Perceptions of first-generation Canadians on Rights and Deservingness of Healthcare for Canadian Newcomers

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Abstract

The present thesis provides insight into the social context in which the perceptions that first-generation Canadians have towards access to healthcare for newcomers may emerge. The study was completed in Ottawa-Gatineau in March and April of 2016 and covered the perspectives of nine people, across eight semi-structured interviews. Following the review of the literature and theoretical framework, the present work highlights the role that first-generation Canadians' moral worlds play into how they perceive access to healthcare for Canadian newcomers. On the subject of perceptions of first-generation Canadians, this research goes beyond the practical concerns faced by newcomers and delves into people's moralities as these relate to the interpretation of rights and deservingness of access to subsidized healthcare. In grasping the different ways that health and healthcare are understood, as well as individual perceptions of the granting healthcare to newcomers to Canada, my thesis makes visible moral elements that can help to understand how rights to healthcare can be configured and reconfigured across various contexts.

Keywords:

Right; Deservingness; Privilege; Morality; Moral economies; Moral communities; Health; Healthcare; Canada

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1. Introduction

In Canada, immigration is a significant driver of population growth. According to the 2016 Census of Population:

> *In 2016, Canada had 1,212,075 new immigrants who had permanently settled in Canada from 2011 to 2016. These recent immigrants represented 3.5% of Canada's total population in 2016. The majority (60.3%) of these new immigrants were admitted under the economic category, 26.8% were admitted under the family class to join family already in the country, and 11.6% were admitted to Canada as refugees.* (Statistics Canada, 2017-Oct-25).

In general, Canada seems to be perceived to have a very favourable climate for welcoming newcomers and refugees. This is particularly evidenced over the last few years with the Canadian response to the Syrian refugee crisis, for which Canada was praised by the United Nations Secretary General for its' compassionate leadership and "*huge solidarity with the international community*" (Valiante, February 2016). Canada, however, is not immune to anti-immigration discourses.

In 2015, the founder and current president of EKOS Research Associates Inc., Frank Graves, wrote that Canada's luck in avoiding strife over issues of immigration might be running out, as the country sees opposition to immigration doubling since 2005. This opposition to immigration is

still true today, in 2019. Even though Canada is known worldwide for its generosity on issues related to immigration (Valiante, 2016), opposition to immigration still exists and naturally bleeds into fields of inquiry such as access to healthcare. This brings to the surface delicate issues of not only public health, but also of economic, social, class, and human rights issues. In particular, it is important to pay attention to vulnerable groups of people coming into Canada since, as Hurley (2007) noted, excessive limits have been seen to have been imposed on the enjoyment of their right to health.

Indeed, as was evidenced in Campbell et al’s 2014 article, in many ways, vulnerable groups of immigrants represent some of the most marginalized or discriminated against when it comes to the question of access to healthcare. However, the present research is not directly focused on this marginalization. Rather, recognizing that the experience of having your right to healthcare realized always involves some sort of moral evaluation on the part of others (Vanthuyne et al, 2013), the purpose of this research is to study the issue of the construction of rights and of deservingness of healthcare in Ottawa-Gatineau and to determine what this can tell us about how peoples’ moral worlds may affect how rights are reconfigured in some contexts. This involves an exploration of how people understand and articulate who they believe ‘should’ have access to subsidized healthcare, in the context of newcomers to Canada.

As often seems to be the case with many students, I was drawn to this research topic in part by a personal query. Growing up in a family in which my father was himself an immigrant, who did not have access to subsidized healthcare upon his arrival in Canada, I always wondered why

people in my household seemed so eager to impose limits on access to this crucial service for immigrants. Why was my dad always so eager to reinforce boundaries to healthcare access for newcomers while others fought so hard to break them, especially given his background? The research questions that I developed for my thesis were inspired from both my personal experiences with my family and from a thorough review of the literature relating to the topic of access to healthcare for newcomers to Canada. My research questions are as follows:

> *How do first-generation Canadian citizens, living in Ottawa-Gatineau, understand rights and deservingness to healthcare for newcomers to Canada? What can their perspectives tell us about the ways that their moral worlds may play into how rights get configured and reconfigured in the context of access to healthcare in Canada?*

In chapter one, I will explore what constitutes health and healthcare by bringing to the surface two cultural contexts in which health is often understood. I will also cover how healthcare is governed in Canada and how this impacts newcomers' access to subsidized healthcare services. Then I will examine how rights and deservingness can be engaged with as objects of analysis in Anthropology through different frameworks such as humanism and humanitarianism. As will be demonstrated in this chapter, existing literature often focuses on the perspectives of either those whose deservingness is in question (giving power and meaning to those actually concerned with the problem) or those who are perceived to be the gatekeepers to this access (i.e. healthcare professionals). The chapter ends by highlighting gaps in the literature as well as discussing

political rhetoric, to show how the topic I chose emerged out of the literature in a timely and relevant manner.

Chapter two provides the theoretical and methodological context behind my thesis. In the first part of this chapter, my theoretical assumptions are unpacked. Morality is examined as a concept in anthropology and established as the base of my theoretical framework. The first section of this chapter traces the concepts of moral economies and moral communities around which the structure of my thesis is built. In the second part of the chapter, important methodologies are highlighted. Here, the context surrounding my choice of topic and population of study are identified, and emphasis is put on the depth with which ideas of caring for someone are intrinsically linked to perceptions surrounding access to healthcare. Data tools such as semi-structured interviews are reviewed, as is the recruitment strategy and entry into the field. This section further identifies who I interviewed in order to provide a portrait of my data sources, and identifies related issues of reflexivity. Lastly, in this section, I will describe the structure of my analysis and results.

Chapter three is the first of two content chapters. In this chapter, respondents' thoughts are analyzed in the context of a moral economy that emphasizes healthcare as equated with life and possibility. Here, moral economic logic is metaphorically associated with "a big family of humans" and health and healthcare are explored in experiential terms. This chapter shows that when healthcare is understood in this way, rights (in the sense of something to which a moral or legal entitlement exists) maintain their inalienable character and are not reconfigured.

As the second of two content chapters, Chapter four identifies a different type of moral economic logic than that explored in chapter three. Here the focus is on access to healthcare as defined according to things that can be seen, heard, or perceived. When this moral economic logic is applied, two separate moral communities focusing on types of contribution when analyzing a persons' right or deservingness of healthcare emerge. First, a moral community of contribution and responsibility is identified as one way that those with this moral economic logic relate to both themselves and others. This involves a certain evaluation of others as either "worthy" or "unworthy" based upon certain characteristics that they may have in a given time or at a given place. Second, a moral community of contribution and allegiance is identified as associated with those people who understand deservingness of healthcare within the context of a perceived allegiance to Canada. The moral economy and two moral communities discussed in this chapter identify norms that function as part of a web of affect-related values (such as obligations, responsibilities or allegiances). They also suggest how, when healthcare is understood as a resource to be consumed, the possibility for the reconfiguring of the right to healthcare is opened up. This chapter ends with an important discussion on power as it relates to how our moral community is imagined, and how this gives shape to particular forms of solidarity when it comes to the question on who people believe should have a right to healthcare.

2. Chapter 1: Literature Review

2.1. Health and Access to Healthcare in Canada

In responding to health concerns, all human societies create medical systems, that people use to seek health and alleviate disease and illness (De Burgos, 2009). While disease, according to De Burgos (2009), is defined in biomedical terms as an objectively measurable physical condition (such as fever, diarrhea, tooth decay or broken bones), which can be felt, heard, or smelled, illness on the other hand « is defined as a feeling of not being well and healthy, a subjective experience defined by cultural meanings » (De Burgos, 2009, p. 7). Healthcare can be understood to be the historically and culturally constructed response to both disease and illness in the context of both naturally and socially produced suffering (i.e. functional health and experiential health, as defined by Kelman (1975))[1].

[1] According to Kelman (1975), health can be understood according to two categories (or cultural contexts). "*Functional health*", writes Kelman, relates to the optimum capacity to perform roles within society (e.g. to carry out productive work), while "*experiential health*" relates to the capacity for human development, self-discovery, self-actualization, and transcendence from alienating social circumstances (Kelman, 1975). Importantly, with these multiple ideas of health comes multiple ways of conceptualizing what exactly is meant by healthcare.

In Canada, public healthcare is governed by thirteen different provincial and territorial healthcare insurance plans that work in conjunction with the Federal Government to ensure that all "Canadian residents have reasonable access to medically necessary hospital and physician services without paying out of pocket" (Government of Canada, 2016). While the Federal Government's responsibilities include setting and administrating the standards for the healthcare system through what is called the "Canada Health Act" (CHA), providing funding supports and supporting the delivery of certain other healthcare programs such as the IFHP[2], it is the provincial and territorial governments that are responsible for the organization and delivery of health care services for their residents (Government of Canada, 2016). According to the CHA:

> *The health care insurance plan of a province must entitle one hundred percent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions* (CHA, 2012, p. 6)

One might ask, however, where newcomers to Canada fall in all of this? Are they considered "*insured persons*" in the Canadian provinces and territories? While the above specification by the CHA states that the terms and conditions under which provincial healthcare is to be applied should be universal, this appears to relate mostly to defining the types of services which are to be offered, and not necessarily regulating who the "*insured persons*" actually are in each province. On that note, even though the primary objective of the CHA is "to protect, promote,

[2] The IFHP was established by the Federal government in 1957 to provide "*limited, temporary, taxpayer-funded coverage of health care-care benefits"* to persons not eligible for provincial or territorial healthcare insurance (Citizenship and Immigration (CIC), 2015-nov-05).

and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial barriers” *(*CHA 2012, p. 5), I wish to emphasize that “inclusion and exclusion from the imagined national community is not obvious or objective, but rather debated and reworked over time (Heyman, 2011, p. 796). In fact, questions on access to subsidized healthcare services often find themselves caught up in the ways that inclusion and exclusion are constantly being re-worked. This is particularly true when talking about who people believe ‘should’ be allowed this access.

Access to healthcare services is at the forefront of many debates surrounding health policy in Canada, as many newcomers to Canada still appear to face barriers when it comes to access to it. Studies on the barriers faced by newcomers and immigrants in terms of access to healthcare have often been explored from the perspective of those actually facing the barriers, giving important power and meaning to the opinions and perspectives of those whose access is actually in question, and bringing to the surface to make visible the consequences of both public policies and practice that can be felt in a very personable way. Jennifer Asanin and Kathi Wilson (2008) contributed to this discussion on how access to healthcare is understood among the immigrant population in general. Their findings revealed that three challenges of accessibility were often a common concern for immigrants: (1) geographic concerns, which refer to the physical location of the health care services offered and a persons’ ability to actually receive care at that location (2) socio-cultural concerns, referring to the cultural appropriateness of the care and (3) economic concerns, relating no doubt to the affordability of healthcare (Asanin and Wilson, 2008).

A qualitative study reporting on the experiences of permanent residents, refugee claimants, and undocumented immigrants, by Campbell et al. (2014), echoes these findings, and takes the research even further by exploring how permanent residents, refugees and people with precarious immigration status interact with the healthcare system in Toronto, and how their experiences compare with one another. Maintaining a focus on both access and experiences of accessing healthcare, they contrast the experiences of undocumented migrants with refugees and with permanent residents. They found a series of results, with the most prominent one being that immigration status of an individual affects their access to and experience with the healthcare system. For example, they note that since permanent residents are covered under the provincial and territorial insurance plans, they have little difficulty accessing healthcare services. Refugees and refugee claimants, however, experience much more difficulty. Despite being covered for healthcare services under the Interim Federal Health Plan (IFHP), they often report increased stress associated with having to appeal denied healthcare claims on the base of compassionate or humanitarian grounds (Campbell et Al., 2014). Unsurprisingly, they note that the group of newcomers that struggles the most is those with precarious immigration status, as fears of being deported interact with peoples' willingness to even try and see a doctor in the first place (Campbell et al, 2014).

