. Secretary of State for Health* relied on documented cases of people who had been refused care, but the named applicant was a refused claimant from widespread charging reforms who died

²⁰² Kris Harris (Research & Policy Worker, Medical Justice), interviewed by author, October 25, 2016.

²⁰³ Moyra Rushby (Medact), interviewed by author, August 16, 2016.

²⁰⁴ Deighton Pierce Glynn represented the asylum seekers; the firm also funded Refugee Council UK's 2006 report on the impacts of secondary care restrictions: *First Do No Harm: Denying Healthcare to People Whose Asylum Claims Have Failed*.

after being denied treatment²⁰⁵. This challenge differed from that in Canada in that advocates were challenging the regulations as a whole; this meant also arguing that undocumented migrants should also be allowed access to care. In this way, the British system requires an ‘all or nothing’ approach – either changes are implemented, and charging is possible, or all reforms are resisted, and charging remains elusive.

In April 2008, the judicial review found in favour of the coalition: restricting refused claimants’ access to secondary services was unlawful. The verdict was not based in human rights language or England’s responsibility to asylum seekers, as it was in Canada’s decision that IFHP reforms constituted “cruel and unusual punishment”. At the core of this case was the concept of who was considered ‘ordinarily resident’ in England. Refugee solicitors successfully argued that refused asylum seekers, even those awaiting deportation, were in the UK legally because they received temporary leave to remain when they entered England, and were not required to leave until they received ‘removal directions’. These deportation orders are typically issued shortly before someone is removed. Because the decision hinged on questions of legal residence, the judgement did not alter undocumented persons’ access to care. The judge also found that the instructions issued to health authorities in 2005 – those that *recommended* (but did not require) that GPs *not register* rejected asylum seekers – was unlawful. The DH instruction’s lack of clarity, and confusion as to whether the DH’s instructions were enforceable, had created considerable confusion. However, even after the judge ruled the instructions as unlawful, the DH failed to release new guidelines until 2012; as a result, many physicians are still unclear as to whether they are permitted to register patients for primary care.

The DH successfully appealed the decision in March 2009 at the Court of Appeal, and secondary charges were reinstated for rejected asylum seekers, whose stay on deportation was deemed not equivalent to legal status. Coalition members opted to not appeal to the High Court because, as with German advocates, they struggled to find persons who would be suitable applicants to the appeal. Moyra Rushby recalled:

We were finding less and less cases ... enough cases that would have made it credible to take it to the most senior court. We were scraping around for cases and we decided that at

²⁰⁵ The applicant entered the UK as an asylum seeker with a chronic and inadequately diagnosed liver disease. When his condition worsened, he was denied by an Overseas’ Patients Manager because as a rejected asylum seeker, the Manager did not perceive him as entitled to care.

that point it wasn't sensible to appeal the appeal. You go to the High Court once, and you have to make a case that you have a case to make – and the barristers and I agreed that we probably didn't at that point.²⁰⁶

This was in 2009 however – since the ruling re-imposed secondary care charges, evidence of persons being turned away have again mounted (Doctors of the World, 2015; 2016)²⁰⁷. Interviewees stated they have still yet to challenge the issue in the highest court for two reasons: first, like the Germans, a final decision on this issue would preclude rejected claimants with finality. This, argued public health specialist Lizzie Moore, would harm rejected claimants but also provide momentum to the DH in its ongoing efforts to impose charges for primary care. Second, the advocacy coalition that brought the initial application has dissipated. While interviewed persons from GHAP and Medact are still active, their efforts continue to focus asylum seeker healthcare access more broadly, including on protecting primary care from charges. This suggests that the DH's consultations and continued charging proposals elicit secondary effects by creating multiple targets for advocates to focus on. As in Germany, this disperses advocacy power while also diverting resources away from targeted demands to reinstate secondary care access for rejected asylum seekers.

Meso (Organizational) Level

Diverse Coalition and Multi-Pronged Effort. England's pro-access movement emerged immediately following the 2004 secondary charging consultation. Prior to the reforms, physicians typically had a low-level of engagement with healthcare advocacy unless they worked with refugee-serving organizations, whose efforts would focus primarily on undocumented persons. Pre-2004, there was simply less need for an organized push for asylum seekers' health rights as there was in Canada and Germany before their reforms, as England and indeed the UK did not withhold primary care from any group. Full primary care access for all minimized the chance asylum seekers would be excluded, even if mistakenly. However, starting in 2004, the

²⁰⁶ Moyra Rushby (Medact), interviewed by author, August 16, 2016.

²⁰⁷ Important for advocates however, in the same ruling, the Court also found that the DH was unlawful in its guidance to NHS Trusts regarding persons who are unable to pay and may not be able to or reasonably expected to return to their country – these persons, the Court found, must still be provided treatment, reinforcing the principles of universal access regardless of financial situation in the NHS. Still, refused asylum seekers are formally excluded from free secondary care.

series of consultations injected doubt and confusion into hospitals and practices, creating new barriers in practice and in policy. In response to these new barriers, the medical sector mobilized alongside major non-profit organizations to challenge the regulatory reform and clarify questions now raised amongst providers and asylum seekers.

England's pro-access movement paralleled the other movements along several planes. Like Canada, England's movement had a clear, specific goal – though like Germany, this goal was to reintroduce healthcare for failed asylum seekers *and* undocumented persons. Like both Canada and Germany, the nation's top professional and regulatory associations offered strong and vocal support to the movement's goals. But unique to England, overall advocacy most strongly involved persons from the non-profit sphere, other healthcare providers as well as medical students, all of whom were central in developing the movement in its early days. Other aspects further distinguished the British movement, including its relationship with the press and the scope of its demands. This section focuses on the movement's composition, its aims, and its accomplishments, and identifies where institutional constraints and opportunities shaped the movement's behaviour.

Movement Composition: At first glance, that the British pro-access movement was reportedly launched by *Médecins sans Frontières* (MSF) may seem surprising: in 2004, MSF members operating international-facing programs out of the London office called a meeting of major refugee-serving organizations to discuss the recent proposal to charge rejected claimants for secondary care. A multinational organization with almost no domestic footprint in England turned the switch on British health advocacy because prior to 2004, few organizations *had* a locally-facing mandate. Likely provoked into action because of their widely-known name, MSF contacted fellow London-based organizations including Medact and Amnesty International, all of which had a global mandate and focused on domestic concerns infrequently. While MSF and Amnesty continued to support the movement in principle, Medact became a core driver of the British efforts. As with the Canadian and German movements, informal ties were crucial to building initial networks of support.

