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“I was trying to speak to them to their human side”
Coping responses of undocumented migrants to barriers in healthcare access in urban settings in Belgium

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Purpose: Undocumented migrants experience major legal constraints in their healthcare access. Little is known on how undocumented migrants cope with these limitations in healthcare access as individuals. In this study we explore the coping responses of undocumented migrants when they experience limited healthcare access in face-to-face encounters with healthcare providers.

Methodology: We conducted multisite ethnographic observations and twenty-five semi-structured in-depth interviews with undocumented migrants in Belgium. We combined the “candidacy model” of healthcare access with models from coping literature on racism as a framework. The candidacy model allowed us to understand access to healthcare as a dynamic and interactive negotiation process between healthcare workers and undocumented migrants, to understand their different coping responses.

Findings: Responses to impaired healthcare access can be divided into 4 main strategies: (1) individuals can react with a self-protective response withdrawing from seeking further care, (2) they can get around the obstacle, (3) they can influence the healthcare worker involved by deploying discursive or performative skills, or (4) they can seek to confront the source of the obstacle.

Implications: These findings point to the importance of care relations, social networks, as well as discursive and performative skills of undocumented migrants when negotiating barriers in access to healthcare.

Value: This study refines the candidacy model by highlighting how individuals respond on a micro-level to shifts towards exclusionary health policies and, by doing so dynamically, change provision of healthcare services.
Introduction

“The people told me: ‘No, wait till Monday, till you have a medical card.’ I needed urgent care. It was a Saturday. I couldn’t breathe...”

In this quote, Ahmed describes how he arrived at the emergency department in a hospital in Brussels and was refused further help because, as an undocumented migrant, he didn’t meet the administrative requirements. This article aims to investigate how undocumented migrants cope with such obstacles in access to healthcare. In recent years, this topic has gained considerable attention in public health research in high-income countries (Agudelo-Suarez, 2012; Suess, 2014; Woodward, 2014). Research in this field distinguishes and analyses the different factors, determinants and barriers operating at the individual, institutional and political level that affect the utilisation and accessibility of healthcare services of undocumented migrants. Some barriers are common to migrant communities and low-income communities in general (Fleishman, 2015; Gil-Gonzales, 2015), such as linguistic and cultural barriers and lack of social/financial capital to obtain services. Others result directly from their undocumented status. On a structural-political level, undocumented migrants often experience legal restrictions to the public health insurance net (Martinez, 2012). Within the health system they are confronted with institutional organizational complexity, discriminatory practices of healthcare workers and administrative burdens; and on an individual level they experience barriers when seeking healthcare, due to fear of deportation, shame about not wanting to be a burden, as well as concerns about being stigmatized and discrimination (Hacker, 2015). However, knowledge of the impact of these issues on health outcomes and health inequalities remains limited (Magalhaes, 2010; Martinez, 2012).

Although public health research provides us with important insights into the difficulties associated with limitations in healthcare access for undocumented migrants, such an approach has also been criticized. Firstly, this public health approach implicitly presupposes a kind of ‘unmarked’ patient and relies on a set of poorly substantiated normative ideas about what is a pre-set, fixed, adequate level of healthcare utilisation (Dixon-Woods, 2006). Next, identifying different barriers to healthcare doesn’t provide information on the relative significance of the identified factors, as well as nor on how these factors intersect (Mackenzie, 2013). Further, migration researchers have been calling for more research on the coping strategies of migrant groups rather than a problem-based approach (Campbell, 2008; Magalhaes, 2010). This problem-based approach seems to ignore the agency of undocumented migrants in challenging these barriers. It thus implicitly portraying them as passive and powerless (Magalhaes, 2010; Squire, 2017). This last argument is also the reason why migration researchers have been calling for more research on the coping strategies of migrant groups rather than taking a problem-based approach (Campbell, 2008; Magalhaes, 2010). Although a systems perspective is a quintessential aspect to understanding the processes that shape care practices, it is equally important to take the impact of face-to-face interactions into account, as well as and the impact of resilience of individual undocumented migrants in these processes into account. (Campbell, 2008; Willen, 2012; Huschke, 2014).