While articles such as those written by Asanin and Wilson as well as by Campbell et al. are very good at revealing some of the most pressing issues and practical concerns faced by newcomers and new Canadians in general, they do not reveal much about the political or social context in which these concerns emerge. Diop's article "*The Bogus Refugee: Roma Asylum Claimants and*

Discourses of Fraud in Canada's Bill C-31" (2014) is quite helpful at opening up the discussion to include an understanding how social attitudes towards "*the other*" that manifest in public discourses, may shape newcomers' access to refugee status, and thus to services available under that status (one of which is healthcare). Although Diop's article only focuses on a specific group of refugees, the Czech Roma, what comes forth in her article relates greatly to the context in which the premise for my thesis emerged. Drawing upon the case of the Czech Roma refugee claimants, Diop analyzes the Canadian Bill C-31[3] with respect to how it will (or did, since the article was written in 2014) result in the exclusion of certain groups of refugees, based on the rhetoric surrounding terminology of fraudulence and bogus. According to Diop, when refugees are equated with "*the other",* the figure of the asylum seeker becomes the vehicle through which the performance of sovereignty can be enacted as the state promulgates a particular discourse about those who appear to be threatening the borders (Diop, 2014). The power of policies, as Diop notes, lies in their ability to constitute what is deemed to be "*truth*", and as such, help to understand how ideas may become ingrained as norms, especially if the discussion is framed "as a matter of national security and protecting Canada from being fleeced by unwelcome and undesirable outsiders" (Diop, 2014, p. 69). As such,

[3] **Bill C-31:**
"On June 28, 2012, the Protecting Canada's Immigration System Act (Bill C-31) received Royal Assent. This legislation:

- *Brings further reforms to the asylum system,*
- *Add measures to address human smuggling, and*
- *Adds the requirement to include biometric data as part of a temporary resident visa, work permit, and study permit application "*

(Government of Canada, modified: 2015-02-23)

> *By ingraining this type of discourse that associates 'the other' to part of a larger threat to sovereignty, into how the public thinks about collective values* [e.d which includes ideas surrounding healthcare], *people's realities, as well as their understandings of both their own and the others' place in the world and in Canada, are almost certainly affected* (Diop, 2014, p.p. 68, 69).

The type of rhetoric referenced in Diop's article (2014) is also visible in regard to healthcare access for groups of protected persons, refugee claimants more generally, and certain other groups of non-citizens who are not eligible for provincial (or territorial) insurance, but who are covered under the Interim Federal Health Program (IFHP).

In 2012, as part of the effort of the Government to deter "bogus" refugee claimants, the coverage for IFHP was dramatically scaled back by the Federal Government. This effectively eliminated subsidized healthcare for some groups by differentiating refugees by category for the purposes of determining their level of healthcare (Barnes, 2013), making the ways that rhetoric can impact upon peoples' social existence in the context of healthcare very visible. In spite of the Federal Court of Canada declaring these cuts to be "*cruel and unusual*", as well as unconstitutional, the Conservative Government under Stephen Harper continued to argue that they would vigorously defend the interests of Canadian taxpayers. In an article published in CBC news in 2014, the Minister of Citizenship and Immigration at the time, Chris Alexander, is quoted saying that the Government would continue to defend the "*fair, just, and absolutely generous refugee determination system*" of which the IFHP is a part of (CBC News, 2014). Not only are

these words deeply problematic, but they also bring forth false ideas that this group is taking away from honest and hardworking Canadians (Harris and Zuberi, 2015; Caulford and D'Andrade, 2012).

What the above reveals is the rhetoric that was developed and used by the Government at the time. In revealing a very specific normative notion of who that government believed "*should*" be entitled to access healthcare, this rhetoric certainly contributed and continues to contribute to what guides how we interact with different groups of people in the context of healthcare. This no doubt continues to fuel debates that exist with regards to healthcare access for refugees, despite the fact that these cuts have since been reversed by the new Federal Government in 2016. For instance, by framing those receiving IFHP benefits as receiving different (and often better) services and benefits than those Canadian "*actually paying into the system",* we see how the ways that people imagine not only themselves but also others can be shaped within the context of a fictitious 'right' or 'wrong'. This in turn can create expectations and attitudes towards one group or another as these normative notions interact with reality to not only shape healthcare policies but also shape how these policies will be experienced by users of the healthcare system.

2.2. Engaging with the Concept of a 'Right to Healthcare': Theoretical and Practical Considerations

The right to health is grounded in principles of justice and social good, and presumes fundamental equality before the law as many have noted (Vanthuyne et al 2013; Rylko-Bauer and Farmer, 2002). However, rights often become detached from their legal contexts, as many have also noted (Willen, 2012; Vanthuyne et al 2013; Rylko-Bauer and Farmer, 2002). This opens up the door for gaps to emerge between the level of access to health care that is guaranteed by the right to healthcare and the perceived "deservingness" of it. It is from this point of departure that I wish to explore how the concept of the right to healthcare has been engaged within the context of access to healthcare for newcomers.

Thinking of this normative notion about whom people believe "*should*" be entitled to healthcare services, how does literature on access to healthcare for newcomers engage with the concept of rights? To transition into this, I first look at the literature on access to healthcare in general, focusing not only newcomers but on access to healthcare for vulnerable groups more generally. By looking at market-based medicine as it is contextualized in economic terms, and by contrasting conceptions of "*managed care*" with "*managed inequalities*", Rylko-Bauer and Farmer (2002) illuminate some very important ideas and aspects relating to rights in the context of access to healthcare, on a general basis. They argue that the type of dominant logic associated with managed care (which emphasizes profits) is incompatible with the view that healthcare should be seen as a right. This is because the one-size fits all policy associated with "*managed care*"

cannot manage inequalities (Rylko-Bauer and Farmer 2002). For Rylko-Bauer and Farmer, to view healthcare as a right would mean grounding access to healthcare in principles of justice and social good, something which cannot be done when medicine is seen as a business (Rylko-Bauer and Farmer, 2002). "Medicine as business is bound not by obligations of justice, but, rather, those of economics and the bottom line" (Rylko-Bauer and Farmer, 2002, p. 479). They conclude their article with a section that suggests three major ways that anthropologists can help expand and contextualize the debates surrounding the market's role in medicine, both in the United States and abroad. First, they suggest that more ethnographic data, focused on what happens when people get sick, would "make more visible the very real consequences of public policies" (Rylko-Bauer and Farmer, 2002, p. 490). Second, they suggest that by questioning the underlying bases of social policies through re-readings of policy science documents on the subject, anthropologists can help to understand how healthcare policies come in to being, and how the ideas behind this translate into action. Policy documents, they write, are too often focused on program evaluation, without questioning the ideological and material elements that underpin them. Third, for Rylko-Bauer and Farmer (2002), documenting critiques and forms of resistance by individuals against problematic policies or programs is another way which anthropology can greatly contribute to this discussion.

Speaking to these points, particularly to understandings of how ideas behind health care policy translate into action, Sarah Horton (2004) describes how health care institutions can be seen as playing a crucial role in applying value-laden conceptions about the deservingness of newcomers to public benefits like healthcare, as these institutions act as a sort of intermediary between the

state and its' new citizens. In studies such as hers, there is a core tension which gets exposed between the rights of individuals to access healthcare and the social conceptions of citizenship that govern its' access (Horton, 2004). Focusing on the Buena Vista Hospital in Albuquerque, United States, Horton shows what happens to public health institutions in the context of market forces. As the hospital dealt with increasing financial restrictions, human capital assessments of specific immigrant populations increased, and the staff became more involved in drawing comparisons among the groups of population that attended the clinic. This fostered the creation of value-laden conceptions of the deservingness of one group versus another. In the context of a hospital that relied on county funds, those who were not understood to be contributors were not seen as constituents, but this was weighted differentially, according to Horton. For instance, while deservingness was sometimes evaluated based on financial discourses, it was also evaluated based on risk discourses, which present certain groups as a drain on public benefits (Horton, 2004). It was the latter which Horton's article emphasized as playing a more predominant role. Mexican and Cuban immigrants were constructed differently from one another in the eyes of the public health system that Horton studied. While Cuban immigrants were often portrayed as "a resourceful group that had earned its right to government assistance" (Horton, 2004, p. 479), Mexican immigrants were considered the opposite of self-reliant and thus underserving of in the eyes of the hospital, despite the fact that many of the staff members disagreed. This reflected new categories of either "*deserving*" or "*undeserving*" immigrants based upon standards that involve individual responsibility and self-discipline *(Horton, 2004).* Thus, when financial discourses intersected with discourses of deservingness, there was a sort of hierarchy of deservingness that was created, which resulted in in the exclusion of certain groups

of people and not others and led most obviously to different health outcomes for the groups in question, as was evidenced in Horton's article.

While exploring negative health outcomes of those perceived as 'undeserving' or care in relation to those perceived as 'deserving' does shine a light on the need for reforms and reinforces the importance of the 'right to health' by tapping into our deep desires for social justice, more is needed. According to Willen (2011), if we are going to look at rights, we need to take the right to health as an anthropological object in and of itself. For her, this means not taking the right to healthcare for granted but instead acknowledging that it has become detached from the legal framework in which it arose and instead now functions more like a moral and political discourse used to speak about power relations. Her article "*Do 'Illegal' Immigrants have a right to health? Engaging in ethical theory as social practice at a Tel Aviv Open Clinic*", shows us that looking at healthcare from the perspective of rights actually depends less on formal points relating to law and more on vernacular moral assessments of deservingness of care. So, in the context of increasing human capital assessments in the context of managed care, how deservingness is reckoned in the case of healthcare becomes ever more important.

According to Willen (2012), health-related deservingness emerges as related to the formal juridical discourse on rights, but also as separate from it. Whereas rights discourses presume universality and equality before the law, deservingness claims are articulated in a vernacular moral register that is situationally specific and context dependent. She writes that in a sense, deservingness can be understood as the flip side of rights, but it is also so much more than this.

For Willen, deservingness emerges on the basis of two key factors: "First, an implicit sense of one's own deservingness, and second, one's sense of actual or presumed social connection to those whose deservingness is in question" (Willen, 2012, p. 814). Willen found that this is particularly important when talking about unauthorized immigrants as members of a deserving public. Noting how this group is often cast as non-contributing members, freeloaders, or criminal aliens, she writes that deservingness is "reckoned in ways that negatively assess immigrants' moral worth and reinforce exclusionary local politics" (Willen, 2012, p. 814). Her article specifically touches on how this translates into social practice, with her focus on people seeking health care on an unauthorized or undocumented basis in Israel. Willen's work also shows the importance of understanding how vulnerable groups understand their own deservingness of healthcare. By understanding how deservingness is reckoned by all people involved (those whose deservingness is in question, and those who are assessing the deservingness of others), we can see how it becomes like a lens to understand the broadening, contracting and shifting of the "right to health" itself as it cycles through difference discourses, policies and practice. It also shows us the importance of taking the concept of *"rights"* with a grain of salt and exploring how these (rights) can be invoked, debated, and even resisted in specific contexts. This is a starting point for Vanthuyne et al's article (2013).