Domestic organizations focusing on specific issues of health access were also early joiners, including the National AIDS Trust and Terrence Higgins Trust. Both organizations fight for the rights of UK residents to access HIV/AIDS medication and support. While asylum seekers were not previously a discrete area of advocacy, because long-term HIV/AIDS treatment

is considered secondary care, rejected asylum seekers became constituent groups of these powerful and well-respected organizations. These organizations “came together to ask how to get the Department of Health to look at the policy; “it wasn’t just a moral issue”, explained a non-profit leader; “[this reform] just wasn’t going to work”. The coalition of organizations thus evolved in a unique landscape. Unlike Germany and to a lesser extent, Canada, the movement formed and was managed out of one major city – London. However, it received support from GPs and healthcare providers across the country, who joined in efforts including MP letter-writing campaigns and refusing to deny persons care. How GPs in refugee-adverse Northern England came to join the pro-access movement can be linked to refugees and claimants who arrived in their practices in the early 2000s.

Historical institutionalism also stresses the importance of unintended consequences to institutional change (Hall & Taylor, 1996), which may elicit feedback effects that shape and support advocacy movements. In the case of England, refugee housing reforms and the implementation of dispersion policies in the late 1990s sowed the seeds for future health policy action. Here, timing, the sequencing of events, and the role of early events in shaping the opportunities available to collective action actors are important. As described in Chapter 3, England’s lack of strong subnational units permitted centrally-led legislation to redistribute asylum seekers away from London into peripheral towns throughout England in 1998. While it is a mistake to view England as absent multilevel governance, especially vis-à-vis integration policies (Scholten & Verbeek, 2014) here the central government was able to respond to powerful subnational policy demands (i.e., those of the City of London) to distribute the ‘refugee burden’ throughout the country, despite resistance from weak municipal governments (Sales, 2002). The result was small and medium-sized towns receiving refugees according to a quota; for many asylum seekers, this meant a disconnect from key services, and for service providers this meant having to provide for a new set of population needs. Physicians in areas receiving refugees for the first time sought advice from organizations including Medact, which responded by creating the Medact Refugee Health Network to connect physicians across the country with experienced London providers. The resulting 250+ member network of providers across the country included a majority of members who had never previously considered refugees’ health rights. This widespread, cross-sectoral network of physicians were now engaged as refugee health providers, and were among the first Medact turned to when starting its inward-looking

physician awareness campaigns following Dept. of Health 2004 proposals to charge for primary care.

Respondents described the network's effects as normalizing refugee issues in healthcare circles that were previously unfamiliar of claimants' care needs. The Medact Refugee Health Network also had inertial effects; its membership was open to any physician or academic, who joined via word-of-mouth. Such institutions that "trigger mechanisms of reproduction...[set] into motion self-reinforcing sequences that are path-dependent" (Mahoney, 2000: 516) before alternative institutions – for example, the DH or Home Office – are able to sow their ideas and diffuse power. Indeed, the DH proposal to charge asylum seekers was described as galvanizing the Network members' support in 2004, producing an important strengthening feedback effect into the Network, which continues to present day.

From 2003-2004, advocates began meeting regularly in London, and dispersing meeting minutes and action items throughout the Medact Refugee Health Network, which continued to grow. While each organization or individual GP focused on their strengths or adapting their existing mandates to respond to current demands, the coalition initially agreed upon two core items. First, the movement would focus on one issue: preventing the enactment of secondary care and later, primary care chargers; and second, efforts would focus on building an advocacy coalition amongst fellow healthcare providers and politicians, with little effort placed in building a media profile. To the first point, organizations leveraged their existing efforts and created new strategies to protest against the consultations (see Table 9). These included submitting memorandums to Parliamentary Home Affairs Committee (GHAP, 2008). The movement also received support from London Mayor Ken Livingstone, who lobbied the DH to reverse the changes out of concern they would overburden A&E departments (Hinsliff, 2008). After secondary care charges were ultimately enacted in 2005, Medact and GHAP collaborated with refugee-serving lawyers to challenge its legality (see *Meso Level: Institutional*). When primary care was not restricted, multiple organizations changed gears to focus on educating providers and GP practices on the current law, emphasizing that restrictions were not implemented and continuing to promote the support of institutional partners such as the Royal Colleges. Moyra Rushby stated:

Health professionals took an information role, but also got letters from Royal Colleges, articles in to the BMJ, Lancet; letters whenever they could – they wanted to keep the issue central for physicians, that’s what we could do. For instance, Terrance Higgins and NAT did it mostly frontline because they were working with people on the frontline.²⁰⁸

To the second point, Britain’s notoriously tabloid-focused popular press did not present as a strategic move to advocates. While Canada found allies in journalists who were long-conditioned to report on issues of immigration, England’s advocates took a stance not unlike those in Germany. However, while in practice both had fairly limited purposive engagement with the press, the British movement stands out in this decision because it was made consciously and collectively by a cohesive, centrally-located movement:

We realized that to talk to the press wasn’t going to happen. Press is pretty hostile, but also it was very difficult to get a complex story across to a journalist. If you talk about an asylum seeker, they talk about an immigrant.²⁰⁹

When advocates did communicate with the media, they consciously attempted to connect with agency-laden institutions such as the NHS (Morris, 2000), and called on everyday Britons to support the movement in its efforts to keep the NHS intact. Advocates reported that this message was also repeated to providers who expressed reservations about asylum seekers.

