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On the Role of Structural Competency in the Healthcare of Migrant with Precarious Residency Status

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Abstract: The literature on the health care of migrant patients has often emphasized the importance of cultural skills and cultural humility that caregivers must bring to their care. Recent work has emphasized the importance of adopting a structural reading of this competency. Based on two empirical surveys conducted in France and Germany in facilities providing access to care for migrants with precarious residency status, this article demonstrates the importance of competency linking in terms of what is produced by structures and institutions and what is produced during medical interactions between patients, medical professionals, and volunteers. The complexity of accessing health protection systems for migrants with precarious residency status is often the main structural and institutional barrier to care. To remove this barrier, health professionals can develop legal and administrative competency regarding residency and health rights. They can also develop institutional and practical competency regarding the possibilities of access to health care for people without health coverage in the local geographical context. Structural competency is also effective in deconstructing the stigma and discrimination that minority groups experience in the healthcare system.

Keywords: structural competency; access to healthcare; migration; medical training

1. Introduction

Research devoted to health disparities and social determinants of health has developed considerably over the last few decades. While this research mainly centered on the study of gender and class inequalities and disparities until the 1980s, it has since expanded to include other determinants, notably those of ethnic origin and nationality. It became apparent that people belonging to these groups experienced excess morbidity and mortality [1–3]. The literature has shown that the reasons for this situation are multifaceted and combine socioeconomic [4] as well as cultural factors [5]. On the one hand, socioeconomic inequalities faced by ethnic minorities negatively affect quality of life (poor working conditions, low income, poor housing, etc.) and thus health. On the other hand, differences in culturally determined beliefs, values and behaviors that are revealed in interactions between health professionals and patients also influence health to the disadvantage of patients from cultural minorities. Perceptions of the body, suffering, illness, etc., differ from culture to culture. In order to reduce health disparities and inequalities related to cultural factors, the health care community has, since the 1970s, expanded its clinical gaze [6] and developed cultural competency training that helps to reduce some of these gaps.

Cultural competency in healthcare delivers effective, quality care to patients. The US Department of Health and Human Resources define as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" [7]. The key competencies for cross cultural interactions are (a) sensitivity, as the capacity of individuals to appreciate cultural differences, (b) awareness, as the capacity to understand how culture affects thinking, behaviors, and interactions, and (c) skills, as they are reflected in effective communication and intercultural interactions [8,9]. Since the 1990s, many handbooks addressed to health professionals have attempted to train them in cross-cultural competency in order to improve

the care of patients from cultural and ethnic minorities [10,11]. The cultural humility approach [12], constructed as a critical development of the cultural competency approach, incorporates a dimension of self-reflection and self-critique in the practice of healthcare professional "to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities" [12] (p. 123).

More recent critical works [6,13–15] have shown the limits of an approach focused on culture in the fight against social disparities in health, especially those related to nationality and ethnic origins. Approaches in terms of cultural competency or cultural sensitivity challenge culturalist, racist, classist, and sexist biases present at the inter-personal level during interactions between caregivers and patients. However, this approach tends to overlook how the structural context (economic, political, legal, social) can also produce health inequities independently from the positionality of the caregiver. Numerous studies have shown that the legal barriers that prevent migrants from accessing health protection systems, and by extension, health care are among the main elements contributing to social inequalities [13,14]. Beyond legal barriers, migrants face other types of discrimination that result from structural and institutional racism [16,17]. The link between structural/institutional racism and poor health has been known for a long time, yet this topic is only weakly integrated in the training programs of health professionals. Highlighting this gap, Metzl and Hansen [15] propose a new paradigm of structural competency to be integrated into medical education, i.e., structural competency. They define structural competency "as the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication 'non-compliance', trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health" (p. 128). The focus on structures in their definition is not intended to distract from the cultural dimension in the health care context, but rather to invite us to pay attention to the ways in which "culture" and "structure" are mutually implicated in the production of inequalities and stigma. The authors identify five intersecting skill-sets that shape the paradigm of structural competency, which are (1) Recognizing the structures that shape clinical interactions in order to better understand how economic, physical, and socio-political forces impact medical decisions; (2) Developing an extra-clinical language of structure and "by imparting fluency in disciplinary and interdisciplinary understandings of structure as they pertain to illness and health in community settings" (p. 129); (3) Rearticulating "cultural" representations in structural terms; (4) Observing and imagining structural intervention; and (5) Developing structural humility (as the "trained ability to recognize the limitations of structural competency", p. 131).