Returning to the Canadian context, Vanthuyne et al's article "*Health workers' perceptions of access to care for children and pregnant women with precarious immigration status: health as a right or a privilege" (2013*), explores how people who work in the field of healthcare argue for, or against the provision of healthcare services for uninsured pregnant women and children, in

Montreal (Vanthuyne et al, p. 80). They found that, in a context that is marked by financial cuts to healthcare, drawing the boundaries between who deserves covered medical care and who doesn't, brings to the surface conflicting ideas about "the costs and affordability of medical treatments, in addition to contrasting perceptions of host societies' moral obligation, and the perceived worth of precarious status immigrants" (Vanthuyne et al, 2013, p. 82). According to them, healthcare workers' arguments to give (or not give) access to their services to this vulnerable population fell into three categories:

> (1) Those arguing against universal access to healthcare (i.e. against viewing access to healthcare as a right) generally argued that migrants were abusing the Canadian health system and taking resources away from those who are considered to be part of the native Canadian population;
>
> (2) Those arguing for universal access to healthcare, who tended to see uninsured migrants as "*precarious*" and thus as deserving of healthcare on the basis of rights stemming from their precarious status, thus emphasizing humanitarian, human rights, and social justice frameworks (Vanthuyne et al. 2013); and finally,
>
> (3) Those whose views incorporated both positions, thus "*evoking tensions at play between abstract conceptualizations of a universal right to healthcare and practical engagements with its implementation*" (Vanthuyne et al. 2013, p. 82).

For Vanthuyne et al, humanitarian conceptions of the right to health that were determined "not from the realm of citizenship, but from the realm of compassion, and therefore, moral sentiments" is seemingly about the exceptions to the rules (*deservingness*) rather than the rules

themselves (*rights*) (Vanthuyne et al, 2013, p. 84). Work done by Foucault (1985) and by Fassin also shows how emphasis can be seen to be increasingly placed on the suffering body as the vehicle through which this type of exception is determined.

In a 2005 article "*Compassion and Repression: The Moral Economy of Immigration Policies in France*", Fassin delves into the tensions between these two discourses of repression and compassion. Asking why in societies that are perceived to be hostile towards immigrants, there is still a concern about those who are deemed undesirable, he illuminates the economy of the values and norms of a given group, in a given moment (economy of moral), in the context of immigration policies in France. In his work, he found that humanitarian reasons (in place of formal asylum channels) were increasingly becoming the best mechanism for asylum seekers to be granted residence. Under this type of humanitarian principle, the suffering body became the main legal resource for undocumented migrants, showing how the "moral economy of our times" is:

> *A unique combination of policies of order and a politics of suffering, in which the protection of security for the few within the polis is maintained while a compassionate treatment for those within the camps is assured. (Fassin, 2005, 382)*

Humanism, in contrast to humanitarianism, means thinking not in terms of these fluid types of mechanisms, like having a precarious status attributed to oneself, or being in a state of suffering, but instead "in terms of quality and diversity as well as quantity and unity" (Huxley, 1961, p. 14).

According to Huxley, this means that humanism is universal instead of particularistic, affirming the continuity of people with the rest of life (Huxley, 1961). It is also global instead of divisive, affirming the unity of all humankind (Huxley, 1961). In the context of healthcare, humanism, therefore, becomes a way of thinking that is possibility enhancing and it forms a single uniform entity of human beings entitled to a right to healthcare. In practice, this implies a certain blindness to individual particularities (Willen, 2012). I wondered, however, if this could tell us anything about the actual practice of rights in the context of healthcare? For this, I needed to look specifically at rights violations.

Paul Farmer and others have argued that "rights attributed on paper are of little value when existing political and social structures do not afford all individuals the ability to enjoy these rights" (Gastineau and Farmer, 2002, p. 152). So, although rights are grounded in principles of justice and social good, when they become detached from their legal context, questions of power become central to the discussion, bringing to the surface the social nature of justice[i]. In his book *Pathologies of Power*, Farmer encourages us to think about human rights violations in particular as:

> "*Symptoms of deeper pathologies of power*" [ed. , which] *are linked intimately to the social conditions that so often determine who will suffer abuse and who will be shielded from harm*" (Farmer, 2005, pg. 7).

Farmer's main point is that if we omit the analysis of structural violence from the discussion on human rights, we will not get a true picture of what suffering really is. For him, the task at hand is, therefore "to identify those forces conspiring to promote suffering, with the understanding that these are differentially weighted in different societies" (Farmer, 2005, pg. 50). This means that human rights violations should be linked to the historically given processes and forces that cause them to exist. What we want to get at, therefore, is the social, psychological, historical and other forms of knowledge that may impact how rights are understood. These elements are, according to Walker (2007), not only linked with people's moralities, but actually represent them.

Therefore, when applying the ideas put forth in the above citation (by Farmer) to the current study at hand, I cannot attempt to understand how rights can be configured and reconfigured without exploring links between justice and morality. In his 1971 book, *A Theory of Justice,* Rawls explains:

> *"What I have attempted to do is to generalize and carry to a higher order of abstraction the traditional theory of the social contract as represented by Locke, Rousseau, and Kant"* (Rawls, 1971, Viii)

Given this citation, when exploring ideas of justice as conceptualized in the many chapters in Rawls' book, it becomes important to keep in mind the social nature of justice that exists within Rawls' definitions and applications of justice.

> *"Justice is the first virtue of social institutions, as truth is of systems of thought. A theory however elegant and economical must be rejected or revised if it is untrue; likewise, laws and institutions no matter how efficient and well-arranged must be reformed or abolished if they are unjust" (Rawls, 1971, p. 3).*

This citation brings forth many questions pertaining to whether justice could (or should) be understood as synonymous with good society. In a review of Rawls' 1971 book, Vinit Hakasar writes that certainly, Rawls did not confuse justice with an "all-inclusive vision of a good society" (Hakasar, no date, p. 149). In fact, Hakasar believes that Rawls, in his book, actually allowed the claims of justice to conflict with claims of morality (no date). This can be made clearer by directly looking at Rawls' two principles of justice:

> *First: each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others.*
>
> *Second: social and economic inequalities are to be arranged so that they are both (a) reasonably expected to be to everyone's advantage, and (b) attached to positions and offices open to all.* (Rawls 1971, p. 60).

One way that these two principles display the contradiction mentioned above, is that "reasonably expected to be to everyone's advantage" may at once be moral and unjust (Hakasar, no date). In fact, this line seems to be the most important section of Rawls' principles, when relating them to discussions concerning the provision of health care by the welfare state. Points relating to how one defines "to everyone's' advantage" might often be utilized in justice arguments for or against

health care for all people residing in Canada whether citizens, residents or otherwise. Where though, does one draw the moral line with regards to what is *reasonably* to everyone's advantage?

Rawls does acknowledge that "everyone's advantage" is quite an ambiguous term but offers only the argument that this is meant to apply primarily to governing assignments of rights and duties (1971 p. 61). Interestingly, Rawls' also acknowledges that many things from laws, institutions, social systems, and types of actions (including decisions, or judgment) can be said to be just or unjust (1971, p.7); this becomes very important for the study at hand, especially as it pertains to questions surrounding opinions for or against access to health care for all newcomers to Canadian society as these are opinions that tend to be grounded in social life.

3. Chapter 2: Theoretical and Methodological Framework

The purpose of this chapter is to unpack the theoretical assumptions that guided my research, and also to highlight the various methodologies that were employed in my work. In the first part of the chapter, I will cover the theoretical framework that holds and supports the analysis presented in my thesis. This theoretical framework is two-fold and draws upon both moral economies and moral communities. In the second part of this chapter, I will focus on the specific methodological elements of my thesis. This chapter will conclude by addressing how my theoretical framework and methodology led me to structure my analysis and results.

In order to respond to my research questions, which focus on what peoples' perspectives can tell us about the ways that their moral worlds may play into how rights get reconfigured in the context of healthcare, it is important to note that morality always involves a view from somewhere (Vanthuyne et al. 2013). According to Milgrim and Browne (2008), people's moralities are what set in place norms, dispositions, and conceptions of what is just and unjust. Thus, in a sense, morality can act as a social contract. The concept of moral economy and moral community provide the lenses into people's moral worlds. Moral economies provide a lens into these moralities because they help to understand not only how these normative social contracts come to exist, but also how they function in everyday life. The concept of moral community is linked to that of moral economies because it, in turn, allows us to understand how people react

to norms and dispositions that surround them. This lens will allow me to shed light on the varying ways that the right to healthcare can be configured and reconfigured in different circumstances. Further, in this section, I will also address how this theoretical framework guided me toward my specific methodological choices.

3.1. Theoretical Framework

Morality, as understood by Rawls (1971) as well as others like Foucault, helps to understand how people can become bound to one another. For Foucault (1985), morality relates to the ways that people comply (or don't comply) with a standard of conduct. This involves not only *"the manner in which they obey or resist a specific prescription"* but also the ways in which they "respect or disregard a set of values" *(Foucault, 1985, p. 26).* Moral ideas form an interplay of elements that "counterbalance and correct one another, and cancel each other out on certain points, thus providing for compromises and loopholes" (Foucault, 1985, p. 25).

According to Walker (2007) moral knowledge is not separate, but instead embedded and intertwined in social, psychological, historical and other forms of knowledge. Morality, therefore, can be treated as "a socially embodied medium of mutual understanding and negotiation between people over their responsibility for things open to human care and response" (Walker, 2007, p.9). This impacts upon how we see obligations and duties and invites us to look at how people believe they ought to live, as this relates to the particular set *of* "historical, cultural, and material circumstances which surround them" (Walker, 2007, p. 13). Importantly, according to

Walker (2007), these may already include some legacy of moral understandings and practices of responsibility. Additionally, for Walker, morality is related to responsibility in so far as these practices of responsibility "implement commonly shared understandings about who gets to do what to whom and who is supposed to do what for whom" (Walker, 2007, p.16).

Thinking in these terms, where morality is related to the norms of behavior that exist between people, moral economies can help to explore and understand normative contracts that may govern these relationships. This is evidenced in what is generally understood to be the first use of the concept of moral economy by E.P. Thompson in 1971. Taking as his subject class conflict and the British food riots of the eighteenth century, the work of Thompson helps to understand how social contracts come to exist, and what happens when they are broken. Thompson looked at the process by which grain got turned into bread which could then be consumed by everyone, and what happened when parts of this process broke down. For him, the resulting food riots were not only triggered because of hunger, but also (and perhaps more importantly) because of an outrage against the breaking of the moral assumptions that governed this process. Thompson called the resulting moral economy the "moral economy of the English crowd". Importantly, this moral economy didn't require much physical organization to confront rising food prices since actions were based on a particular set of social relations with their own set of objectives and restraints. Therefore, I understand the concept of moral economy in this case to reflect the fundamental place of material subsistence in human activity (Thompson 1971; Carrier 2018); It refers to the set of activities and relationships that things (goods or services) move through in order to satisfy people's needs and wants (Thompson 1971; Carrier 2018). But, what about the

place of values within all of this? Surely these activities and relationships are related to peoples' values as well? For Fassin (2005), moral economies can be defined as the economy of the values and norms of a given group, in a given moment (moral economy). But this, as Carrier (2018) noted, is a departure from the substantivist view that characterized the concept, moving towards employing moral economy as a symbol to be invoked rather than a concept with substantial meaning (Carrier, 2018, p. 19).