Interestingly, the pro-access movement also fought for the inclusion of undocumented persons, who were equally affected by the 2003 reforms. Interviewed persons stated that rejected asylum seekers were most often the public face of their campaign because this was also the focus of the media (e.g., Mulvey, 2010). Yet, aggregating asylum and undocumented issues did not problematize or hinder the British campaign as it did the German campaign, because the issue is tied fundamentally to the underlying healthcare payment system and how exclusion therein would function. In Germany, the health system is designed for charging users through private and public sickness funds. Thus, calling for the *inclusion* of one group does not necessitate calling for the inclusion of all. Thus, structurally advocates were resisting changes to the NHS structure that would allow for charging for services. To support this position, this required also supporting undocumented persons’ access, as the underlying causes for claimants and

²⁰⁸ Moyra Rushby (Medact), interviewed by author, August 16, 2016.

²⁰⁹ Ibid.

undocumented persons' exclusion were structurally identical. Even still, the movement was still perceived as having a singular vision: "Everyone did their own thing", said an early movement organizer from a major non-profit; "but there was a lot of cooperation between organizations, more than I'd ever seen. Probably because we had one piece of legislation we needed to overturn. It wasn't a wide broad coalition looking at improving healthcare for refugees, it was quite defined"²¹⁰.

Like Canada and unlike Germany, there is a substantive academic community in England that researches and publishes on the health needs of asylum seekers, including the effects of NHS proposals and reforms. These include the impact of cuts to maternity care for failed asylum seekers (Gaudion et al., 2006); providing commentary on the efforts of non-profit refugee advocacy groups (Frauenfelder, 2006); alerting GPs of potential impacts of proposed charges for rejected claimants' primary care, from an ethical and practical perspective (Vernon & Feldman, 2006); and questioning the evidence behind the health tourism argument (Hargreaves et al., 2005) as well as the cuts' compliance with the NHS ethos (Ashcroft, 2009; Taylor, 2009). Consultations and proposals, in particular the successful 2004 reform to withdraw access to secondary care for rejected claimants, drew ire in trade journal op-eds such as the *British Medical Journal* (e.g., Hall, 2006; McColl, 2006) and were the subject of critical analysis in academic press (Joels, 2008; Yates et al., 2007).

Royal Colleges, professional associations, and humanitarian groups also condemned the policies and drew on varied narratives to advocate for asylum seekers' full NHS access. Of note is the diversity in these key actors' opposition, which drew on humanitarian causes as well as practitioners' duty of care (RCGP, 2013), the link between health and poverty (Royal College of Psychiatrists, 2015), international human rights obligations (Faculty of Public Health UK, 2008), public money (Royal Society for the Promotion of Health in GHAP, 2009), public health and its effect on social cohesion (National Aids Trust, 2009) and implications for professional actors (BMA & Royal College of Midwives, 2009 in GHAP, 2009). Historically speaking, support from the Royal Colleges was not historically expected by members. An RCGP representative stated:

²¹⁰ Anonymous physician, interviewed by author, November 2016.

It's only relatively recently that Royal Colleges have been prepared to be political. They've been Ivory Towers, they've run exams, they upheld standards on quality but not necessarily as a politically campaigning body...But there's been a chance in the last 10 years for RCGPs to be more prepared to speak out about policy.²¹¹

In England, support from the Royal Colleges was potentially most important at the onset because it signaled to government actors that the movement consisted of more than individual doctors or refugee advocacy organizations. Moyra Rushby of Medact recalled:

We realized the best way we would win the argument would be to win over the medical profession – in this country the people at the top are basically the Royal Colleges. That was when Medact came into its own – we had the network, and some members were quite senior in the health world, some were leading figures in the Royal Colleges. So, it was easier to mobilize people to get the message across. We would start off with ones we could do easily, and bring them on board, and use them to get the others on board.” Because they're doctors and particularly, the Royal Colleges, because they're focused on medicine health policy and public health policy you just have to make your case. If your case makes sense medically, if it's scientifically correct, if they see – then the politics doesn't come into it. You've got to use people within their own profession – but once you've got someone who's in there who can make the case it was only in a few occasions very difficult [to get them on board].²¹²

A Medsin-UK member agreed that the support of Royal Colleges was critical because:

Very few would stand and pick a fight with a Royal College. Well, they are doing it now, but at that point they wouldn't. It also made it easier...[because] you've taken it out of the immigration and refugee arena and you're talking about healthcare and health policy. You could talk to MPs and make them listen because they're listening to experts in their field.²¹³

As noted, organizations including the BMA and RCGP also issue guidelines to their members and through other outlets, encouraging them to follow the law and register all patients regardless of immigration status. However, confusion still remains – an RCGP representative explained:

²¹¹ Anonymous physician employed by the Royal College of General Practitioners, interviewed by author, August 2016.

²¹² Moyra Rushby (Medact), interviewed by author, August 16, 2016.

²¹³ Anonymous medical student (Medsin-UK), interviewed by author, August 2016.

One of the reasons is that not all people are members of the College and so don't get the information. A significant amount of members unsubscribe from the newsletters. Other organizations like the BMA give information on this, through structures like Local Medical Communities, who will send information to practices...the vast majority of practice managers can access information through the LNC. But why there is still a gap? I don't know.²¹⁴

Table 9 provides an overview of major organizations that support the movement currently through efforts to stave off further regulatory change and/or educate providers of the regulations. Doctors of the World UK is a particularly interesting example, both because it the London-based free clinic and domestic UK mandate were only developed in 2006, following the reforms – all other major organizations existed in some form as global health advocacy groups that focused on local issues when the consultations began. Moreover, Doctors of the World UK also has a strategic competency-building focus. By training junior doctors on key issues of asylum seeker healthcare and access, Doctors of the World UK leverages the British medical school training curriculum which uniquely, focuses heavily on peer-to-peer training amongst junior doctors. Investing in advocacy efforts on the front-end of physicians' training may have cascading effects on keeping asylum seeker healthcare accessible in the future.

Table 8: Selected Examples of England's Pro-Access Organizations

Organization	Description
Doctors of the World UK (<i>Médsins du Monde</i>)	<ul style="list-style-type: none"> • Domestic-focused threefold mandate: • Service provision: Free clinic run by volunteer support; provides primary care to persons who are denied GP access despite all persons being entitled • Advocate for patients: Connects patients to GPs and/or advocates to GPs to register persons on their list • Advocacy skills building: Works with medical students to (i) build advocacy skills and (ii) provide curricula materials for junior doctors to teach fellow physicians with, as part of NHS training system; • Policy reform: 'Classic' Parliamentary lobbying (e.g., lobbying MPs through constituents and through health professionals); public campaigning • Other: Sits on NHS reference groups (advisory committees); responds to DH consultations; publishes reports and research

²¹⁴ Anonymous physician employed by the Royal College of General Practitioners, interviewed by author, August 2016.