Following Metzl and Hansen, this article contributes to a better understanding of the interplay between structural and cultural dimensions during interactions between health professionals and patients. The work accomplished in this article relies on two different empirical surveys (one conducted in France and the other in Germany) among groups that are particularly affected by institutional and structural racism, termed the "precarized migrants." The "precarized migrants" are understood here in relation to their immigration status, i.e., whether they are in an irregular situation or have a precarious residency permit (for example, a set of short residency permits that do not entitle them to all the social rights available in the host country). This article highlights in particular the importance of a body of knowledge relating to the structural and institutional place assigned to groups of precarious foreigners in the health system and the role they can play in health care. This knowledge relates to the structural realities of exclusion of these groups from public health care systems and the possibilities of accessing care in this hostile environment (both in the public and humanitarian sectors). We argue that the lack of expertise in the domain of healthcare has a negative impact on the care provided to these groups. In particular,

we will show that this lack of expertise leads professionals to wrongly orient patients in the health system, thus prolonging structural discrimination at the inter-individual level and using negative moral categories in their interactions with patients (who are seen as undeserving).However, the identification of the ways in which structural factors are negatively reflected at the local level of care allows for the development of a specific structural competency that improve care, sometimes by acting on structural discriminations reproduced in healthcare structures at the local level (structural intervention). The first Section presents the method, the surveys and the context that frame the analysis. The second part of the analysis then focuses on structural competency linked to the interactions between migration policies and health policies. We focus on two case studies. The first focuses on emergency care and how structural competency can improve access for those who are excluded. The second case study examines the importance of administrative and legislative skills in optimizing referrals to support systems for disadvantaged foreigners. In the third and final Section, we describe the processes of categorization to which precarized migrants are subjected in healthcare institutions and the way in which these institutions reduce their perceived health-related deservingness.

2. Materials and Methods

We used two surveys to gather the empirical material on which the analysis of this article is based. The first survey was carried out between 2011 and 2017 as part of a doctoral thesis in sociology at the University of Paris 13 [18]. The author gathered observations made in 16 Healthcare Access Unit (Permanences d'accès aux soins de santé—PASS) and 40 semi-structured interviews conducted with professionals working in and around these structures. The interviews attempted to grasp social representations about practices in PASS. PASS are small hospital structures instituted in France in 1998 via the law to combat exclusion [19]. Through medical and social work, PASS provide access to healthcare for patients who are excluded from the health system, for example, for persons who are not insured. Social counselling aims to integrate the patients concerned into the mainstream system whenever possible. There are approximately 400 PASS centers across France.

The second survey was conducted as part of a postdoctoral project on the interactions between health and migration policies in Germany between 2018 and 2020. The survey gathered observations and interviews (*n* = 20) in collaboration with two NGOs providing free healthcare for people without healthcare insurance (Medibüro: Berlin, Germany and Open.Med: Berlin, Germany), as well as one state subsidized organization (Clearingstelle: Berlin, Germany) offering social counseling and healthcare access for people without health insurance. Precarized migrants make up a large proportion of the patients treated in the health care facilities studied in these two surveys.