An alternative conceptualization of healthcare access, that addresses some of these critiques on the existing literature on access to healthcare of so-called vulnerable groups, has been
offered by the notion of candidacy. Candidacy as a concept captures the idea that whether an individual is a candidate and/or eligible for care is socially constructed. It is the result of a dynamic interactive process, in which both patients and professionals continuously shape and reshape their understanding of who are appropriate ‘objects’ of medical attention (Dixon-Woods, 2005). The process of negotiating candidacy comprises 7 stages, including the identification of candidacy, the appearance at health services, the permeability of these services, the adjudications by professionals, the navigation through services, the resistance of offered services and the local availability/suitability of resources. These 7 elements offer a theoretical model of candidacy that helps to explain how patients and health services interact and how they may (or may not) receive (compromised) care. Specifically, this model also offers a framework to understanding how potential health services users assert candidacy by the way they position themselves and by the way they articulate and present their needs (Dixon-Woods, 2005; Mackenzie, 2013). By doing so, it also allows a better understanding of the role of greater insight in coping behaviour in the health-seeking journeys/trajectories of individuals in vulnerable circumstances.

Coping responses have been extensively studied in other fields, psychology, amongst others in studies on such as stigmatization, discrimination and racism studies (Brondolo et al, 2009), yet when it comes to health seeking behaviour coping responses to experiences of difficulties in access or rejection of care are under researched. In racism studies, individuals’ responses to racism are seen as part of an interactive dynamic process. In these studies, coping is conceptualized as the different types of responses of individuals dealing with an acute or chronic stress in interpersonal relations (Brondolo et al, 2009). This conceptualization implies a sense of choice between different strategies (Brondolo et al, 2009). In racism studies, individuals’ responses to racism are seen as part of an interactive dynamic process and individual-level responses to racism are usually divided into two broad domains: strategies confronting the source of the racism-stress and strategies avoiding dealing with the problem (Mellor, 2004; Stevens, 2015). However, it’s unclear from the existing literature whether responses to avoid or reduce the impact of perceived obstacles to healthcare services difficulties in healthcare access are restricted to the same options. The presence of illness or the authority of the care-taker might alter the range of available alternatives.

Recently Chase et al. (2017) were the first to use the candidacy model to study how asylum seekers experience their access to healthcare. This study shows that hostile public representations of migrants lead to depressed candidacy. Further, the authors suggest that the role of coping responses such as self-advocacy and recourse-seeking is limited in case of access difficulties, and that access difficulties impact negatively on how asylum seekers identify and assert their future eligibility/candidacy. Similarly, literature on deservingness draws out how “intangible” factors, such as an atmosphere of fear and “intangible” factors, climate of fear and suspicion (Larchanché, 2012), as well as circulating assumptions about undocumented migrants as “free-loaders” (Willen, 2012) contribute to a self-perception of undervingness. Yet, other studies describe how undocumented migrants present themselves as helpless sufferers (Huschke, 2014) or emphasize their symptoms (Kramer, 2015) to perform their deservingness. However, in general, the current research only offers a fragmentary idea of the possible coping strategies of individual undocumented migrants facing obstacles in healthcare access.

The aim of this paper is to refine the candidacy model, by incorporating insights about coping responses. Therefore, we study the different coping responses (both in terms of emotional and behavioural responses) of undocumented migrants in Belgium when they are confronted with
problems to access healthcare. Belgium’s law on ‘Urgent Medical Aid’ provides a legal framework about whom should account for medical services provided to undocumented migrants. Undocumented migrants are entitled to a ‘medical card’ after going through a complex administrative procedure. With this medical card undocumented migrants can access mainstream public healthcare services for 3 months. However, several reports show that this legislation is inadequately implemented in practice: compared to the Belgian population, both the utilization rate and the per capita expenditure are far lower (Chauvin, 2009; Roberfroid, 2015). This is attributed to barriers similar to those described in the international literature: the complexity of the administrative procedure, financial barriers and fear of arrest (Sannen, 2003; Chauvin, 2009). Biswas (2011) mentions the existence of informal strategies challenging these financial barriers through negotiations between undocumented migrants and healthcare workers. Taking experiences of access difficulties – such as Ahmed’s case – as a starting point, we study the coping responses of undocumented migrants in Belgium.

Both the candidacy model, and research on strategies for coping with racism serve as complementary frameworks to guide the interpretation of the data. Having an overview of the repertoire of available responses to actual barriers should allow a more informed reflection for us on the role of agency of undocumented migrants in challenging barriers during interactions with healthcare services in Belgium.