Medact	<ul style="list-style-type: none"> • Global health organization located in London • Launched Medact Refugee Health Network to connect providers on issues of asylum seeker healthcare
Medical Justice	<ul style="list-style-type: none"> • Provides medical assistance to persons under immigration detainment • Document evidence of torture and present evidence to immigration hearings • Calls for improved care for detainees as well as objects to charging
Medsins-UK	<ul style="list-style-type: none"> • Student-led global health charity focusing on local and global health issues • Local education efforts for medical students on relevant issues • Created the Global Health Advocacy Project (GHAP), which published results of freedom-of-information request

Micro (Individual) Level

At the individual level, efforts must be made to parse out the individual effects of persons who were pro-reform, and those who were pro-access leaders. To the first component, one name was consistently raised in interviews: John Reid, former Health Secretary of the DH with a hardline view on asylum seeker access. Reid served under the Labour government from 2003-2005, and it was under his guidance that the initial consultations and reforms were instigated, and cooperation with the Home Office increased. Under Reid, asylum controls were framed necessary to protect the integrity and legitimacy of England’s immigration system (Mulvey, 2010), and called for “mature debate” on immigration in Britain, a public position not typically adopted by Secretaries of Health (BBC, 2006). Reid’s approach to managing the DH was outwardly critiqued by senior management in the NHS. In 2006, the DH’s workforce director Andrew Foster stated the NHS had lost confidence in the DH’s leadership under Reid: “When John Reid came in we produced a series of major policy changes without consulting people...we produced a series of documents...and just sprung them on an unsuspecting NHS in 2004-2005. It’s not surprising that they didn’t feel the same level of ownership” (Carvel, 2006: n.p.). While it is not clear if Foster was referring to the regulatory changes for asylum seekers, this signals the contentious role played by the health secretary. To this end, while primary data could not be collected regarding the particular role (i.e., level of discretion, power) held by Reid at the time of reform, Foster’s statement hints to level of contention between the DH, NHS, healthcare and professional associations, and the discord Reid’s controversial positions fostered. Dr. Michael Andrews felt individual actors were instrumental in pushing the Home Office’s framework

through NHS policies: “It also really matters the personalities at the Department of Health – John Reid, for example was very quite hardline on that...I think it was driven by particular people in the Department.”²¹⁵

Again, as in Canada, key leaders emerged as agentic entrepreneurs that drove key initiatives, including Moyra Rushby, a nurse who represents the most central non-physician activist across the three studied cases. Interestingly, while experience with advocacy and protest can be important predictors of movement leaders’ efficacy (Morris, 2000), the case of England’s medical student leadership suggests that fresh perspectives can also make effective leaders. While students fed the movements in Germany and Canada, but in England their efforts produced artefacts that became key components of the movement’s repertoire, and helped to consolidate the movement’s purpose and efforts – namely, the GHAP 2009 report documenting students’ Freedom of Information request. This report and the efforts of students to widen access for asylum seekers often leveraged the agentic normative power of the NHS vis-à-vis access for all, and potentially reflected the energy and exuberance of students new to healthcare.

Conclusion

England’s advocates face differing pressures than their Canadian and German counterparts. While the reform affected fewer people, the threat of expanding the reform has been persistent and ongoing since initial changes were implemented in 2005. The movement’s strategy thus differs in that advocates seek to pre-empt regulatory change through education and training – in essence, by growing their movement’s base of supporters. In response, the DH has subverted regulatory constraints by issuing muddled guidelines around physicians’ responsibilities towards asylum seekers, while also providing resources – including maps of chargeable countries, posters alerting persons to charging for hospitals, and links to non-profits that serve without charges – to NHS trusts to “help” the “NHS to recover costs of care from visitors and migrants” (Department of Health, 2017, n.p.).

Still, several factors have shaped the British movement since it launched in 2004. Practical barriers such as a dearth of institutions to absorb the fall-out of rejecting claimants for care places limits on the central government’s ability to restrict NHS access, problematizing the

²¹⁵ Dr. Michael Andrews (Member, Medsin-UK), interviewed by author, August 19, 2016.

assertion that unitary states can execute social reforms with more ease than federal states. This analysis also suggests that institutional norms (here, free-at-access, universal care for all persons) can have profound effects on the government's ability to restrict care. These norms are operationalized by on-the-ground practitioners; indeed, the pro-access movement's greatest strength are the physicians who refuse to comply with proposed reforms. Certainly, normative buy-in from British physicians is not necessarily stronger than that from their Canadian and German counterparts. However, while Canadian and German doctors face financial consequences if they do not comply with asylum seeker healthcare reforms (i.e., they will not be paid, as claimants will lack insurance), British doctors do not face this threat – under the current nationalized health service, they are paid per head and immigration data is not collected. In fact, the threat of imposing charges is what would actually cost doctors, as GP practices would be required to fund the implementation of charging systems.

To this end, the British case also shows that healthcare payment systems can shape stakeholder networks, as the financial threat this possibility posed to doctors implicated their powerful professional trade union, the BMA. Relatedly, the universal access norms of British health policy, alongside health care's single stream of service for citizens and refugees, place strong constraints on the degree to which the bogus refugee ideational institution can take hold. Collectively, these factors support the pro-access movement agenda and limit the ability for uniform political will to restrict refugee access to translate to widespread charging reforms. However, advocates continually assert that while the aforementioned macro, meso, and micro-level factors have worked in tandem to stave off reform thus far, these institutions and symbols may not withhold change forever. Indeed, as attacks on the NHS' public funding model continue and Brexit ushers in a new norm of anti-immigrant culture, the power of physicians and their supporters to resist charges for asylum seekers may wane.