The two empirical surveys use the method outlined in the grounded theory developed by Corbin and Strauss [20]. This inductive method entails elaborating on theory by starting from the research field in which observations and interviews are carried out. From here, the empirical data is then constructed and compared according to the theoretical sampling method. In this sense, the research field acquires a double function, in that it facilitates the production of data and functions as the place of interpretation. There is a continuous back and forth movement between empirical data and theory, both of which feedback onto each other. The grounded theory aims not to verify previously constructed hypotheses, but to understand the internal workings of the social object studied and to identify intelligible social mechanisms that are elaborated in hypotheses.

3. Structural Competency Related to the Interplay between Migration and Health Policies

3.1. Limits of the Public Healthcare Coverage System and Structural Competency

"That's it, in fact I realized at the end of my studies [...] that medicine was not free for everyone. [...] I began to wonder about this because in the emergency room, when I learned by chance that the patient didn't have health insurance, I went to see the social worker, I

asked her what we could do to help him. And that's when I started to think that it's not normal that, well, how is it possible that I haven't yet realized that there are people who don't have Social Security! There are people who only live by the medical emergencies... uh who come by chance, who don't have the means to... well, we don't pay enough attention to it, we may not be aware of it enough" (interview, doctor from a PASS, Paris, 2012).

The physician in this quote talks about the awareness that led her to improve the care of patients who face difficulties accessing health care. This particular case involved a lack of access to the French Social Security public health coverage system. Her awareness is not easily obtained, however, because the medical training of physicians rarely includes learning about how the health insurance system works and even less about patients' criteria for eligibility. In the French case, the name of the main public insurance, Universal Health Coverage ("Couverture Maladie Universelle"), can be misleading and lead one to believe that in France every person is entitled to benefit from this form of protection healthcare. Similarly, being insured is mandatory by law in Germany. The right to access health protection is in fact enshrined in many international and European legal instruments [21]. However, in France, Germany and the vast majority of European countries, there are groups within the population that are excluded from health insurance systems or have difficulties in accessing them, such as certain groups among the precarized migrants [13,21–23].

The structural exclusion of precarized migrants lies mainly in the strengthening of migration policies in the Global North over the last several decades, which has been achieved in two ways. One way has been a reduction and precarization of the residency permits issued, which has resulted in an increase in the number of undocumented migrants and migrants with precarious immigration status (asylum seekers, Duldung, poor European nationals, temporary residence permits, etc.). The second involves restrictive migration policies which have permeated all areas of the welfare state. In order to create a hostile environment [24] for illegalized migrants [25] or those whose residency status has been precarized, legislators have implemented restrictions on access to social and health rights in most European countries. Thus, access to public health protection systems has often been prohibited or restricted for these categories of migrants. This is the case in France and Germany, where undocumented migrants cannot be covered by public insurance systems [22,23]. The lack of awareness of these exclusion mechanisms by health professionals often leads to inadequate care in different ways and at various stages.

3.2. Emergency Care and Structural Competency

In France and Germany, hospital emergency departments are often a preferred gateway to the health care system for patients without health insurance and who have no choice but to go to them. Historically open to all patients in need, these departments have however undergone specialization [26] and are increasingly subjected to strong budgetary constraints, similarly to other departments in hospitals. This evolution has gradually distanced this service and its staff from the care of the most excluded populations. The most marginalized patients face different reactions from hospital staff. In instances where the medical request could be handled by the primary care system and the patient does not have health insurance, the hospital staff may refer the patient to the former without checking that the patient has access to it. This situation is especially prevalent in Germany [27].

Even in cases in which patients are cared for, they may receive less attention from health care professionals because they hold less mobilizing worth [26,28]. The socialization of hospital doctors in general and emergency physicians in particular encourages them to value the "interesting cases" (those that are technically challenging or whose diagnosis is complicated to make) and to devalue ordinary cases [26,28]. This differentiation in the mobilizing worth is a symptom of the institution towards specialization and technicalization of care. As the most outward-looking care setting, emergency departments are often the only gateway to the health system for excluded patients experiencing structural discrimination. Reminding personnel of the mission of emergency department accessibility could help avoid these harmful practices. Through the knowledge acquisition regarding

the structural and historical mechanisms that lead to inequalities in access to care, as well as to the exclusion of certain groups from care, health professionals can act at the local level. They can, for instance, imagine "structural intervention," which places access to care for affected patient groups back at the center of the practices of their emergency department or their hospital.