Study context, methodology and research questions

This paper is part of a wider project, researching how both healthcare workers and undocumented migrants face dilemmas regarding access to healthcare in Belgium. The first author performed focused multisite ethnographic observations and in-depth interviews with undocumented migrants living in urban areas in Belgium and with healthcare professionals working in humanitarian organizations and the public healthcare system between September 2016 and June 2018. In this paper, we mainly report findings from twenty-five in-depth interviews with undocumented migrants, supplemented with relevant data from ethnographic observations. The participants for the interviews were recruited in Brussels using snowball and purposive sampling. The first participants were recruited during ethnographic observations in a hospital, a community of undocumented migrants, and a reception centre that provided legal advice to undocumented migrants. When we recruited the participants, we strove for as much variety as possible in the sample in terms of region of origin, gender, length of stay, health care access and living conditions. Interviews were conducted with participants from Sub-Saharan Africa, North Africa, the Middle East, South Asia and South America. 11 participants were female, 14 were male. The average age of participants was 38.7 years, their length of stay in Belgium ranged between one and 14 years. All respondents had accessed or tried to access healthcare services at least twice. The living conditions of the respondents varied strongly: some had a relatively stable source of income and rented a flat, others lived in communities of squatters, still others were living on the streets.

During the interviews the respondents were asked to describe their experiences and relations with healthcare workers in Belgium. They were asked to describe a situation of conflict they had experienced when trying to access healthcare services, how they felt and how they responded to the particular situation. They were also asked to describe how they would react in a hypothetical case of refusal of healthcare. The data involved interactions with clinicians, but also with receptionists and social workers responsible for the allocation of the medical card. The interviews didn’t solely focus on care-episodes in acute life-threatening situations, but also on every-day situations where undocumented migrants seek healthcare for common medical ailments. We didn’t explore whether the care was refused for reasons that could be
legitimised or not, instead we focused on the response of undocumented migrants that perceived a need, sought care and were confronted with one or more obstacles.

Interviews were conducted in 4 different languages; one interview was done with a translator. Coding was carried out by the author. The data were coded in the language of the interview. The data were coded and analysed with NVIVO 11.0, a qualitative data analysis-program. Respondents sometimes mentioned more than one possible response in a particular situation, yet for the clarity of the analysis, we considered them as separate responses. We studied the responses of undocumented migrants who effectively faced actors in the healthcare system. We omitted data on auto-medication, informal care or social support by sharing stories with community members.

A very wide range of performative and emotional responses emerged from the data. Broad themes were initially derived deductively based on models from coping literature on racism and the candidacy model. During the coding, subthemes were generated inductively and added as the coding progressed. Along the coding process both the overarching themes and subthemes were continuously reworked until a satisfactory taxonomy of coping responses was reached. Relevant quotes were translated in English for this publication.

Findings

Respondents described a variety of obstacles in their access to healthcare, such as dismissive or discriminatory attitudes of healthcare professionals as well as delayed or inappropriate treatment, mainly due to administrative obstacles related to the medical card. Their responses varied and can be divided into 4 categories, according to the strategic function of the response.

The first theme groups responses of participants who do not confront the obstacles met, nor challenge the opposition by healthcare workers. Within these self-protective coping responses we can distinguish three sub-themes. Some undocumented migrants display resignation, some reinterpret the events, and some leave the situation while non-verbally showing some discontent. The second theme consists of responses that aim to circumvent the obstacles to get access to care. To detour the perceived obstacles, individuals can resort to information about differentiated permeability of health services, mobilize social networks or existing connections with health professionals. The third theme revolves around those responses trying to influence individual health care workers or negotiate institutional policies. Respondents describe discursive and performative tools to placate or shame healthcare workers, or to make them feel responsible. The fourth theme includes responses confronting the source of the ‘obstacle’. This could be done by external support seeking or intransigence, but can also lead to violence.

(1) Self-protective coping responses

Resignation

After being turned away at the emergency department when consulting with severe tooth pain, C2 stated:

“[The healthcare worker said:] ‘yeah, we can do nothing’ and stuff, I was like: ‘yeah, whatever.’ And I left. So I didn’t do a big deal out of it. Because I was there when
people were doing big conflict and screaming and... and trying to get more and... it never worked out.” (C2)

Undocumented migrants, accepting the denial of care and disengaging from further care-seeking, often hope the health problem will disappear spontaneously. Others minimized the initial need that triggered the help-seeking, stating “I actually don’t need their help” (C21), which can be interpreted as a kind of ‘passing behaviour’. Resignation to the refusal of care usually results in refraining from seeking healthcare for similar health problems.