9. Conclusion

Physicians are almost by definition, advocates. Every day, they advocate for the health of their individual patients by collaborating with other healthcare providers and helping patients navigate complex health systems. This history of advocacy runs deep; Dr. Rudolf Virchow, the father of modern pathology famously stated that physicians “were natural attorneys of the poor” (Mackenbach, 2009: 182). Virchow’s career focus on the social and economic determinants of health helped carve an image of the physician as a tireless advocate for all patients that puts medical need before ability to pay; this image of social medicine forms the basis of universal healthcare systems around the world. This commitment to advancing patients’ individual needs and supporting the needs of the disenfranchised is enshrined in many medical professional associations’ mandates, including the Canadian Medical Association, which states that doctors “must be able to freely advocate when necessary on behalf of their patients” (CMA, 2012: 1).

However, while advocating for individual patients or even entire marginalized populations is rightfully commonplace in physicians’ circles, leading sustained social movements to change legislation is not. Yet this is exactly what doctors in Canada, Germany and England did in response to central government retrenchment on asylum seekers’ healthcare access. Physicians created or joined organizations, devised messaging and protest strategies, and rallied behind individual leaders in an effort to reverse restrictions placed on refugee claimants’ access to care, to varying degrees of success. This success is a function of strategic decisions doctors made as social movement drivers, but also a reflection of the context in which doctors were operating. To understand how strategic decisions (organizations, people) interacted with contextual factors (government systems, healthcare and judicial institutions) to shape these physicians’ ability to make change, this research project asked: Under what conditions are physicians successful in changing asylum seekers’ access to healthcare? Identified factors are interconnected and complex and thus, an ecological model was devised to understand how different factors interact to shape physicians’ impact. Factors at each the macro-systems, meso-institutional, meso-organizational and micro-individual level were analyzed for each case, illustrating that physician-led movements do not form in vacuums.

Of course, physician-led social movements are formed in response to a key event: national government-led asylum seeker healthcare retrenchment. Thus this project also posed the

question: Under what conditions do central governments expand or liberalize asylum seeker healthcare access? Understanding how these reforms came to fruition is critical to painting a comprehensive overview of these physician-led movements, but also identifies factors at each level that impacted how movements responded to these reforms. Certainly, a key ingredient in each country was strong political will. In universal healthcare countries, political actors must perceive considerable rhetorical or material benefit before they consider excising asylum seekers from healthcare, even when asylum seekers are the subject of public distrust or disdain. However, political will alone cannot account for asylum seekers' exclusion from a national healthcare system. The findings to this second research question are thus also organized using an ecological framework in order to understand what conditions must be present in order to facilitate asylum seeker healthcare reform.

This concluding chapter highlights key insights from each analyzed country at the macro, meso, and micro-levels. It begins by unpacking factors that impacted governments' ability to implement asylum seeker healthcare reforms, followed by an examination of the factors that shaped the physician-led movements in Canada, England, and Germany. This chapter concludes with an overview of new avenues for research.

Question 1: Under what conditions do governments restrict or liberalize asylum seeker healthcare access?

Political will is not enough to change asylum seekers' access to healthcare in countries with longstanding universal healthcare systems. This is true regardless of the country's relationship with immigration and refugees. Governments seeking to enact refugee reforms encountered barriers and vectors at each the macro, meso and micro levels that impacted how reforms were enacted as well as the resistance they fostered; indeed, many factors identified as shaping government's ability to enact reform also shape advocates' ability to successfully counter the government's intentions.

First, at the **macro-level**, reform-seeking legislators must consider the wider system of government in which they are located. Studies have suggested unitary systems can create permissive conditions for social policy reform, while federal governments hold multiple veto points but create fertile grounds for social policy downloading. However, this study suggests

central government exit from a policy can be frustrated by strongly-held ideational institutions, such as norms around universal healthcare, across federal and unitary systems. Where strongly-held programmatic beliefs are present, federal governments cannot simply exit a policy because practitioners will continue to deliver the service according to the policy venue's longstanding traditions. Cancelling a program or excluding a population, regardless of citizenship status or popular appeal will not translate to actual change if practitioners insist on continuing to provide a service. This was seen in Canada, where physicians' continued provision of care prompted provinces such as Ontario to create temporary gap-fill insurance programs despite federal opposition to the province's decision. To a lesser extent, it was also seen in Germany, where continued practitioner demand on state governments prompted the creation of policies to widen asylum seekers' access to care. In unitary England, downloading was not feasible, though neither was national exit, largely because of the normative power of the NHS and GPs' perceptions around healthcare universality. In each instance, many physicians continued to provide care, despite a lack of legislative support, prompting gap-fill policies (Canada) or permanent responses (Germany), or precluding exit altogether. Still at the systems level, available policy vehicles for reform also impact how easily governments can restrict health access. Both Canada and England used mechanisms that avoided public scrutiny and debate: in Canada, the Order-in-Council, and in England, a simple regulatory reform instead of a legislative shift. In Germany, a far more consequential approach was taken: the constitutional reform, which was enacted as a precursor to the 1993 *AsylbLG* policy. While further constitutional reform would not be required to expand healthcare offerings, conceptually, the two changes are joined as components of the Asylum Compromise, a politically contentious agreement that staves off future reform.

At the **institutional level**, policy venues will also shape a policy's vulnerability to reform. A policy's ministry impacts which actors and norms underpin asylum seeker healthcare, as well as the complimentary policies that surround it; these factors can provide protections against retrenchment, or leave a policy particularly susceptible to dismantlement. At the time of reform, the Canadian IFHP was located in the federal Ministry of Citizenship and Immigration. This located the policy within a ministry that was also responsible for exclusionary-centred practices such as border services and refugee determination. Conversely, in England, asylum seeker healthcare is undifferentiated from citizens' healthcare; claimants receive care from the National Health Service, and proposals to exclude claimants from NHS primary care creates

ripples of concern for the future of citizens' care, because it is one in the same. Finally, in Germany, asylum seeker reforms excised claimants from citizens' care in 1993, as claimants were constructed as incompatible with Germany's notions of contribution-based social citizenship. Bracketing the population off into distinct, separate legislation that was now overseen by the Federal Office for Migration and Refugees (*Bundesamt für Migration und Flüchtlinge*) increased the ease and acceptability of legislating claimants as underserving and of denying them full access to care. Finally, at the **individual-level**, issue champions can be as important to policy reformers as they are to advocacy movements. The Canadian case is perhaps most interesting in this regard. Canada has the strongest history of asylum seeker support and not surprisingly, the IFHP reforms were opposed by physicians and non-physicians alike. However, the movement's architect, Minister Jason Kenney had laid the groundwork for IFHP reforms with early amendments to other asylum seeker policies. These reforms fostered a sense of suspicion towards refugees, likely expanding the realm of reform supporters.