Hospitals' evolution towards a neoliberal approach to efficiency and budgetary savings is increasingly central to the organization of care. This emerging attitude tends to accentuate the phenomena of the exclusion of groups of precarious foreigners, even in emergency departments. These patients, for whom there is no health insurance coverage and who generally do not have the means to pay out of pocket for the care they require, pose a problem for hospitals, which are under increasing budgetary pressure. The episode reported below from my fieldwork at the Medibüro in Berlin illustrates possible abuses arising from cost concerns in hospital emergency departments.

> The other day, Ms. B called me to ask for help because of severe pain in her genital area. Ms. B lives illegally in Berlin and has no health insurance. I met her during my activity in the Medibüro. On the phone she told me that she had had the pain for over a week. She only called me when the pain became unbearable and she was seriously worried about her health. I recommended that she go to the nearest hospital emergency room and tell the health care staff that it was an emergency treatment. An hour later, very distressed, she called me again and said to me that she was not allowed to see a doctor unless she paid 300 euros first, money that she did not have. I recommended that she go to another hospital that cooperates with the Medibüro and where I knew that patients without health insurance were not turned away. An hour later, I received a message from Ms. B saying that she was about to undergo an emergency operation because of blood poisoning.

Several hundred thousand people in Germany live without proper residency status [29] and are excluded *de facto* from the health care system. One reason for this is that since the 1990s, state institutions of the health care system have helped implement a repressive migration policy. Institutions become active players in migration policy by excluding certain migrant groups (e.g., undocumented migrants) from statutory health protection and restricting or impeding access to health care for other groups (e.g., asylum seekers, EU citizens). This phenomenon has consequently afforded them inferior health protection in the health care system.

The limited right to health care for illegalized persons enacted in the Residence Act (AufenthG) [30] is further undermined, or made impossible *de facto*, by the so-called "Übermittlungsparagraph" (often referred to more simply as the "denunciation paragraph"). According to §87 of this law, public bodies are required to transmit the personal data of illegalized persons to the immigration authorities. As a result, these persons are threatened with deportation. Social welfare offices are obliged to report undocumented migrants that apply for health benefits. However, out of fear of deportation, these migrants renounce the health protections to which they are actually entitled.

Only in case of emergency, when the life of the illegalized person is threatened, is it possible to receive treatment directly in the hospital. In this particular case, data transmission to immigration departments is prohibited, as hospitals are bound by medical confidentiality. The so-called "verlängerte Geheimschutz" (extended confidentiality) also applies in social administration. However, migrants in emergency medical situations often do not know what is meant by an "emergency medical treatment" and thus avoid going to the emergency room, even in life-threatening situations. Furthermore, social welfare offices regularly refuse to make payments to hospitals, which is why hospital managers try to keep the cost of treatment as low as possible.

Even in the case of an emergency, medical care for undocumented people is not guaranteed. As one learns from Ms. B's story, many hospitals demand money (usually an amount between EUR 100 and 300) from patients without health insurance in order to even see a doctor. This practice is against the law, as the bill for people without health insurance and people in need is supposed to be paid by the German social welfare office (*Sozialamt*)

in case of a medical emergency. However, because the bureaucratic barrier is high and the *Sozialämter* reject many applications for emergency assistance, the hospital administrations attempt to pass on the costs to the patients. This all-too-common situation arises from a general austerity policy that affects all public agencies, as well as from the political refusal to allow social services to find practical solutions for emergency care repayment for illegalized people.