Yet, three respondents also expressed that they have (definitely or over a period of several years) disengaged from all further care-seeking after a bad first encounter with healthcare services or after being confronted with recurrent experiences of refusal, as is illustrated by the following quote:

“[The social worker] asked a lot of questions, I answered, but they didn’t give me the medical card. She gave me another appointment, because the way she did, it discouraged me. You come and you expose your problem and your coordinates and everything; do they give you the card? No, they give you appointments, appointments, appointments, ... At a certain moment you drop it, you are fed up with it...”  (C16) (translated from French)

Only when the need is critical or extreme, e.g. “maybe, when I have collapsed in public” (C25), might they unwillingly get in a situation where they receive care. It is noteworthy that the response of (C16) also points to the role of affective interpretation of information, as opposed to its literal verbatim meaning.

The abovementioned quote of C2 illustrates the importance of conflict avoidance. Some respondents consider the risk in appealing as too high, or that there is no way or no reason to change the way they were treated. As C16 said: “You won’t even try, you will tell yourself: ‘I have no right.’” Another interviewee (C6) said that it was useless to confront obstacles, as he feels that healthcare workers are just executing the law. Further, several respondents also expressed a certain fatalism “God wanted it this way” (C9), or at least acceptance of an unknown future. Lastly, for some respondents, the need to get permission for every step in the care process is seen as intrusive. They voice a preference for self-control and self-sufficiency over “somebody [who] is getting into your life”, even if it comes at the price of ill-health, and disagree with representations of abuses and excessive needs.

Alternative interpretation

Some undocumented migrants attribute the refusal of care to the ignorance, the moral inferiority or the weakness of the healthcare provider. This can be done by referring to race, gender or the (perceived) lower level of professional training of the healthcare professional concerned (E.g. “It was just a trainee” – C5). Another way of reinterpreting the perceived obstacle is by stressing that the same situation happens to Belgian residents too, thus restoring a sense of equality.

Show your heels

An undocumented migrant who asked to see the ophthalmologist and noticed that the (native Belgian) patient in front of him was getting a much quicker appointment than him, reported:
“I noticed that we don’t have the same priorities as those who have legal documents. [...] I said: ‘just cancel it, in 8 months, it’s not worth it...’ And I left.” (C5) (translated from French)

The participant refused the offer made by the healthcare worker, because it is perceived as unsatisfactory and discriminatory. By doing so, the participant abandoned his request for care, yet, whilst forsaking, also performatively showing his discontent with the refusal. During ethnographic observations we observed several ways to show discontent. Some individuals hesitate and drag their feet when leaving, or, on the contrary, stomp off. Others leave without saying a word, or by mumbling or slurring some unintelligible words or phrases.

(2) Detouring coping responses

The majority of the responses in our sample were formed by detouring and dialogical (cf. infra) coping strategies. The longer our respondents had stayed in Belgium, the more likely they were to have developed detouring strategies to challenge obstacles in healthcare access.

**Trial and error**

One respondent described how he got around obstacles by deliberately avoiding those healthcare workers that look or are known to be obstructive. This is expressed by C21:

“Last time I went... I saw that social assistant, I know her, she mistreats people and everything. I had number 8 and when she called my number, I went to hide in the toilets. Then she called number 9... I saw someone with a smile and went there. ‘It’s already number 10.’ ‘Oh, I was at the toilets.’” (C21) (translated from French)

Further, respondents also mention consulting at different healthcare providers and organisations (public, private or charity), or at different levels (first or second line) or by presenting oneself in different ways (making an appointment, calling, turning up unannounced) to look for the path of least resistance to access health services, because “there is always a solution” (C19). In other words, knowledge about variations in permeability of healthcare provision allows the detouring of barriers to healthcare services.