The definition of moral economy that I will use draws on Thompson's, but with a slight adaption to account for the place that I believe values play. I employ moral economy to understand the activities and relationships that healthcare moves through, and how this creates specific values, assumptions and obligations about its usage. In analyzing my data, I asked "what moral values, assumptions and obligations does accepting the principle of healthcare actually rest upon?". By moral economy, therefore, I mean the moral space in which healthcare exists as a principle.

Moral communities allow us to understand the breadth of action and thought within the context in which each unique moral economy exists. This provides a lens into an understanding of how people react to the norms and inherent assumptions that surround them. According to Johnson and Mullins (1990), moral communities provide a lens with which to view ones' life. But, they also provide a lens with which to view the lives of others, as I learned throughout my research. I will now explore three important characteristics to moral communities which help to open the

door to understanding the creation and maintenance of a sense of community, through collective articulations and notions of imaginaries (Anderson 2006/1983; Johnson and Mullin 1990).

First, according to Teppo (2015), moral communities are bounded and emplaced in different ways. For him, this means that their scale can vary from involved neighborhoods to global, more diasporic communities. Since moral communities, therefore, build their external boundaries in distinct ways, according to Teppo (2015), occupants of each different moral community would have diverse relations with people in their moral community but also beyond it. This puts moral communities in a uniquely useful position when we want to study how the social and spatial boundaries of conceptions on access to healthcare are imagined, and how these imagined communities are then engaged with.

Second, Teppo (2015) writes that moral communities can relate differently to the surrounding (or to the external). This second criteria becomes important since it helps to understand how two moral communities can come to exist in some cases within one moral economy. For instance, although people may share in the values associated with the activities and relationships that healthcare moves through, they may still relate to this in different ways. Importantly, this allows us to uncover and understand the complexities of the ideas we study, and in turn, shows how moral groupings cannot be mutually exclusive.

Last, according to Teppo (2015), moral communities have a material existence (2015). This emphasizes how material conditions can shape the cultures and institutions that foster their

reproduction (Teppo 2015; Calhoun 2016; Anderson 2006/1983). As a result, moral communities depend on and define themselves through the material. For instance, Teppo (2015) writes that moral communities set limits pertaining to belonging to a certain group. Thinking in terms of healthcare access, understanding these material elements (for example, how someone contributed to healthcare, or how they received it) is therefore very important since it helps to understand how individual moral communities can be tied back to their related moral economies.

3.2. Methodology

Access to healthcare is, no doubt, a pressing and substantial issue protected under international human rights law, yet many first-generation Canadian citizens (like my father), seemed to lean towards reinforcing boundaries to these services. The choice to study first-generation Canadian citizens was in part based upon my experiences with my own family and also based upon one of the major assumptions I made in the early stages of my thesis, which was that the ideas of first-generation Canadian citizens towards access to healthcare for newcomers would have something to do with their own experiences and interactions with the healthcare system. This, I thought, would be able to tell me something about morality in relation to understanding perceptions on access to healthcare, that goes beyond that which already exists in the literature. I strive in my thesis to contribute to the literature by exploring the social context in which these debates grow and exist, thus building and contextualizing upon how debates relating to access to healthcare grow and exist within society.

3.2.1. Defining "newcomers"

In order to build upon and contextualize how the debates about access to healthcare grow and exist in society, it is important to understand the frame of reference. For instance, the scope of the research question is defined around access to healthcare for newcomers to Canada: "*How do first-generation Canadian citizens, living in Ottawa-Gatineau, understand rights and deservingness to healthcare for newcomers to Canada?".* With this in mind, I wish to note that "newcomers" was never defined for my participants. This was because I was seeking individual perceptions on processes associated with gaining healthcare, and I needed to understand this from their perspectives, not mine. Therefore, the category of "newcomers" was defined by each of my participants during the interviews.

3.2.2. The field, semi-structured interviews and my participants

For my interviews, I originally hoped to recruit twelve first-generation Canadian citizens (male and female + English and French), aged 18 years and over who were willing and who consented to participate in my research. These participants had to have lived, at the time of the interviews, in the Ottawa-Gatineau region. As the hub for Canadian politics, this region provided an interesting area to conduct this study, especially given the correlation between the time of the study and the Federal elections in the fall of 2015. The present research contains information gathered from interviews with nine people, that were conducted in March and April of 2016, just after the new Liberal Government came into power.

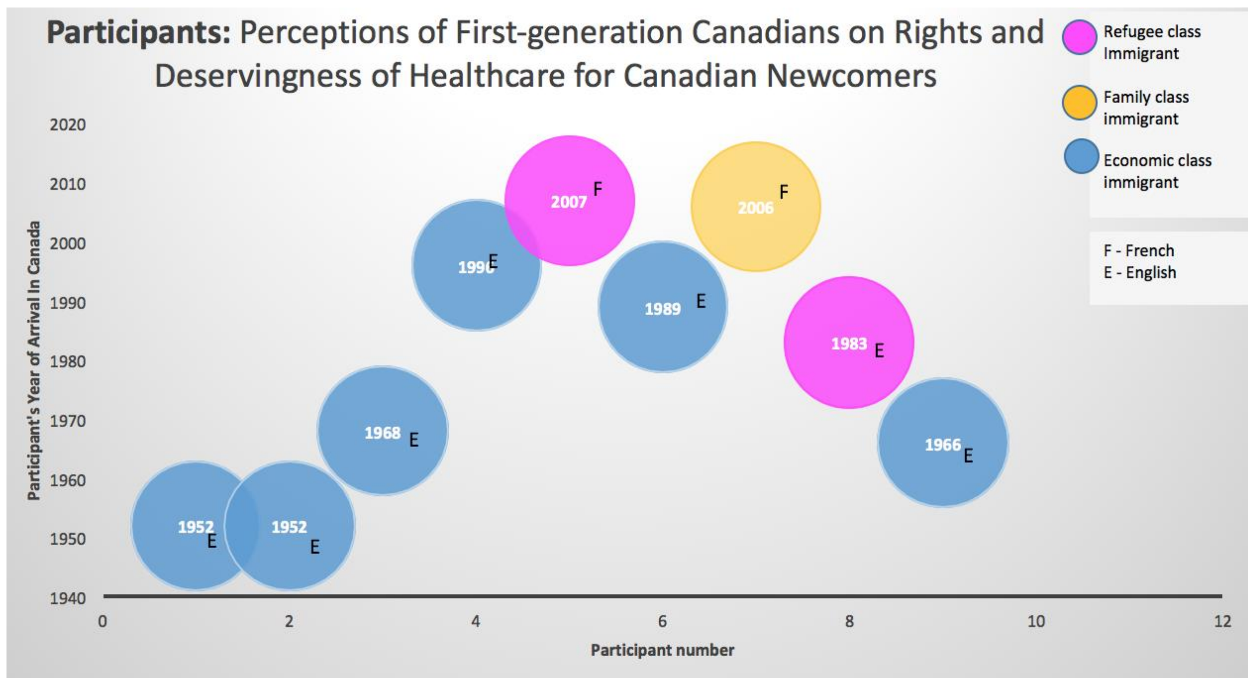
Interview participants were recruited for this research via posters that were put up around the University of Ottawa, local community centers, and other public places in both Gatineau and Ottawa. One example of a strategic place that posters were put up was the Ottawa Arthritis Society, which I had connections to through my mother. Importantly, the clinics are very accessible since no referrals are needed and only a valid health card is required to receive treatment. As such, a wide range of patients receive treatment there, which made it the perfect place to put up posters for recruiting purposes. A copy of the poster is available in appendix [ii].

Recruiting participants via posters proved to be much more difficult than was originally anticipated. This, coupled with the pressures and time constraints associated with maintaining a full-time job while completing my master's degree prevented me from being able to recruit and perform my desired twelve interviews. I ended up conducting interviews with nine people. This translated into only eight interviews though, as one interview was jointly done between a husband and wife, at their request.

Participants' names and some socio-demographics were collected but will not be disseminated individually, as they are kept confidential. The socio-demographic characteristics that were collected are as follows: age, gender, current province of residence (Ottawa or Gatineau), occupation, marital status, the method of entry into Canada (which had a choice of four broad immigration categories), year of arrival into Canada, and country of origin. These were important as they helped me to think about ways in which people related to not only themselves on the issue of access to healthcare, but to others as well. Chart 1 visualizes some of the variables that

will be referred to later in the analysis. Importantly, a focus on year of arrival was taken as opposed to time spent in Canada, which could have easily been derived. This is because I felt that year of arrival would be more useful for the purposes of my analysis as it could be correlated directly with policies that existed at various points in history.

Chart 1:



As outlined in the chart above, most of my participants (6/9) had arrived in Canada as economic immigrants (two form Scotland in 1952; one from the Netherlands in 1966; one from the United States in 1968; one by way of the United States (arrived in US from Somalia in 1987) in 1989; and one from Bangladesh in 1996). I also interviewed one young man who arrived as a family class immigrant from the Democratic Republic of Congo (DRC) in 2006, and two women who arrived as refugees. One of these women came to Canada from the Czech Republic (Czechoslovakia at the time) in 1983 and the other came from Burundi in 2007. It is important to note that each

participant was assigned a number, as opposed to each interview being assigned a number. This was done so that distinctions between the two interviewees in interview # 1 could be easily made in my writing. The participant number is also included in the chart, and will be referred to from now on.

I conducted my interviews using an interview guide, which I designed and prepared in English and French. Interviews were conducted in both languages, as table 1 shows. I had a core list of open-ended questions and anticipated follow-up questions to ensure that everyone received a minimum set of identical questions which ensured not only consistency and comparable data quality across the interviews that I conducted, but also that participants had room to add relevant information where they felt necessary. Interview questions were structured around the following main themes: perceptions beliefs and attitudes regarding access to healthcare, participants' personal experiences with Canadian healthcare, and participants' identity and sense of belonging to Canada. My interview guide, as approved by the Ethics Committee, can be found in appendix [iii].

Despite the fact that biases could be difficult to rule out (see the following section), this structure of interview was the most beneficial choice. Semi-structured interviews accounted for the fact that the types of information sought were often difficult to get at by providing a flexible and adaptable way of following my line of inquiry. Conducting semi-structured interviews allowed me to probe on information points and seek clarification as needed, which did give me some very interesting data that I would not have otherwise received.

3.2.3. Issues of reflexivity

At this point in my thesis, I wish to acknowledge an awareness of the ways in which my social identity and background may have impacted the work at hand, although every attempt was made to make sure this was minimal. For instance, realizing that I was particularly struck by the ways that some of my participants articulated their views with great emotion, I had to constantly reflect on how I was analyzing and writing up my findings to ensure that I recognized any possible biases. This involved going back and ensuring that I was not overquoting some participants, and underquoting others. I also wish to acknowledge that in the case of 2/8 interviews, I had a relationship with the participants prior to conducting the interview. These also happened to be the two interviews in which the views that would be considered the furthest right were given. Although this might be inconsequential, it is worth acknowledging in case their perceptions of me, or their comfort levels with me, affected their responses.

3.2.4. Accounting for subjectivities of my participants and the need for a bottom-up approach.

From the literature, it has been noted that the ways in which people perceive themselves in the world, as well as the ways they perceive others, is certainly not free of subjectivities. Rather, the way people's perceptions are formed and reacted to seems to be related to the way that these interact with varying factors in society. Diop's article (2014) shows that state-level analyses are important as they represent knowledge that can shape the way people think. I also believe, however, that the deeply ambivalent realities presented in individual cases, understood from a

bottom-approach, can be a testament to the weight held by individuals' moralities on their perceptions and understandings.