Question 2: Under what conditions are physician-led movement successful in expanding asylum seekers' access to healthcare?

The core finding of this study is that social movements are responsive to their political and institutional surroundings, and that the ability to shape refugee health policy is positively correlated with strategic decisions that leverage a movement's surroundings. A movement's context – such as the system of government or the variety of universal healthcare that is practiced – can foster strategic connections or disperse power across multiple sites. These same contextual factors can also shape the degree of consciousness and sense of consolidation amongst movement members, which in turn impact how members interact across subnational units and between specialties. At the same time, individual issue champions can deftly navigate barriers to open doors for movements, streamline messaging and action to leverage their ideational contexts, and create partnerships with powerful institutions to further drive the movement's agenda.

This analysis of physician-led movements provides a fertile ground to extrapolate and explore larger thematic questions, such as – how do elite actors differ as social movement leaders, and how do they leverage their social capital? How important is message framing, relative to physicians' well-established social legitimacy? Are centrally-led movements

important, or can smaller movements effect the same change? While not a prescription or recipe for change, this section highlights in particular the conditions and strategies that were successfully leveraged by pro-access movements across countries.

Macro (Societal) Level. Macro-level factors are those on the outermost ring of the ecological model. As overarching societal-level issues, they can exert downward pressure on advocates' decisions or can act as scaffolding, against which advocates chart their structure such as system of government. Social movement literature has examined the role of macro-level factors – in shaping political opportunity, but less attention is paid to how these factors – including government system, normative considerations, complimentary policies and the media – can shape movement's behaviour. This project sought to reconcile these considerations by mapping institutional contexts and opportunity alongside the shape and behaviour of the movements.

System of government shapes what opportunities are made available as well as how advocates organize to maximize these opportunities. In unitary Britain, doctors all operated within the same NHS system and thus, they spoke the same 'language': their experiences navigating asylum seeker reforms were structurally uniform, as were their perceptions of the NHS as a universal system. This collective physician identity vis-à-vis the *national* health service helped the pro-access movement foster solidarity. But, it is not as simple as linking federal or unitary systems to a given result. In federal Germany, the Second World War prompted the creation of a strongly decentralized system that gave deference to state and municipal-level implementation powers. This encouraged physician advocates to target subnational government units to improve asylum seeker health access. While this led to quicker policy gains, it ultimately impeded national movement solidarity, suggesting that Germany's federal structure dispersed advocate power and discouraged national coordination. It also heightened confusion around asylum seeker entitlement, creating problem definition issues amongst even pro-refugee doctors. Canada is also relatively decentralized, however physicians across the country formed a national movement akin to England's. This is in part because IFHP's unique location as a federally-governed healthcare program made its retrenchment uniformly felt across provinces. These provinces, unlike German states or municipalities, do not have the power to implement taxes or other revenue-generating mechanisms to fund provincial-level asylum health programs. Thus, provinces either did not respond, or created gap-fill programs and

pledged to send the bill to the federal government; physicians viewed these responses as temporary. This fostered a sense of solidarity amongst advocates in provinces with and without gap-fill programs and helped drive the national nature of the movement. Importantly, across cases, the universal nature of each healthcare system would shape advocates' normative expectations for healthcare delivery. Physicians in each country felt compelled to treat persons for medical need, and not citizenship status or ability to pay, fostering a sense of shared values and duty amongst advocates that frustrated the government's ability to implement reform.

How national governments proposed reform will also shape advocate responses. This is true in terms of how the reforms were framed, and how they were executed. In Germany, the new asylum healthcare bill was ushered in by a constitutional amendment. The dramatic reform was framed as a necessary response to quell Neo-Nazi violence, spurring discontent amongst protesters. In Canada, reforms were framed as a necessary response to quell bogus invaders and were executed without warning or debate through an Order-in-Council. A similar vehicle was used in England. The proposal to limit primary and secondary care was framed as a means of protecting scarce resources. The successful effort to limit secondary care was executed through a regulatory change, which shielded the issue from Parliamentary scrutiny. In each case, the reform's framing and mode of execution fueled advocates' resolve to reinstate asylum seeker healthcare.

This analysis also highlighted the importance of exogenous shocks to shaping political opportunity. The arrival of more than 1.4 million asylum seekers to Germany starting in 2015 created new pathways for pro-access advocates to grow their coalition and demand their government implement the electronic health card to ease bureaucratic frustrations. Similarly, in Canada Syrian arrivals became an electoral issue, signaling the country's turn towards accepting refugees and thus, their limited appetite for the government continuing to pursue refugee healthcare reform. But shocks can also tighten pathways to change; in England, the arrival of refugee claimants to Europe spurred xenophobic discontent and in part, the UK's decision to Brexit. While it did not lessen claimants' access to care, it bolstered anti-refugee sentiment.

Meso (Institutional) Level. Meso-level institutional factors are frequently explored within political opportunity literature vis-à-vis judicial systems, and the opportunities created by institutionalizing rights and rights-related discourses. This study confirmed the importance of the

courts for creating political opportunities for advocates – in Canada for example, physicians led a successful Charter challenge against the federal government. However, courts also represent a risk to advocates; in both Germany and England, advocates chose not to pursue the courts because a negative ruling would impose permanent restrictions on refugee care. This signals that courts and rights-based discourses may create political opportunity where asylum seekers are historically well-received, as in Canada, but may narrow opportunities in places like England and Germany, where ‘rights’ and ‘refugees’ rarely dovetail in public discourse. However, the case of Germany also suggests that even when the judicial system presents an inopportune venue, it can create new, secondary political opportunities in the legislative sphere, such as when a positive asylum seeker welfare decision spurred a campaign for legislators to simultaneously reconsider refugee healthcare.