The contemporary treatment of undocumented migrants in German hospital emergency rooms demonstrates the exclusionary effects of the structural and institutional racism to which precarized migrants are subjected. To counteract these inequalities, the laws that govern the institutional structures of health care need to be modified. However, as Hatzenbuehler and Link say, structures are not unidirectional and static. "Social structures actively shape individual- and group-level processes; at the same time, however, structures are themselves molded and altered by individual and interpersonal factors" [16]. In this sense, the exclusions from care documented in this article were also made by the hospital professionals. Additionally, while there are laws that exclude precarized migrants from German emergency rooms, other laws that are inclusive toward such migrants are not enforced. The interviews and observations conducted with Medibüro activists have shown that awareness-raising work among health professionals in hospitals has made it possible to prioritize access to care over budgetary concerns. By informing people of their right to access health care and by explaining the barriers (e.g., financial) that prevent them from accessing it, one hospital in Berlin was able to significantly improve access to emergency care for illegal migrants.

3.3. Structural and Administrative Competency Developed in Organizations Specialized in Access to Care

The work of specialized civil society groups, implemented in the countries of the Global North since the 1980s, has often been fundamental to reducing the structural and legal discrimination faced by precarized migrants in the field of health care. To this end, health professionals and activists organized in NGOs have developed structural intervention skills [15], such as lobbying and advocacy. Through various approaches to interventions, these organizations have shown the ability to change laws and regulations that structurally undermine access to health care for precarized migrants. In France, for example, Médecins du Monde (Doctor of the World, DOTW) and other associations have succeeded in developing specific standards and practices for the care of people excluded from healthcare systems. These standards, first developed in the humanitarian field during the 1980s, were transferred to public hospitals in the 1990s; the institutionalization of the PASS in 1998 marked the success of this transfer of standards of care for vulnerable groups [31].

Another example can be found in the United Kingdom. Thanks to a campaign ("Stop sharing") that combined advocacy and practical measures, DOTW succeeded in May 2018, in abandoning an exclusionary agreement, between the National Health Service (NHS) and immigration authorities. This agreement, decided in January 2017, allowed the immigration authorities to access non-clinical patient information [32].

NGOs in Germany have also broken down these barriers. A collective of more than 80 organizations launched a campaign in 2020 called "GleichBeHandeln" (Treat Equally Now), attempted to exempt healthcare facilities from the "denunciation paragraph" (§87, AufenthG). This campaign, which also involved advocacy, a petition (which to date has gathered more than 26,000 signatures, [33]), and lobbying work, resulted in the inclusion of the draft law amendment in the contract of the new governing coalition in the Bundestag [34] (p. 139). These initiatives are good examples of how competency can be built within a logic of structural intervention, i.e., with the aim of acting directly on the institutional structures that generate social inequalities in health. Although the examples cited here concern groups that have formed in the associative and humanitarian field, it is quite possible for health professionals to organize and fight against these structural problems

at different corporatist levels (local or national). The action of the organizations of PASS professionals who seek to defend access to care for people excluded from the French health system provides a salient example of such resistance in action [31].

The competency developed in organizations specializing in access to care for precarized migrants is visible not only in structural interventions, but also in practical actions. In the above examples, the humanitarian and public organizations developed several care practices that take into account the interactions between structures and cultures that constitute barriers to health care. Firstly, these organizations made it possible for these migrants to access health care by offering free, anonymous, walk-in services specifically directed towards them. Secondly, these organizations contributed to the fight against health inequalities by providing both medical and social care, taking into account the medical, social, legal, cultural and environmental aspects of patients' lives that influence their health. They developed an approach of health that extends their clinical gaze [6] and takes into account these aspects in order to optimize care. For example, the Clearingstelle in Berlin offers legal aid, because they know that the main factor preventing precarized migrants from accessing healthcare is their precarious residency status. The development of collaborative ways of working between health administrations, hospitals, translation services, and associations, also allow them to act on intertwined aspects of the patients' lives. By doing so, health professionals go beyond a narrow framework of medical care, and reach a broader yet more decisive approach to healthcare. Finally, networks with doctors and health professionals adopting a stance of cultural humility and structural competency improve (or simply make possible) treatment for these groups.