State-level analyses of social imaginaries, while excellent for analyzing and processing information about how knowledge might be ordered, thus informing our understanding of the various components of society, do not appear to provide the same ability to gather information about people's perceptions[4], one of the very core components of this study. As mentioned earlier, understanding policies and rhetoric may help to understand how certain ideas have become deemed as "truths". However, I believe that when attempting to look at rights and deservingness as objects of analyses themselves, one becomes aware that morality is much more complicated and diverse than what state-level analyses have been able to get it. I also believe that in order to fully understand it, a focus on individual feelings and perceptions is necessary.

A look at the language used by first-generation Canadians to convey their perceptions and opinions could provide insight on and how they may be informed by pre-existing forms of knowledge that exist in society. It could also provide background for looking at the perceived relative importance of the issues at hand according to the participants, as Sabatier (1986) pointed out is a fundamental positive of bottom-up approaches. By structuring my methodology from the perspective of the people actually concerned with the problem, instead of the principal decision maker, or the analyst who is reserved from the problem, the problem can be more thoroughly explored. This choice of approach also allows for the ability to make connections between things

[4] I refer here the commonly understood definition of perceptions as the way that people understand or interpret something.

rather than simply looking at the effectiveness of a program or how policy can guide perceptions (which seems to be rather linear).

3.2.5. A note on studying in Ottawa-Gatineau

Prior to undertaking my thesis, I came across literature that made me think of the importance of internal borders, such as that which exists between Ottawa and Gatineau, and how these could impact research questions such as mine. According to Veronis (2013), the importance of internal borders lies with the fact that they may in some cases generate distinct processes of citizenship formation. This could potentially impact beliefs and attitudes that may exist concerning access to subsidized healthcare for newcomers to Canada, as people may relate differently to the systems with which they engage with this. Furthermore, I also noted that internal borders may not only create gaps, but also exacerbate existing gaps in understandings of rights and deservingness of care between provinces, as policies differ provincially, even in areas border cities such as Ottawa-Gatineau. As mentioned, I collected province of residence as a contextual socio-demographic variable. I had originally planned on using this for the purposes of analysis and coding, but a few factors prevented this from being analytically useful.

While movement across the internal borders in border cities was something that had originally intrigued me because of some of the differences mentioned above, among my participants, the movement was such that it didn't allow me to make any inferences about perceptions depending on the individuals' province of residence. For example, one of my participants who had lived in

Québec since arriving in Canada, was a nursing student at a Québec CÉGEP but did all his placements at hospitals in Ottawa. Although Québec was the province of his primary residence, because he and his family were healthy, his reference point on this issue of access to subsidized healthcare was the Ottawa Hospital system in which his clinical placements had occurred. Further, other participants of mine who had originally arrived in Québec and subsequently moved to Ontario (for example, Participant # 7) were unable to make any distinctions between provincial policies. Therefore, in the case of my thesis, to talk about distinct processes of citizenship formation and how these may have impacted peoples' perceptions on healthcare access is out of scope, and it would be misleading to discuss them.

3.2.6. Methods of analysis and organization of results

Once the responses to the eight interviews were transcribed, I examined the qualitative data transcripts, developed an overall understanding of the results, and began to identify emerging categories. In my proposal, I had mentioned that this would be done in order to develop categories for qualitative coding purposes, and that I would use NVIVO and SAS to perform this coding. I had also noted in my proposal that my theoretical framework which was based around morality would allow me to pre-establish some elements in need of coding, and that others would likely be added as I progressed through my project. Specifically, I had said that beliefs, perceptions, and attitudes of each person would each be coded separately. Although I did code my interview results, this was done at the high-level person level, and not at the level of the multiple individual responses given by each person. Furthermore, upon review of my data and

more in-depth analysis of my theoretical framework, the results were much less clear-cut than I had originally anticipated. By this, I mean that categorizing results was difficult as many of them appeared to be in a kind of grey zone, not belonging 100% to any one category. This leads into the organization of my thesis which is structured around the two elements of my theoretical framework (moral economies and moral communities).

As was noted in my theoretical framework section, moral economies provide a framework for understanding the "*economies of the values and norms of a given group, in a given moment*" (Fassin, 2005). Moral communities, on the other hand, tell us how, within a specific moral economic framework, we can relate to ourselves and to others, by providing a lens to understand how people react to the values and norms that surround them. Beginning with an analysis of two people's perceptions that fall into what I call the 'moral economy of humanism' (Chapter 3), where experiential health associated with possibility is emphasized over functional health, I strive to show how people react when moral economic logic associated with humanism is applied. In this case, both people reacted in such a way as to say that everybody physically in Canada should be entitled to healthcare, but this is not always the case. Importantly, multiple moral communities may stem from a single moral economy in some cases. For instance, although people may share in the ways the economy of their moral values function, they may still relate to this in different ways, even within a given moment in time. Chapter 4 of my thesis focuses on what I have called the moral economy of strategic exchange. In the case of this moral economic logic, which emphasized priorities and stability over possibility, there was more than one way in which people reacted to the norms and values that surrounded them.

4. Chapter 3: The Moral Economy of Humanism and the "Big Family of Humans" living in Canada

> *If you have to deserve something that's there, that you might not have access to because whatever they call "deserving" is not based on your humanity, or the fact that you're there, or the fact that there is hope for you. Even if you're not making a lot of money today, or you're not educated as much as they wanted you to be, you're still there and you can become something. Maybe not something they want, but something (…). If we deserve things because we are human beings, and you know, because we are human beings and because we are alive and can be kept in good health, we can contribute to society and to the happiness of everyone - If these were the criteria of deservingness, then I would be able to say, "Yeah, ok you can deserve it" [e.d Healthcare] (...) That's what's healthcare is – It's not something you buy. (...) Healthcare is also life. (Translated from a French interview - Participant # 5)*

As this quote from a 26-year old Canadian woman of Burundian origin suggests, healthcare can be seen by some as being equated with health more generally, and health with life and possibility. When healthcare is understood in this way, where being entitled to healthcare is based upon the fact that those whose deservingness is in question are human beings, the moral economy which emerges can be seen to be regulated by two very specific assumptions. First, the giving and receiving of healthcare are understood as something fundamental in order to allow all people

physically in a place (in this case Canada) to reach their full potential by keeping them healthy. Second, this giving and receiving of healthcare rests upon, or presumes, principles of universal distribution to everyone. The above quote also brings forth a particular sense of responsibility, which could be said to be held together by affective ties that are perceived to exist among all people living in Canada. In the context of access to healthcare, these affective ties signal the embodied ways in which people engage with the issue. For instance, in this case, the people who are associated with the moral economy, which I have called the "moral economy of humanism", do not seem to speak so much about healthcare for newcomers in the context of an inherent need to help "others". Instead, rather than speaking as if newcomers were outsiders, having their deservingness questioned as an 'other', the people in this moral economy speak about newcomers as a part of humanity, as members of "a big family of humans" (Participant # 8) and members of our national community, who should have access to the healthcare they need in order to reach their full potential and contribute to society.

Interestingly, the two people among those I interviewed who share this moral economy of humanism (Participant # 5 and # 8), also had both come initially to Canada through the refugee program. One of them came from the Czech Republic (Czechoslovakia at the time) in 1983, and the other from Burundi in 2007. However, it is not merely the fact that they shared this common life experience that meant that they shared a moral economy, nor was it just the similar ways that they constituted themselves socially within society as being extremely grateful and wanting to repay Canadians for their generosity. Instead, it was how they engaged with this idea of newcomers as part of shared humanity and associated healthcare with this humanity. Now, I wish

to look closer at this idea of a 'big family of humans'. I want to examine how these ideas relate to the types of moral-economic logic that exists in the moral economy of humanism and how this, in turn, impacts how rights to healthcare are configured and re-configured.

4.1. Access to Healthcare in the Context of Belonging to a Big Family of Humans

> *You've got to take care of health and home before they [e.d newcomers] can go to education and growing esteem and contribute to society. And its' Maslow's' hierarchy of needs, you don't get to belonging if your first two levels are not taken care of. So, if your security and food needs are not met, you can't move to shelter. If you have no shelter, then you can't move to belonging. Right, so I think the Canadian umm, and I think the current government's [e.d Federal Liberals] position is like we want people to move to belonging, so we will provide for their basic needs, and for a certain period of time. And then there will be a sense of belonging and a desire to contribute and a desire for self-empowerment, which then you sort of start to contribute. Right so? It's the building block of understanding. So, based on the hierarchy of needs, I think we, if we're going to build health and society, need to provide your basic healthcare needs to really support you to grow from that point of view. (Participant # 8)*

In bringing up Maslow's hierarchy of needs, the information provided by Participant # 8 reveals something important about the values that are associated to healthcare when the logic of '*a big family of humans'* is at work. When the logic associated with this 'big family of humans' is applied,

the focus is not on symmetrical or well-balanced relationships between Canada (as the guarantor of access to healthcare) and those whose healthcare deservingness is in question. In this moral economy, healthcare is more about building a foundation for people to feel as though they belong. Thinking and talking about access to healthcare in the context of this framework implies that what matters is what is possible and not what is visible or measurable. By this, I mean that the emphasis is placed on what people might be able to do if they are kept healthy, and not on measurable or definable attributes that they may have at the time their healthcare deservingness is in question, which would 'earn' them their right to healthcare (for example, being a citizen, paying taxes, being a refugee, or being pregnant). As seen in the quote opening this chapter, in a "big family of humans", healthcare here is equated with life. This is what is generally understood in medical anthropology as experiential health.

According to Kelman (1975), experiential health can be regarded as freedom from illness and alienation, the capacity for human development, self-discovery, self-actualization and transcendence from alienating social circumstances. With this in mind, it becomes obvious that one of the reasons that moral meaning is being given to healthcare is that in the context of this moral economic logic, healthcare is the basis for action because it is the backbone of society. Therefore, according to this perspective, ensuring universal distribution of healthcare is seen as a social and moral obligation that structures not only social relationships, but also our society.
When we think about this "big family of humans" in this context, healthcare is understood to hold a fundamental material place as the backbone of society rather than a resource that must be regulated with care. Relatedly, those accessing healthcare are understood not necessarily as

consumers of healthcare, whereby their access to healthcare would be understood in terms of market logic that emphasizes healthcare as resources to be specifically contributed to (see Chapter 4), but more so as human beings plain and simple who can contribute to society if they are enabled to reach their potential. As such, my research suggests that the logic involved within the moral economy of humanism is one where belonging to a community is related to humanistic thoughts that strive to guarantee a decent human existence, where everyone has the possibility and the opportunity to develop and grow. As such, this moral economy could be seen as challenging traditional ideals of political communities which tend to carry, as Pete Nyers noted, a certain aesthetic property that allows them to constitute their members in very particular kinds of ways to be exclusionary (2010). It is a moral economy in which life and society is not ordered according to what "visible" (Nyers, 2010, pg. 130), but rather what is "possible". Adhering to what is possible instead of what is visible is the foundation of this moral economy of humanism, and it is from this that the moral community of 'lives within our borders' stems.

4.2. Engaging with Members of the Moral Community of 'Lives within our borders'

How do people react when the logic of the moral economy of "a big family of humans" is operating? Who is held in moral regard when this moral economy is the operating logic? How does this foster common attitudes with regards to access to healthcare that help to understand how the social and spatial boundaries of conception on access to healthcare are imagined?