Healthcare payment systems are another institutional factor that matter to healthcare advocates. Both Canada and Germany suggest that single- and multi-payer systems are conducive to refugee charging, making asylum seeker healthcare reforms possible in the first place. However, these systems can also support refugee access. In the case of Canada and England, healthcare payment systems acted as vectors for advocacy growth. The Ontario Temporary Health Program (OTHP), a provincial-level gap-fill in Canada’s province with the largest asylum seeker population, proved unduly cumbersome and inefficient, prompting advocates to continue pushing for national reform. In England, the healthcare payment system reflects the country’s pioneering universal healthcare norms – namely, that it is free at the point of service. This formed physicians’ expectations to provide care without charging, but also implicated the British Medical Association (BMA) as a strong anti-reform advocate, as implementing charging systems for refugee claimants would pose undue financial burdens on its members – doctors. In both cases, this study finds that healthcare payment systems shape physicians’ expectations (that reimbursement be easy; that charging not occur) and coalition members (continued support from Ontario physician despite provincial gap-fill OTHP; support from professional employment association/union, the BMA). Germany’s healthcare billing system improved healthcare access, but almost incidentally. The pro-access movement pushed for Berlin and other municipalities to implement the electronic health card as a means of easing bureaucratic hurdles and thus, improving access. But the new cards increased access beyond what was expected – by using a mainstream health card, responsibility to reimburse physicians’

refugee billing shifted to a private health insurer. These insurers are more likely to accept physicians' billing claims simply because it is cheaper to pay out claims than to pay someone to analyze their validity. Thus, healthcare payment systems can impact the nature of advocacy coalitions, but also widen access through unintended means.

Meso (Organizational) Level and Micro (Individual) Levels. Notwithstanding the importance of the courts and healthcare payment systems, as Schmidt (2008) argues, institutional design “is not destiny” (316). A social movement's context is not determinative of its ability to create impact; to the contrary, organizations and individuals play key roles in guiding advocacy and determining strategies. Given the inextricable connection between organizations and the people who lead them, key findings are discussed collectively here. This study finds that successful movements will consciously and strategically respond to their macro- and meso-level institutional environments. Ideationally, movements make impact when they can hook their message to a broader normative institution that resonates with everyday citizens. When communications align with societally-accepted frames, advocacy can make impact in asylum seeker healthcare.

In Canada, Canadian Doctors for Refugee Care (CDRC), the movement's leading organization strategically deployed messaging around what it means *to be Canadian*, urging people to understand threats to asylum seeker healthcare as threats to what Canada values: multiculturalism and a history of supporting refugees. At the same time, advocates were conservative in their demands, asking for only the reinstatement of healthcare as it had previously existed. This excluded undocumented persons from their list of demands, causing ire amongst some advocacy circles. But, by conforming with societal norms around who was deserving or entitled to support, the CDRC-led movement was appealing to everyday Canadians and palatable to moderate politicians. In England, public appeals were rare but when advocates turned to the public, they oft appealed to the NHS' fabled history and the need to protect it against dissection and dismantlement. They also urged fellow physicians to see reforms as economically unjust and practically infeasible, appealing to the pragmatism of the NHS' self-employed physicians. In Germany, advocates were the least successful in this regard. Coalition members most commonly aligned with more 'radical' perspectives, including calling for healthcare for all persons regardless of status. In a country already concerned about their social

system acting as a magnet to undocumented persons, asylum seekers, and non-EEA nationals, this did not resonate to the same degree. When the targeted campaign *StopAsylbLG.Org* emerged in 2014, advocates decided to colour within policy lines by streamlining their messaging and their ‘ask’: reinstate *asylum seeker* healthcare because it is the economically and socially just change to do.

From this analysis of movements’ framing, we can also conclude that resources matter for social movements. Having access to finances can help drive a cohesive strategy, especially around messaging, the ‘ask’ and a protest’s repertoire. Such is the case of Canada, where physician members of the CDRC pooled financial resources to hire a public relations coordinator, who brought communications expertise to the movement. In England, resources came in form of social and political capital from early movement supporters – major international, non-profit health organizations. Their initial support brought domestic-facing organizations to the table, who in turn drove interest amongst local physicians. In contrast, the German movement suffers from a lack of resources. This is in part a reflection of their macro-context; there are a multiplicity of players spread across states and with different strategic foci. Without a central organization leading the movement at a national level, there is limited coordination of resources, such as sharing legal or policy expertise. It is also a reflection of the major organizations’ disposition; radical and/or anarchist groups that rely on volunteers’ time and donations, and never government funding. While this is also true for other countries studied, in the German case ‘time’ is an important variable, as these volunteers have donated their own resources to drive the movement since 1993.

All countries successfully engaged two tactics: partnering with elite professional institutions and deploying a diverse protest repertoire. To the first point, advocates uniformly identified local and national-level professional associations as critically important to signaling their legitimacy to citizens, the media, and politicians. Organizations such as the Canadian Medical Association, the Royal College of General Practitioners, and *Ärzttekammer Berlin* provided much-needed legitimacy and professional clout to these movements. Their support lessened perceived barriers to entry for everyday physicians and were instrumental in growing these advocacy coalitions. To the second point, the three movements each engaged in a variety of tactics to broaden their reach and appeal. Physicians wrote letters, waged educational campaigns to other physicians, published in medical journals, and resisted reform by providing care without

expectation for reimbursement. Moreover, each movement's protest repertoire reflected their greater context. Canadian advocates were public-facing and thus, took to the streets or staged publicity stunts to drive support; British advocates primarily focused within the medical profession, and thus focused on educational interventions and publications in trade and academic journals. German advocates lacked an overarching focus, which again reflected their disparate macro-context.

However, which organization is at the heart of a movement can also impact the range of protest options available. While partnerships with longstanding organizations can be helpful for fledging movements, having an established, institutionalized organization driving a movement's strategy can impose constraints on action. In Canada, the CDRC was launched in response to the IFHP cuts. It was purposively lean, flexible, and single mission-oriented. Its purpose was clear to legislators, healthcare providers and the public, and it was not beholden to any constraints imposed by an overarching institutional partner. In Germany, advocacy is driven largely by longstanding organizations with deep institutional legacies. To be sure, the main organization *was* formed in response to the *AsylbLG* cuts. However, the MediBüro launched in 1994 with the main purpose of serving irregular migrants; thus, this population is entrenched in the organization's mandate and the greater pro-access movement in Germany. While the healthcare for all framing of Germany's advocates is in alignment with the movement's beliefs, strategically, it does not align with what greater German society and thus, German legislators value or perceive as deserving.