The complexity of systems of aid available for these groups represents another challenging bureaucratic maze. In order to meet the standards of treaties on fundamental rights, realize public health missions, or respond to pressure from NGOs, Western European countries have devised systems allowing access to reduced care for groups of people that have been excluded from health protection upstream. This access may only cover certain categories (those identified as vulnerable, for example) or specific cases (for urgent care or infectious diseases, for example). The result is a patchwork of reduced and targeted protections often complicated to navigate. Access to rights for precarized migrants has become so complex that it requires specialized knowledge of the bureaucracy. The administrative and practical knowledge of the bureaucracy is consequently highly valuable; Consider following excerpt from the field notebook:

> *A patient and her companion arrive at the office of Medibüro, a Berlin association that helps undocumented migrants access health care. Neither of them speaks German, and the conversation is conducted in broken English. The patient is seven and a half months pregnant and has no health insurance. Being in an irregular situation, the patient is afraid of being deported if she goes to the hospital or the social welfare services. She asks what she can do and worries she will have to give birth at home. The volunteer from Medibüro explains to her that the city of Berlin has set up a fund so that pregnant women in an irregular situation can give birth without the risk of being deported or having to pay a bill. To benefit from this fund, the patient must go to a center for reproductive and sexual health in the city of Berlin and meet with a social worker. The social worker will take over the care of the patient and organize the administrative procedures to release the funds necessary for the birth organization. The volunteer advises her to go to a particular center with which Medibüro cooperates and where it is sure that the employees are used to working with undocumented migrants and know the procedures to follow in this specific case. After making the appointment for her and before letting her go, he advises her to contact him if she encounters any problems in the further course of treatment. Field notes, Berlin, June 2020.*

The above example reveals how informants are essential for navigating the intricacies of medical assistance systems that protect those at the bottom of a highly stratified health system. Practical knowledge of private and associative support systems may complete these administrative and institutional knowledge.

To counteract hostile policies towards precarized migrants at the local level, NGOs and public organizations have built networks and systems parallel to the main health system. These parallel systems allow individuals excluded from the classic health services to access care. These systems are located in the public sector, private sector, and voluntary and non-profit sectors. Local public programs target particularly vulnerable populations. The fund for pregnant women in Berlin mentioned in the field note above is an example. Other examples include the Clearingstelle set up by municipalities or local governments in Germany, which allows people without health insurance to access care. In the non-profit sector, programs target specific populations (such as the Roma missions of DOTW, for example, or associations helping drug addicts). Networks of militant doctors have also been formed locally, such as the Medibüro in Berlin. In the private sector, healthcare services for precarized migrants can range from one-off charity actions (for donating hearing aids or glasses) launched by large private companies to the action of committed doctors who discreetly receive the patients concerned in their consultation.

During my observations with the social worker of the PASS in a Parisian hospital, I was astonished by the complexity and diversity of aid reserved for migrant patients with precarious residence statuses. In order to determine the possibilities of care, the social worker methodically asked for information concerning the immigration status of the patients. Depending on both a migrant-patient's administrative category and medical request, specific administrative procedures can be carried out (Aide médicale d'État, activation of the fund for urgent and vital care, Universal Health Coverage, etc.). To be effective in her work and best help the patients who come to her, the PASS social worker explained that she needed to keep herself regularly informed, mainly due to the frequent changes in administrative procedures. The social worker periodically consulted a specific association's website that monitors the literature on this subject. She also regularly called colleagues who work in other PASS and with whom she shares practical information on possible support.

All these systems and programs that allow access to health care for precarized migrants constitute an intimidating labyrinth that requires a significant amount of knowledge, both legislative, administrative, and practical, to find one's way through. Identifying these resource persons and distributing flyers containing information on the health care services available to precarized migrants would undoubtedly improve access to healthcare services.