> *Are you a member of the family? Do we kick members out of the family tribe because you know, they have gangrene and will need a complicated surgery because they came out of a war-torn country? Or this person will need mental healthcare care for a long time because of trauma? I mean they're your brothers and sisters whether you like it or not. (Participant # 8)*

This quote suggests that when the basis for action is what is possible, and not what is visible, everyone physically in Canada is included in the corresponding moral community: the moral community of lives within our borders. How do members of this moral community engage with ideas surrounding this 'big family of humans? What does this engagement look like? The following quote from a "Canadian of Burundian origin" (to use her words), who came to Canada alone in 2007 (10 years prior to my interview), may be helpful:

Over those ten years, I found myself in situations, in moments, where all of a sudden I found myself saying "Wow – This is a good country!". There are laws that protect me, people who helped me, who were Canadian, who didn't know me, but [e.d whom] you could feel that they had values – Dare I say, values that are truly Canadian. Even institutions - There was like this institutional spirit that made it so that I had access to things. (...) When I arrived here as a refugee, the people that I met, they just acquired me. So, there was like this structure, in Canada, all ready to acquire me so that I could integrate. (Translated from a French interview - Participant # 5)

This quote suggests a way of thinking about belonging to a family (to Canada) that both emphasizes this woman's personal experience with joining the 'the national community' and the importance that belonging itself has in relation to her fundamental values when it comes to healthcare. By this I mean that the process by which her specific views of what it meant to belong to Canada were imagined had a lot to do with her own experiences. This, in turn, translated into a very specific view of what deservingness meant in the context of healthcare:

Somebody could destroy my argument in one minute, but I believe that there are some things that are fundamental. I mean, in a place where there is almost nothing, (...), I mean I've seen that. You wake up in the morning, and you're like "Hey! No bombs fell on my head last night, Helleyua (…). And then, when you wake up in the morning and you are alive, [e.d this is a precarious situation], in the midst of which, people still share. In a context where we have technologies, we have money, [e.d Where] some people don't even

know what to do with their food anymore, there is so much extra (...), and there is this little thing [e.d healthcare], that will keep you alive, and they think you don't deserve it because in their case, you don't have what it takes for you to deserve it? (...) In this context of abundance, you have to earn a little bit of life, like really? (Translated from a French interview - Participant # 5)

Equating healthcare with life, and having been accepted into the Canadian community as guaranteeing her that life, one can see how the boundaries of this moral community (both socially and spatially) are imagined:

It's like, I have bizarre analogies, ok – It's like to receive love, from someone from whom you never had to earn it, (...), when that happens, it's a gift, and that connects you, you know, to something that is great. So, you feel like something just, something just acquired you with open arms, and you're a part of it, no matter what. (Translated from a French interview - Participant # 5)

So, although the experience with the healthcare system itself is subjective, as the above quotes demonstrate, there are real material conditions (Anderson 2006/1983; Calhoun 2016) that underpin the way this moral community is imagined, both in her case and in the case of participant # 8. When healthcare is put back into the context of the life which it is trying to preserve, articulations of definitions of deservingness of care become very clear because people can seemingly imagine that everyone's life is valued and preserved.

The other woman with who I spoke, who shared this moral community, talked about the same issue, but tied it more precisely into politics and guaranteeing membership to a national political community and its associated services.

> *I like the social safety net (...). I am glad I am in this country, (...) and my reasons for needing healthcare may be very … like I wasn't beaten, you know, I wasn't. My parents were educated people. All of the sort of socioeconomic/psychological/biological, like what kind of genes you inherit… All of that, you're not in control, you don't orchestrate that. Most people want a good life, but you can get stuck with the package that you've been given (...) and you can't really blame people (...). I mean, how do you know you would respond if you were given a pretty crappy file for your life? When we left, we like literally escaped by boat from communism, right. (...) So when we arrived [e.d in Canada] (...), we kind of fell into a support system. (...) That was actually a really good experience in the sense of our basic needs being taken care of. (...) But if your neighbor is umm, unethical in the way they are asking for help and services how does that assessment come into play? So it's very complicated. Its complex, and it's touchy. [e.d However], I think it really, it's like, are we a family of humans, or are we not a family of humans? And whether we like it or not, we are moving towards like global family, right? Like, so, there's that in the like bigger picture.* (Participant # 8)

The above quote, as well as those from participant # 5, suggest ways of thinking that may emerge out of experiences that people had. The particular qualities of the social experiences that these two women had in both acquiring healthcare in Canada and witnessing others trying to acquire it, may suggest something about morality in the sense that the social, psychological, historical and even other forms of knowledge that made up their experiences can be brought to the surface and articulated as part of their beliefs in a coherent way. In the process of analyzing this moral community, I uncovered moral elements that may not otherwise have been visible. These moral elements (e.g. compassion towards all other human beings, perceptions on the importance of belonging, perceptions on the complexity of moral demands for care etc…) are all necessary in order to understand how the ways that people's moral worlds play into how they configure (or reconfigure) rights in the context of access to healthcare in Canada.

When the ideas associated with this moral community are applied, the vision of the national community, which governs the access to healthcare, is of a community in which things are framed not according to what is retrospective, but what is prospective. By this, I mean that the moral community of lives within our borders does not delimitate its' borders according to mere aesthetics (where things are framed according to retrospective aspects like what has been perceived, seen, or heard by or from those whose deservingness is in question) (see Nyers, 2010, p.g. 130). Rather, the boundaries of this moral community of lives within our borders are understood in terms of the prospective nature of which potential itself is understood, and can seemingly be guaranteed through the country's application of what is generally known as the human rights framework.

In the context of healthcare access, the human rights framework, which when applied guarantees people's potential within the national community, is based on an assumption that access to healthcare is a fundamental human right that should be based on principles of universal access, where people are treated unconditionally because they are subjects of those rights (Vanthuyne et al, 2013 p. 81). We can see how the attitudes associated with this moral community of lives within our borders are collectively articulated as being in harmony with the concept of humanism. Now, I would like to further delve into this, in order to understand what this can all tell us about the ways that people's moral worlds may play into how the right to healthcare is configured in the context of humanism in particular. What type of human is being posited when this logic is employed?

The type of human that is being posited by my participants associated to this moral community is one which is equal in all respects, regardless of origin, background, or present situation. Rather than conceptualizing people in terms of their political nature within the national community, people within this community are imagined in terms of their humanity. Importantly, rights, which are generally understood in this case as something to which a moral and/or legal entitlement exists, therefore come to be configured as the only possible way to look at this question on access to healthcare. This is because the type of humanism people morally associates to is one not of tension or of identity but of equality between and among people physically residing in Canada. Therefore, what endures is a sort of idea that access to healthcare is not dependent on the events of the present or of the past, but on one's humanity, where humanity itself can be seen a morally-

enduring concept. By this, I mean that when humanity endures as a moral concept, embedded and intertwined in people's experiences and forms of knowledge, then the language of abuse that we often hear in the media when it comes to issues of access to healthcare becomes almost irrelevant. In this context, the language of abuse would not even be relevant language because everyone physically in Canada would have a right to access healthcare.

The "moral economy of humanism" and the "moral community of lives within our borders" thus leave behind an environment in which language of "deserving", "privilege" or "earned" are irrelevant. They also, therefore, bring forth questions of knowledge production in a new (or at least different) framework because when we think of these issues in terms of humanism and a human rights framework, the power to specifically define the 'deserving' or the 'undeserving' would seem to disappear. However, different moral standpoints, often competing with this one, still exist relating to deservingness of healthcare. These different standpoints involve moral positionings on the right to healthcare which involve views on whose bodies and whose lives matter in the context of the Canadian healthcare system, and specifically under what circumstances. These will be explored in the following chapter.

5. Chapter 4: The Moral Economy of Strategic Exchange - Priorities and stability

> *Having a health system is wonderful, I've already said that. Its' a privilege to have it. But, it's only available to other people here [e.d in Canada] because Canadians have paid by their taxes and other revenues, which enables these other people to have this. It's admirable that we can open our arms and give them [e.d Newcomers] this, we welcome them, but remember that free everything, that's great, if your country is stable and can afford to do that, but the question is "Is Canada financially able to do this?". (Participant # 2)*

This quote suggests that in this moral economy, there is an organizing narrative that surrounds access to healthcare, and it would appear to have a lot to do with the set of activities that access to healthcare (as a "Canadian resource") is perceived to pass through. Therefore, according to this perspective, there is two-fold way that healthcare can be understood, where both the giving and the receiving of it are equally important to discussions surrounding its' access. This means that healthcare becomes understood as a national/provincial resource that is to be carefully managed and distributed. This view, however, does not mean that healthcare has a singular meaning or that it must be managed in any one particular way. In fact, as information gathered during my interviews (Participants # 1, # 2, # 3 , # 4, # 7 , # 9) suggests, discussions on access to healthcare, when the following moral economic logic is at work encompass ideas surrounding

managing the distribution and funding of healthcare, as well as managing the receiving of it. In fact, this two-fold perspective on access to healthcare suggests that access to subsidized healthcare, in the context of the Canadian federal and provincial healthcare system, posits theoretical similarities to Mauss' concept of the gift. In much the same way that Mauss emphasized the need to give and to receive something as being societally structured, the granting of healthcare in the case of this quote suggests a similar sort of logic. By this, I mean that when this moral economic logic is applied, perceptions on the giving and receiving of healthcare, to use the words of Rose and Lentzo, who wrote on a similar subject, are "*enmeshed within webs of obligation, identification, and allegiance*" (Rose and Lentzo, 2017, p. 33). For Willen (2012), both peoples' perceptions of social connectedness to those whose deservingness is in question as well as their own experiences with healthcare play a role in how people understand deservingness, as it exists within this web.

In the context of a moral economic logic which emphasizes healthcare as a resource, something like the right to access this healthcare becomes flexible. It is open to the set of processes that work together to create a situation in which the market logic can become the only possible logic in which the functioning of the healthcare system can be analyzed. This logic is what allows us, in the context of the healthcare system, to relate to both ourselves (as the taxpayer who has the right to use our healthcare system), and the other (as the privileged "consumer" of the benefits of our healthcare system). By relating to ourselves and others in a system where this type of market logic is presented as the only viable option, questions on access to healthcare for newcomers can be seen to be interpreted as a "*political hot potato*" (Participant # 9).

In a moral economy derived from types of logic that focus on things that can be seen, heard or perceived, often when it comes to the question of access to healthcare, people end up being imagined as consumers within a system that is structured by market-logic. This brings to the surface the fact that when this moral economic logic is applied, it becomes necessary to find a way to categorize "everyone else". In this moral economy, a contribution is desired. However, when this is not applicable or not reasonable, other rules may come into play. This politically charged nature of looking forward and desiring contribution for access is what brought me to qualify this moral economy as "strategic". This is because contribution can be judged for its' value, and a person can be judged for their ability to contribute. However, this contribution does not always have to be monetary and may also include social exchanges, for example contributing to your community through volunteer work. When the logic of this moral economy is at play, these types of exchanges (monetary and social) work together to determine perceptions on deservingness of care. Monetary exchanges in this context can refer to, for example, a financial contribution to the healthcare system which, "*is postulated on the fact that as Canadians we've paid our dues in Canada. [* E.d *For example], we pay our taxes and have jobs, which is where the money to pay the healthcare comes from*" (Participant # 1). Social exchanges also encompass a contribution of sorts, but it is one that cannot necessarily be financially measured. For instance, participant # 1, # 2, and # 9 all mentioned that taking on "*Canadian values"* and becoming part of Canada, whether that be through the scouting movement (participant # 1), by undertaking studies in Canada that will help improve the lives of others living here (Participant # 7) sitting on a committee to improve your neighbourhood (participant # 1), or simply being inclined to do things "the right way" by respecting our laws (Participant # 9). These types of contribution were

important when we talking about becoming part of a national community and earning access to Canadian-funded services.