**Navigator**

When confronted with difficulties accessing hospital, due to a large hospital bill, that was caused by not having a medical card before admission in emergencies, respondent (C5) mentions:

“There is an NGO. I have a volunteer there who follows my file since 2008. She understands me well; she knows my situation. [She] took care of the situation.” (C5) (translated from French)

When confronted with obstacles, undocumented migrants often mobilize “experience and other opinions from people you know” (C2). These navigators are family members, volunteers, or members of the same ethno-racial minority group, who are considered to be trustworthy, know the Belgian healthcare system and/or have better language skills. These local actors mobilise the practical, social, cultural or even financial resources to overcome
specific barriers to healthcare. One interviewee (C22) also mentioned using the medical card of a relative to avoid obstacles.

**Attach**

“So, [in case of illness] it’s always preferable to go see the social assistant and explain the problem to him, he gives the directives to follow.” (translated from French) (C9)

Many participants describe a close and committed relation with one particular healthcare professional who facilitates healthcare access. They anticipate or cope with failed attempts to access care by consulting a trusted key figure in the healthcare system, even with health problems that are not his/her expertise. They rely on his referrals and networking skills, to coordinate the care, perform administrative requirements or to bypass obstacles.

(3) Dialogical coping responses

Along with detouring coping responses, most participants use dialogical coping responses as a way to cope with difficulties in healthcare access. In case of financial barriers, they can negotiate the payment period or resort to out-of-pocket payments, even in situations where they believe the service should be covered. But respondents mention that they frequently use discursive and performative tools in response to situations of access difficulties.

**Placate**

“[when talking to a doctor] you have to be calm. You don’t have to become agitated, because otherwise, it doesn’t work [lowers her hand towards the floor whilst saying this...] I try to show him [the doctor] that I’m not a problem.” (C 11) (Translated from French)

In many interviews undocumented migrants mentioned the importance of specific attitudes to facilitate access to healthcare. Most often they mentioned the importance of performing a yielding attitude, showing humility, politeness, niceness, patience, gratitude or subjugation. Further, the abovementioned quote – specifically the notion of trying – also suggests that the participant consciously modifies her appearance to facilitate access. Similar to the findings of Huschke (2014), respondents mentioned that displaying a cooperative attitude and compliance with administrative procedures, even when they were deemed frustrating or useless, was seen as an important facilitator. During ethnographic observations, the role of humour (E.g. clownsing or performing like an artist) was also observed as a possible way to influence healthcare workers’ willingness to overcome administrative barriers.

The respondents also mentioned the use of certain arguments to soften the healthcare workers. Some stress their vulnerable position or poverty, e.g. “As an undocumented migrant you have all the problems” (C13). Others invoke personal moral ‘characteristics’ such as self-sufficiency and stress that they don’t want to free-ride. This is illustrated by the following quote of C5 who couldn’t pay for his care, but had mental health problems for more than two years:

“Because I don’t like to beg you ‘help me, please, help me please.’ I’m someone who manages on his own. But unfortunately, I happened to encounter this... this problem. I can’t handle it anymore.” (C5) (Translated from French)
Appeal to responsibility

One respondent (C13) mentioned the possibility to actively make healthcare workers feel more accountable. As he’s referring to staff from an ambulance-team that refused to take an undocumented friend from the same squat to the hospital, after finding out he had no legal residence status:

“You even have to threaten him. You have to say: ‘so, if something happens who is the responsible? [...] It’s an emergency, it’s not the moment to ask if the person has papers or not. He’s ill.’” (C13)

By asking the healthcare worker’s name the responsibility is individualized. As the same quote illustrates, respondents also frequently report the use of clinical or medical arguments to overcome administrative or other barriers. By focusing on the need, the pain or the emergency – and thus ‘medicalizing’ the situation the patients appeal to the core responsibility of healthcare workers and assert their legitimacy as a patient.

Questioning, blaming and shaming

Some respondents mentioned the use of more assertive dialogical coping strategies, as is illustrated by the following quote, of a woman who was refused care for a sick child:

“They were behind this huge glass and they were like: ‘[...] bla bla.’ And I was trying to speak to them to their human side, like ‘Don’t you have a fucking shame? Come on, you just see the girl with a huge cheek.’” (C2)

“Telling the truth” (C2) is mainly done in contexts of an acute crisis, where the needs are considered to be entirely obvious, or when abovementioned dialogical coping strategies have failed, and when the respondents have little hope left of still being ‘accepted’. This is often done by referring to the possible consequences of refusing a medical card, a consultation or a specific treatment, or by guilt-tripping and denouncing health professionals by making use of moral judgments, e.g. by characterizing a practice as “unacceptable” or an individual as “unfair” or “inhuman”. In our sample access problems are more often confronted in moral terms (blaming, shaming), than in legal ones (health rights, law). Depending on the situation this response sometimes leads to further escalation or was followed by a more defensive response.