4. Moral Judgement in the Assistance and Humanitarian Systems: Working on Health-Related Deservingness

As shown in this article, the medical care provided by voluntary structures always remains incomplete and precarious. As precarized migrants are (practically) not entitled to healthcare protection, the healthcare they receive often takes the form of a favor. In fact, structural exclusion turns people entitled to healthcare into supplicants who are obliged to be grateful for the provided help. Conscious or unconscious ignorance of conditions and causes of exclusion leads healthcare professionals to categorize precarized migrants as less legitimate to receive healthcare as the usual patients they see. Many works on migrant health have shown how the health-related deservingness of precarized migrants tend to be denied or diminished by healthcare professionals [35–39]. This concept "highlights the ways in which assumptions about whose health deserves attention and care influence every aspect of healthcare provision. Groups with considerable health needs—including migrants, asylum seekers and refugees—may be treated as though they are less deserving than other patients, with significant consequences for morbidity and mortality" [35] (p. 2).

Several authors have outlined the production of social norms and identities via the categorization of poor populations by state agents, mainly in places that provide assistance to poor populations [40,41] and in administrations dealing with migrants [42,43]. These authors have shown how state agents transpose and translate the administrative categories during face-to-face interactions into social identities that they impose onto users. These mechanisms are rooted in a more general movement of individual accountability in the organization of welfare provision in an "active social state." The criteria for granting

benefits have been transformed, being less and less linked to entitlements (generated by a status or the payment of contributions). They are instead increasingly subject to the judgement of those who provide assistance. This shift is especially true for aid and benefits aimed at the poorest populations [40], but it is also true for humanitarian associations offering direct assistance to persons in need.

The French PASS or the German Clearingstellen are particularly interesting in that they are archetypes of structures described as "assistance-charity." Patients can only benefit of one-off assistance under certain conditions. A healthcare voucher specifies that the patient is being cared for within the framework of the PASS or the Clearingstelle for a limited period. The "assistant-charity" thus creates a context in which the patient is put in a position of inferiority in the healthcare system. His health-related deservingness is not guaranteed at the beginning of the process. On the contrary, professionals have to determine the deservingness during interactions and are incited to classify patients into "good" and "bad", thus attributing them a degree of merit. The issue of deservingness. Consider the following field notebook excerpt, which powerfully demonstrates how the stigmas related to social, racial, economic, and residency status produced at the structural level spill over into interactions between professionals and patients.

> *A woman arrives in the social worker's office at the PASS of hospital X in the Paris suburbs. She asks for information about her sister, who came from Algeria a few days ago. She wants to know how her sister can get medical care when she does not have social security. The social worker replies rather abruptly and in a stern tone that this is not possible, that she needs proof of three months' presence on French territory (a condition for initiating the procedures for the State Medical Aid (AME)—the health coverage for undocumented migrants). The social worker did not explain the PASS system to this person and the possibility of obtaining free care, which was equivalent to excluding her from the system. This may seem surprising because the sister's profile corresponds, at first glance, to that of a PASS patient: she has no health coverage and no access to the health system. When the woman leaves, the social worker explains to me in an annoyed tone that this is a typical case of "medical tourism", that the sister has only come to France to benefit from the health system for free and that the PASS is not made for that. Field note, PASS, hospital X 2014.*

This situation clearly represents a professional in a public health institution categorizing a patient. Categories contribute to the development of a hierarchical and standardized social order in the field of healthcare (and by extension, in society).

During the observations carried out in the framework of my different research projects, I have found that the "good patient" is often one that professionals identify as a suffering migrant. This categorization is reminiscent of what researchers who have worked on other public structures interacting with migrants have identified as humanitarian logic [44,45]. The organization of the public or humanitarian clinics rests on a system of favor and is based on principles of good social morality [40] and social justice [46] in which compassion, recognition of the suffering body, and deservingness are central. Healthcare professionals recognize patients as passive victims who earn the right to be helped. These moral categories echo other structuring categories of the moral economy of migration, which exist throughout society (e.g., are the distinctions between "forced migration" and "labor migration," or between "refugees" and "migrants" [47]. A dual vision of the migrant underpins these moral criteria: there are good migrants and bad migrants. On the one hand, the suffering of refugees fleeing repressive political regimes is considered worthy of empathy. On the other hand, the suffering of economic migrants is afforded less value, and that of migrants who come because they have no access to health care in their home country is not valued at all.