There is, therefore, both an economic and a social meaning associated with the deservingness and utilization of healthcare, both of which can be specifically judged for their value. On the one hand, the economic aspect relates to the functioning of the system itself and desiring contribution in order to not break this financial balance that allows Canadians to have this system in operation. On the other hand, the social aspect relates to the particular view of what we mean by 'valuable' contributions to society.

5.1. Coming to Canada as a Conscious Choice: Moulding the Moral Economy of Strategic Exchange

Over the course of my research, I found that those who shared in this moral economic logic (Participants # 1, # 2, # 3 , # 4, # 7 , # 9) had all come to Canada as family class or economic immigrants. These participants were those who seemed to share similar social experiences and relationships with their experience of coming to Canada and with Canadian healthcare. Those who shared in this moral economy were those who had made a conscious decision to not only come specifically to Canada but to make their lives here, contribute to Canada, become part of Canada, and eventually become Canadian citizens. However, I do not plan to look at this in relation to how this relates to the decisions that are made in terms of perceptions of healthcare access, Rather, I look at this as part of "the set of activities and relationships" (Carrier, 2018, p.

22) that people went through, forming a particular quality of social experience (See Heyman,2011, p.19) and relatability to the issue of access to healthcare for newcomers. This seemed to assert a palpable pressure on respondents who shared this moral economic logic to desire the same sorts of obligations, identifications and allegiances from others as they thought had been desired from them.

This amplified sense of association between types of contribution associated with these obligations and allegiances and the corresponding entitlement could be related to how they understood and framed the discussion on rights, reformulating rights as either something that was earned or something that was given as a privilege. It is in this case rights may become detached from their legal context, opening the door for gaps to emerge between the level of access to healthcare that is guaranteed and the perceived "deservingness" of it for newcomers, showing how rights become entangled with aspects of social life. Importantly, before moving on, it is pertinent to discuss what is meant by health in this case because it helps to understand deservingness of healthcare as it relates to how roles are perceived to exist within our social life. This will also help to further our understandings of the discussion on the moral communities, which will follow.

5.2. Situating definitions of health

Health, in the context of this moral economic logic, could be understood to be closely related to functional health, which according to Kelman relates to the optimum capacity of to perform roles within society (1975). When disease is treated within a functional health context, associations of 'health' are therefore understood in many ways to be related to the body. During my interviews, refugees (mentioned by Participant # 9), people with disabilities (mentioned by Participant # 7), and people who are very new to Canada (mentioned by Participant # 4) were specifically mentioned as not being presently able to contribute, but as potential contributors, if their suffering was alleviated. These groups would, according to responses I got from these participants, be eligible to be receivers of healthcare based on compassionate values, which are determined in the context of functional health.

5.3. Two Related yet Separate Moral Communities

The moral economy of strategic exchange (outlined above), defines the scope of the moral values in the case of certain perceptions of access to healthcare. It defines the moral values, assumptions and obligations upon which understanding the principle of healthcare rests as being related to market values. In this sense, people either deserve healthcare because they have earned it, or they are given this is a privilege. That being said, how people react to an environment in which healthcare is an asset that can be regulated by either monetary or social forms of

exchange is a different question and requires delving deeper into the analysis. In the context of the beliefs and perceptions, developed in the above-mentioned moral economy, towards whom did my participants feel that they had a responsibility?

Thinking of moral communities as communities of beings that one holds in moral regard (Lindemann, (no date)), there are two distinct, yet oddly similar moral communities that stem from the moral economy of strategic exchanges. These are similar as they both stem from common understandings, but they are distinct in terms of how these understandings are applied to foster common attitudes and values that make up the moral community. In other words, both are driven by the same type of moral economic logic, but they are distinct in terms of how the norms and values are deployed to create the community of beings who are held in moral regard. In both moral communities, a contribution is at the forefront, but it is how the "other" eligible groups were determined that made them separate. In this way, both moral communities are animated by the same ideas, but actioned differently. How peoples' ideas come to life varies significantly. These distinctions and variations will be made more clear as we move through the following sections.

5.3.1. The Moral Community of Contribution and Responsibility

When beliefs and perceptions pertaining to monetary contribution to healthcare (part of the basis of the moral economy of strategic exchange) interacted with those of responsibility (which is generally understood as the state of having to deal with something or someone and to feel a

sort of accountability for it), people tended to share in what I am calling "the moral community of contribution and responsibility". Information gathered from my participants suggests that when the logic associated with this moral community is at play, there is an earned quality of healthcare that is often referred to as "*deservingness*". There is also what gets referred to as "*privilege"*, which encompasses the fact that someone has been given healthcare services because "*we're kind hearted and good people*". (Participant # 9)

Participants in my research who shared the values associated with this moral community (Participants #7 and # 9), appeared to be those who seem to be evaluating others who did not contribute financially to the healthcare as either "worthy" or "unworthy", according to specific circumstances that the person may be enduring at the time that their "deservingness" was in question. For instance, in a discussion with participant # 9, it became very clear that when the logic associated with this moral community was at work, rights could be re-configured in one of two ways. Either you could earn your right to healthcare (deservingness), or you could be given it (privilege). Given this, when I asked him if there were any groups of newcomers whom he felt should have an additional right to healthcare, he noted that perhaps, "a right" was not the proper term to use in discussions. For him, this seemed in some ways to create an environment where healthcare providers, and Canadians more generally, had no control over who accessed our services. According to him, for groups like refugees, when, as a country we've decided to take care of them, we have to follow through because this was part of assuming responsibility for them in the first place. "*We assume responsibility for refugees. Ok, so once you've done that, as a country, you've gotta put your money where your mouth is"* (Participant # 9).

Another one of my respondents who was a 24-year-old nursing student originally from the Democratic Republic Congo (Participant # 7) spoke about having lived in '*the hood'* in Montreal when he first arrived in Canada, and how he had perceived the access to healthcare for people in his old neighborhood. He noted that while it bothered him to see people "*in the hood*" sitting around, drinking their beer, and not working at all from morning to night, the idea of a purely earned quality of healthcare still troubled him because it would mean that this would be imposed on everyone . He said that establishing a system where an earned quality of healthcare was the rule would be unjust. He noted that this was because there are some people who would otherwise contribute but at one point or another cannot either due to a disability, or other reasons why they cannot work. Specifically, he spoke about people with disabilities as having a particular need for access to subsidized healthcare, and as feeling a responsibility towards them.

From these two interviews (Participants # 7 and # 9), it is clear that there are two factors at play when it comes to the ways that the borders of the moral community of contribution and responsibility are delimitated. There is the rule of contribution, and the except to the rule of contribution. Understanding that the exception in this case can be understood to be regulated humanitarian ideals and principles of compassion, we can see how people in this moral community relate to those who they perceive as other. The following will explore how these exceptions are characterized such that a persons' deservingness of healthcare is evaluated. A particular emphasis will be placed on the influences of humanitarian ideals.

Thinking about the examples of groups of people who, despite being perceived to not contribute to healthcare, should be able to access it (for example: refugees or people with disabilities), I knew that I needed to understand how "worth" could come to exist in these specific circumstances and not others. How do certain groups of people come to be associated with being able to exercise their rights as "privileges", while others do not? What does this tell us about the ways that rights have been or can be re-configured? In this moral community of contribution and responsibility, how worth is categorized is seemingly very important. Notably, in the context of this moral community, worth can either be understood according to contribution (which translates into deservingness), or what appears to be some sort of perception of a persons' helplessness (which is what allows them to have a privilege to healthcare). According to what was mentioned by participants # 7 and # 9, humanitarian principles were shown to play a dominant role in how we interpret this helplessness. However, that does not mean that this is the only way that these privileges to healthcare are interpreted.

5.3.2. The Moral Community of Contribution and Allegiance

As mentioned, there are two distinct yet similar moral communities that can emerge out of the moral economy of strategic exchange. This is because there are multiple possibilities of evaluating how "privilege" can be achieved, and these can be seen to be intrinsically linked to morality. Earlier in the analysis, emphasis was put on the ways that both monetary and social exchange can be used to analyse the borders around how rights are actualized; When people were uncomfortable with monetary line drawing, they drew on social aspects. Having this

understanding helped to distinguish between the two different yet similar moral communities which emerged from this moral economy. By this I mean that the reason that multiple moral communities can stem from this particular moral economy is that when the right to healthcare is understood in terms of market-logic, which treats it as related to our social lives and thus as perceptive of individual particularities, the ways that privilege can be assessed are multiple. *"Unlike the juridical discourse of rights, which presumes blindness to individual particularities, moral assessments of deservingness are typically relational"* (Willen, 2012, pg. 813). While the first moral community seen above (The Moral Community of Contribution and Responsibility) drew upon humanitarianism and ideas of helplessness when evaluating privilege, in this moral community, allegiance is key. For Willen (2012):

> *One assesses others' relative deservingness on the basis of two key factors: first, an implicit sense of one's own deservingness, and second, one's sense of actual or presumed social connection to those whose deservingness is in question"*. (Willen, 2012, pg. 813)

Participants who I associated with this moral community (Participants # 1 , # 2 , # 3, and # 4) tended to be those who_approached and separated themselves from others based on various perceptions of allegiance and belonging to Canada.

In interviewing a Scottish-Canadian couple (Participants # 1 and # 2), who came to Canada in 1952, before universal healthcare coverage existed, and listening to them tell a story from when

they first arrived here, the emotions were quite raw. The following quote from participant # 2 brings to the forefront the ideas discussed by Willen:

> *"We didn't have that right (e.d to Healthcare) or privilege when we came here in 1952, when my husband got very ill. It was a very hard time for us, but that being said, we managed, we had some people who helped us, not financially, but in other ways, so we never looked back because we could see a bright future for us in Canada. We felt that if we worked hard and made our contribution in different ways, you know whether it was with the scouting movement, uh when we first came my husband started there through the Anglican church, we contributed towards different charities, we got involved with theatre work, anything that we could do to contribute where we were, at the time, to become part of a Canadian citizen."* (Participant # 2)

In listening and understanding this story, the level to which this woman felt that her and her husband had to first contribute before earning access to healthcare and how they displayed their allegiance to Canada, which they had felt they displayed through their actions, was powerful. Whether or not this was required isn't necessarily relevant, it's about their perception of this (their own deservingness) that counts, and how this may get projected on to others in the form of desires for them to do the same. The following quote from her husband (Participant # 1), illustrates this projection:

> *"It's annoying to see, maybe not only healthcare but other benefits, being given to people who have just arrived in the country five minutes ago and who owe no allegiance to anything, and who in some cases even condemn our way of life, and uh … Are they entitled? " (Participant # 1)*

My interview with this couple suggested to me ways of looking at how the moral aspects of perceptions of allegiance and belonging to Canada can help determine perceptions on the deservingness of healthcare for another. For instance, those who share in this moral community seem to be able to both approach and separate themselves from others based on this abstract perception of allegiance. This can then be used when assessing who should have the privilege to access healthcare in Canada. Importantly, as seen above, allegiance can be demonstrated through actions which are subjectively evaluated. But, it can also be demonstrated through an intention to stay in Canada, as participant # 4 noted:

> *"I see it as an intent to stay (…) At the end of the day , when they're in Canada and they need healthcare, they'll pay that back. They're going to live in this country, they're going to contribute. They're gonna pay their taxes… I think that if you're going to contribute to the wellbeing of the (…) then you deserve it* [e.d. healthcare] *as much as anyone who's been doing it for longer. The only time I think that someone shouldn't deserve healthcare is if they're only here for healthcare tourism, that's a different story"(*Participant # 4)

Information from participants in this moral community has suggested that this social connectedness to the other (or lack of social connectedness to the other) can be related to the ways that rights are constructed and re-constructed. The problem, is that assessing this allegiance is very subjective, and results in power dynamics where some people are being are offered healthcare while others are left to suffer. This was also at play in the first moral community in this section "the moral community of contribution and responsibility".