This study also finds that who is leading a movement is of fundamental importance. This can be thought of in two ways. Conceptually, physicians leading a movement is powerful. Doctors are elites; they carry considerable social capital and are well-respected. They are seen as experts in this field, and as gatekeepers to the healthcare system. Their legitimacy and social virtue was expertly signaled by wearing white coats to any public display of protest. This was most strategically leveraged in Canada, where white coat-clad physicians appeared in newspapers and television broadcasts. Conversely, British advocates were less inclined to publicly protest due to limited societal resonance, though still leveraged this important signal where possible. In Germany, the white coat's impact was suppressed by the Residence Act, as physicians were historically reluctant to publicly admit that they provided healthcare to asylum seekers or irregular migrants. However, not all doctors are perceived equally; in Canada and

England, ‘mainstream’ doctors as well as refugee-serving specialists were the face of the movement, whereas in Germany, ‘fringe’ or ‘left-leaning’ doctors were perceived as driving the advocacy, potentially limiting their ability to gain widespread appeal.

Finally, these organizations and greater social movements are guided by agentic leaders and issue champions. These are present and historic; physicians in Canada and Germany cited the work of Dr. Rudolf Virchow as inspiration for understanding health work as advocacy. Interestingly, lead advocates in each Canada, Germany and England had early career involvement with well-known organizations including Amnesty International and the group International Physicians for the Prevention of Nuclear War (IPPNW), as well as anti-torture organizations in their constituent country. These advocates, including Dr. Philip Berger (Canada) and Dr. Torsten Lucas (Germany) cited involvement with these organizations as helping to shape their understanding of physicians as politicized actors. At present, charismatic leaders are needed for public-facing campaigns, such as in Canada where a handful of physicians took risks and made strategic, bold pleas to the public to support refugee healthcare. In inward-facing campaigns, such as England and to a lesser extent Germany, strong leadership is defined by their communication abilities – those who can identify strategic frames and use these to connect with intended audiences. To this end, identifying the correct audience is crucial; while British advocates knew to avoid the press and to focus on fellow physicians, German advocates lacked a central coordinating strategy and dispersed their resources across multiple frames, audiences, and venues. As noted however, the ability to identify and support leaders who can drive a movement’s success is in part a function of a movement’s resources. A movement’s leaders need not be as compelling Dr. Martin Luther King, but being able to afford a public relations manager to support a campaign can be similarly effective.

Directions for Future Research. Future research can expand on questions of geography, time, and subject. Regarding geography, a further examination of variation *within* the federal cases would illuminate the interstitial factors that drive change. For example, in Germany three states consented to implementing electronic asylum seeker health cards before Berlin agreed to the change. Unpacking the specific institutional configurations of these states – including government and relatedly, status as city-state, federal state, governing party coalition, healthcare costs borne by pre-electronic health card systems, composition of advocacy coalition, and

presence of sympathetic government actors – would further illustrate the relative importance of factors identified in this dissertation. To this end, comparing successful subnational units against states where pro-advocates' efforts have been unsuccessful, such as Bavaria, would provide clarity on the importance of factors identified in this study. Similar to Germany, a within-Canada analysis would shed light on the importance of identified factors in facilitating advocacy impact at the subnational level.

To the issue of time, this project ceased analysis in 2015. These chapters have touched on the role of the global Syrian humanitarian crisis on shaping advocacy and policy thus far, but additional research is needed to understand what implications stem from these arrivals moving forward. For example, preliminary research indicates that German and Canadian physician training has added or broadened its focus on asylum seeker healthcare needs since the arrival of Syrian newcomers. Finally, to the issue of subject, further research might also examine advocacy focusing on irregular migrants' access to care. While this project touched on this issue as undocumented persons' entitlements oft dovetail with those of asylum seekers, irregular migrants are decoded differently than refugees by the state and also experience exclusion in different ways. To this end, exploring irregular migrants' *and* asylum seekers' personal experiences resisting healthcare exclusion in Canada, Germany and England would add the voices of precarious healthcare users to this analysis, a critical gap in this project as it is currently written. While research has examined precarious persons' access to care in these countries, less is written about how they navigate these systems and assert their right to have healthcare rights.

This project paints a rich empirical picture of asylum seeker healthcare policy and advocacy in three countries. It probes a research question that is often dismissed as self-evident: under what conditions do countries restrict or expand asylum seeker healthcare? Examination of historical factors across the ecological model reveal important mediators that complicate the assumption that pro-refugee countries support liberal access to asylum seeker healthcare, and restrictive countries support restrictive access to care. It traced historical developments in healthcare and related social welfare policies, creating country-level reviews of relevant literature and historical contexts that will be of use to academics of healthcare and immigration. This project also unpacked a research question that had yet to be asked – under what conditions do physician-led groups impact asylum seekers' health access? Posing this question to study

participants procured insight into the particular strategies of successful physician advocates but also the greater role that elite-driven movements can play in shaping public policy.

This study has been about advocacy and its adaptiveness to context, the elite and the excluded, deservingness, and most of all, asylum seekers' place in three analyzed countries. Occupying space in immigration and healthcare debates, two policy domains defined by oft-competing ideas, asylum seeker healthcare tests the limits of a country's definition of 'universal' and 'inclusive'. A country's asylum seeker healthcare story reveals as much about its politics as it does about its structural and ideational institutional landscapes. By applying an ecological model to government action and advocacy responses in each country, this study has helped to expand our understanding how advocates navigate multiple domains and institutional arenas. The trade-offs and balancing acts that stakeholders make while pursuing their policy or advocacy agendas shed light on the limits to any one individual, organization, institution or systemic-level factor in determining a political outcome. Read alongside the lived experiences and perspectives of asylum seekers, this study might act as a roadmap for advocates, policymakers, and policy users looking to drive change in these fields. Political will or commitment to a cause is necessary to fuel an effort over time, but context must be considered on order to successfully see an effort to its end.

10. References

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