When confronted with migrants whose administrative situation is precarious, professionals and volunteers adopt a position of judging the legitimacy of these patients to receive free care. In doing so, they develop moral categories (e.g., "good patient" and "bad patient") that regulate access to the health system. This manner of allocating aid leads

to inequality according to the patient's expressive and argumentative skills [38] and the professional's moral and ethical dispositions. Mastering the codes of assistance or knowing how to "put oneself on stage" may increase the chance of being integrated into the system. However, protecting one's privacy or claiming a supposed right to medical care may be excluded from the aid system. Similarly, patients are more likely to be treated by a doctor who considers access to care a universal right, than a doctor with a restrictive vision of assistance to the poor or who fights abuses of those "taking advantage of the system." This dynamic encourages placing responsibility on the individual rather than questioning the social structures and conditions that led to this situation. Huschke [36] also showed that the humanitarian context performatively produces specific behavioral expectations: undocumented persons tend to show themselves to be submissive and grateful, while healthcare practitioners in turn implicitly expects patients to exhibit this behavior. Migrant-patients affected by disenfranchisement and discrimination are pushed into the role of passive help-seekers. The encounter between medical professionals and patients is where the internalization of the assigned positions in the healthcare system and, more broadly, in society occurs.

Rationalizing the social structures and conditions imposed upon the social interactions between precarized migrants and professionals could, in part, reduce the effects of moral categorizations. Considering how the structure influences the process of categorizing precarized migrants could improve the cultural humility of health care professionals. Through the cultural humility approach, healthcare professionals can practice individual self-critique and self-reflection to redress the power imbalance in the physician–patient relationship.

5. Conclusions

The numerous social science studies on themes involving access to care and rights, racism and structural discrimination, the organization of the hospital and the health system, public policies, etc., offer fruitful lessons about the production of health inequalities. Until now, however, medical-student teaching has mainly focused on acquiring cross-cultural competency and cultural awareness. While the positive impact of this teaching should not be underestimated, it is incomplete because it overlooks how the structures of society and institutions produce stigmas and inequalities (particularly in access to rights and care).

This article shows the effects of structures on care relationships for precarized groups of migrants and brings together some examples of good practices observed in the field. From the analysis presented above, we can draw several conclusions. Firstly, acquiring basic knowledge of the public health system, such as the criteria for access to the main health protections and which groups are not entitled to them, would make identifying patients for whom standardized care is not possible easier. The acquisition of basic knowledge would require opening up medical work and developing multi-professional practices in collaboration with social workers, translators, and humanitarian or community associations. Health professionals ultimately need to increase awareness that good health care depends on factors beyond medicine. These factors can be addressed with the help of other professionals upstream or downstream of care. A simple referral to hospital social services or NGOs could be helpful. Given the complexity and bureaucratic illegibility of the aid systems, the use of informants seems to be the best solution at present.

Secondly, the values historically constructed by the medical profession and recalled in international treaties of unconditional access to primary care, regardless of residence status or whether the patient has health insurance, need to be put back at the center of medical practice and on the public health agenda. Actions by professionals and local structures can make it possible to mitigate the excluding and discriminating effects. The use of professional organizations, trade unions, or NGOs in lobbying and advocacy work has proven to be effective on many occasions.

Finally, medical professionals need to be aware of the moral categorizations during interactions with patients, especially those who experience structural discrimination because of their social, economic, residency, ethnic, or gender identity status. These categorizations

lead to the relativization of the health-related deservingness of these patients and even sometimes to their exclusion from care. By maintaining an awareness of these mechanisms, health professionals would be able to question them during interactions with patients.

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