5.3.3. Power Dynamics in These Two Moral Communities

The two moral communities presented in this chapter, "the moral community of contribution and responsibility" and the "moral community of contribution and allegiance" helped understand how, when healthcare is understood in terms of a moral economy based around principles of market logic, communities can be created and maintained through collective articulations and notions of imaginary. As Anderson (2006/1983) noted, this question surrounds how our national community is imagined, and, how it is through this imagination that we can give shape to things like justice or forms of solidarity when it comes to the question on who people believe should have a right to healthcare. This chapter has brought to the surface important questions surrounding power that need to be addressed.

In this chapter, the first moral community which was identified was the "moral community of contribution and responsibility". When discussing this moral community, I noted that those who fell into it tended to be those who seemed to be evaluating others who did not contribute financially to healthcare as either "worthy" or "unworthy", according to specific circumstances

that the person may be enduring at the time that their “deservingness” was in question (e.g. having a disability, or being a refugee). The problem here is that this process involves more than just the obvious of deciding who we are responsible for and under what circumstances. It also involves, perhaps more unobviously, deciding who we are not responsible for. Work done by Fassin (2005), helps to understand how, in order to justify ideas regarding who we are responsible for, we pass through (whether consciously or not) a process in which we disqualify others. According to Fassin, “episodes of compassion toward refugees”, or in this case people with disabilities, or any group whom we decide we have a reasonability to protect, appear as “privileged moments” of our collective articulations of what it means to have a privilege to healthcare in Canada (Fassin, 2005, p. 375).

Similarly, assessing allegiance as a marker of membership to the national community eligible for healthcare, as is done in the second moral community identified in this chapter, also has material effects. It results, no doubt, in power dynamics where some people are granted healthcare while other are left to suffer. There is certainly a power dynamic here which is deeply problematic, especially since allegiance itself is much more difficult to measure than something like the presence of a physical disability. Importantly though, in some cases, participants who fell into this moral community acknowledged that they were aware of the existence of a power dynamic, even though they struggled to understand its implications:

> *“[*e.d. When we came to Canada*] , we were lucky in a sense because many of the institutions in Canada were derived from the same institutions “[*e.d. as in Scottland*], so it wasn’t completely foreign to us. Now, if I was a Saudia-Arabian who had never been outside an Arab community in my life, how would I (…) I don’t know (…). But, as I say, coming form the UK,(…) speaking English, coming to Canada, uh, we were just moving from one background to another one which was different but awfully close. Very similar. Policemen, the language was same, that sort of thing.* (Participant # 1)

In this case, the roles that this gentleman associated with a displayed allegiance to Canada and to the community living in Canada, for example being involved in the Church or in the scouting movement or sitting on committees to improve your neighborhood, were much more obvious given his background.

6. Concluding remarks

The data collected for the purposes of my thesis, on how first-generation Canadian citizens understand rights and deservingness to subsidized healthcare for newcomers, is rich in information pertaining to people's moralities. In this work, I used moral economies and moral communities as lenses to understand how and when rights may get reconfigured under the guise of deservingness or privilege. Through the lenses of moral economies and moral communities, I was able to illuminate norms and values that appear as moralities, the ways in which these function in everyday life, as well as how they translate into specific moral views on healthcare.

The first of my two content chapters identifies a moral economic logic in which the values and norms associated with healthcare are understood according to humanistic ideas where health is associated with life and possibility, and healthcare in understood as enhancing these. This moral economic logic functions such that healthcare for Canadian newcomers is understood and functions according to the understanding that those whose deservingness is in question are a part of our Canadian humanity and not a group of "others". When this moral economic logic is at work, the reason that healthcare is given moral value (or meaning) in the first place, is that it is the backbone of society. It is because of this specific moral value that rights to healthcare, in that context, are able to maintain their inalienable meaning. For instance, when this moral economic logic is engaged with in everyday life, the scope of action and thought available is not limited to a realm associated with specific criteria or characteristics which would allow rights to be

reconfigured. Rather, everyone physically in Canada is deemed to have the right to healthcare services in the country.

The second content chapter takes a different perspective. Looking at a moral economic logic in which health is understood as "functional", norms surrounding the question of access to healthcare for newcomers are set out in terms of certain parameters (for example, a person must contribute financially to healthcare before being allowed access). These norms function as part of a web of affect-related values such as obligations, identifications, and allegiances. When this moral economic logic is at play, healthcare is understood as a resource to be consumed, and people as consumers of this resource. When healthcare is understood in this way, the possibility for the reconfiguring of rights to healthcare is opened up, and such rights have the possibility to lose part of the inalienable character that their name implies. The ways that people relate to both themselves and others in this context are slightly more varied than in the first chapter, and results in two moral communities stemming from the same moral economic logic: the "moral community of contribution and responsibility" and the "moral community of contribution and allegiance". Both of these moral communities suggest that when people engage with healthcare as a consumable resource, rights take on a new life. This allows them to be reconfigured as something that is either deserved or earned. Importantly, this involves a discussion on power as it relates to the way that we imagine the communities of people eligible for healthcare to exist.

In the literature, practical concerns faced by newcomers was discussed at length by authors like Asanin and Wilson (2008) and Campbell et Al (2014). Political rhetoric was also discussed by

authors like Diop (2014), as was the context in which perceptions of healthcare workers towards newcomers’ access to healthcare (Vanthuyne et al (2013); Willen (2011)).

Where my thesis actually builds on existing debates and subject matter is when it comes to showing how specific conceptions regarding first-generation Canadians’ perceptions on access to healthcare can grow into more complex ideas which can foster the creation of imaginaries that can then be taken up in social practices. By accessing the social context in which concerns regarding newcomers’ access to healthcare emerged among first-generation Canadian citizens, a group who had once been newcomers themselves, the present work adds original content to ongoing academic discussions. Rather than comprehensions of rights or deservingness affecting who people believe should have access to subsidized healthcare, it is the normative notion of who people believe are entitled to access this care, as grounded in their moralities, that affects how they understand rights and deservingness of healthcare as concepts themselves. This helps to understand how rights may get reconfigured in some contexts as deserved privileges, while in others they maintain their inalienable character.

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ii

Participants Needed!!
Research on Percep
tions, Beliefs and Attitudes of Access to Healthcare for Newcomers to Canada

Participants demandés!!
Une étude sur les perceptions, croyances, et attitudes envers l'accès aux soins de santé pour les nouveaux arrivants au Canada

To participate you must …

- Be a first-generation Canadian Citizen
- Currently reside in Ottawa/Gatineau

Pour participer, vous devriez …

- être un/une Canadien(ne) de première génération
- Résider actuellement dans Ottawa/Gatineau

You will be asked to

- Share your experiences, perceptions, beliefs, and attitudes through your participation in one individual interview (duration: 45 minutes to 1 hour).

Vous serez demandé de

- Partager vos expériences, perceptions, croyances, et attitudes à travers la participation dans une interview individuelle (durée: 45 minutes à 1 heure)

In appreciation of your time, you will receive refreshments during the interview & a $5 gift card to a coffee shop

En appréciation de votre temps, vous recevrez des rafraichissements durant l'interview ainsi qu'un bon de 5$ pour un café

First come first serve! / Premier arrive premier servi!

https://www.longwoods.com/content/25099/healthcare-policy/reforming-refugee-healthcare-in-canada-exploring-the-use-of-policy-tools

[iii] **English Interview Guide and Questions**

1. Hand 2 copies the consent form to participants for them to read over and sign
2. Collection of socio-demographics (to occur prior to beginning qualitative data collection)
   - **Information to be collected:**
     - Age
     - Gender
     - Current Province of Residence
       - Must be Ontario or Québec
     - Preferred language
       - English or French
     - Marital Status:
       - Married
       - Living in Common-law
       - Widowed
       - Separated
       - Divorced
       - Single
     - Occupation/Profession
     - Method of entry into Canada:
       - Economic immigrate category
       - Family class immigrant
       - Refugee
       - Other
     - Year of arrival in Canada
     - Country of origin

3. Qualitative Portion of the Interview:
   a. **Read** the following to the participant:
      i. This section contains the majority of the interview questions, and involves a few close-ended questions, as well as a series of open-ended questions.
      ii. Due to the qualitative nature of the study, you may find that, during the interview, I will use other short questions to make sure I understand what you told me or if I need more information when we are talking such as: "*So, you are saying that …?*), to get more information ("*Please tell me more?"),* or to learn what you think or feel about something ("*Why do you think that is…?").*

   b. SECTION ON PERCEPTIONS, BELIEFS AND ATTITUDES REGARDING ACCESS TO HEALTHCARE :

Initial Question	Answer types	Prompts	Researcher Notes
Do you believe that all newcomers to Canada should have	Endorse, Ambivalent, or Do not endorse		Beliefs

a right to access healthcare?			
Can you explain? What does having a right to health mean to you?	Open-ended	How would you define a right to healthcare? Who should have a right to access healthcare in Canada? When? For what purposes?	attitudes… i.e. how does the participant react to their beliefs, stated above
Are there certain groups whom you feel that as Canadians, we have a responsibility to care for?	Open-ended		If asked to confirm what I mean by groups, the response should be that the intended purpose of this question is to see what groups they would use, or if they would even categorize?
When people talk about deservingness of healthcare, what does this mean to you?	Open-ended	How do you think deservingness of healthcare is invoked? Do you perceive there to be an earned quality to healthcare? If yes, how do you perceive this earned quality? Can you give examples in the Canadian context?	Perceptions Note: If participant asks for clarification of definition of deservingness: In the context of healthcare, deservingness refers to the earned quality of health care.

c. SECTION ON IDENTITY AND SENSE OF BELONGING IN Canada

Initial Question	**Answer types**	**Prompts**	**Researcher Notes**
On a scale of 1-5, (with 1 being "weak sense of belonging" and 5 being "strong sense of belonging" how would you rate your sense of belonging to Canada?	Likert scale (1-5)		
What are the circumstances (or perhaps roles that you play) upon which you are basing this sense of belonging?	Open-ended		Note: I'm looking here for things like for example "taxpayer", « volunteer », "There are people here that make me feel

			welcome" etc... but these examples will not be given in order to avoid bias.
Do you think that these circumstances or roles have impacted upon your views regarding access to healthcare for newcomers? Can you explain?	Open-ended		

d. SECTION ON PARTCIPANTS' PERSONAL EXPERIENCES WITH CANADIAN HEALTHCARE

Initial Question	**Answer types**	**Prompts**	**Researcher Notes**
Do you remember what healthcare looked like when you arrived in Canada? Can you tell me about it?	Open ended	Were services covered / subsidized? Was there a waiting period?	
Did you require healthcare in the first few months after arriving in Canada?	Yes, or No		If yes, answer the next two questions. If no, skip to last question of this section.
Can you tell me about the experience?	Open-ended		
Do you believe your experiences with healthcare as a newcomer have had an impact on your perceptions, beliefs and attitudes?			
Do you believe that the extent of what was available to you, has impacted your perceptions, beliefs, and attitudes?			

e. QUESTIONS/COMMENTS?