(4) Confrontational coping responses

Most respondents didn’t mention confrontational coping responses as an option to counter barriers. Yet, five of the respondents recalled a situation where they expressed anger about difficult healthcare access and advocated for themselves in a more assertive way.

External support seeking

“If I don’t have a medical card and I have a need, I will ask to talk with a superior [of the healthcare worker] to tell him: My situation is... My health situation is... I need care.” (C6) (Translated from French)
Besides formal external support seeking, soliciting support from authority such as the superior of the healthcare worker or the police (Cf. infra), respondents also described more informal ways, e.g. involving bystanders (C9).

**Intransigence**

During one interview the respondent mentioned staying present, despite being refused access. After being denied healthcare access, she mentions that:

“because we didn’t find another solution, we decided to stay at the clinic and wait to see what would happen.”(C19) (translated from Spanish)

This was also observed on two occasions during ethnographic observations, both times without resulting in effective healthcare access. This persevered presence serves as an embodied non-verbal claim to medical attention.

**Violence**

Three respondents mention a situation of verbal or physical aggression, following discussion about access to healthcare. C14 was told on 4 consecutive days to come back the next day, during his application for a medical card:

“So that got me angry. So, the day that I met her I just say my feelings to her, and she also started making me... In way that is about to be in a fight [sic], even police came in. They come and separate the whole thing and I explained everything to the police and then the police tell her to renew the card for me.” (C14)

**Discussion**

(1) Candidacy and coping

These findings show that undocumented migrants respond in different ways to situations of impaired access to healthcare.

Firstly, respondents repeatedly reported disengaging from further care-seeking when confronted with difficulties in access to healthcare. They suppress or divert the desire to confront or challenge the refusal, similar to those responses to racism that suppress the expression of anger. Respondents express several possible motivations to accept denial of care. The large importance attributed to conflict-avoidance by our respondents is likely to be explained by the risk of arrest and deportation associated with the specific situation of undocumented migrants. This also weakens their position in formal procedures or in terms of options to appeal. Several respondents confirmed that abandoning care-seeking after experiencing obstacles depressed their future identification of candidacy. Yet, our findings show that self-protective coping responses sometimes go together with other coping mechanisms. Several respondents project inferior traits onto the obstructive healthcare professional. This reinterpretation allows the individual psychologically to invert the power balance and regain their self-esteem. Moreover ‘showing their heels’, whilst forsaking further care-seeking, also allows undocumented migrants to invoke feelings of guilt in the healthcare workers. Showing discontent, or not engaging with the suggested services, gives the implicit message to healthcare workers that the offer is inappropriate and that a better service is desired.
Secondly, an important finding of the study is the crucial role undocumented migrants attribute to detouring and dialogical responses to cope with obstacles in healthcare access. Detouring coping responses have an ambiguous impact on candidacy. The adjudication by health professionals is known to play an important role in shaping candidacy. Services offering easier access to improve conditions for identification of candidacy (Mackenzie, 2013). Yet, a well-known consequence of coping by detouring obstacles to healthcare services, is the overload of undocumented migrants in very accessible services, such as emergency-departments, humanitarian organizations, … (Roberfroid, 2015). Research also showed that it leads to a concentration of undocumented migrants in those clinics that have a more welcoming attitude (Goossens, 2011), which in turn can lead to secondary problems, such as an increased workload, increased selectivity, frustrations and burnout amongst healthcare workers and financial problems for the institutions where they work due to seeing high levels of economically disadvantaged patients. Previous research stresses that such adjudications by health professionals can inhibit candidacy of asylum seekers and individuals in deprived circumstances. They refer to gate-keeping mechanisms and the implicit social criteria used by health professionals (Dixon-Woods, 2005; Chase, 2017).

However, our participants valued the existence of a strong therapeutic relations in situations of difficult healthcare access as mostly positive. The responses of our interviewees seem to nuance some of the abovementioned concerns and show the importance of care relations to cope with difficulties in healthcare access. A possible explanation is that such relations make the healthcare worker more accountable for the effective provision of care, also by other healthcare workers, because the key healthcare worker takes up commitments beyond his formal duties to honour the relational history. Obviously, having to pass via a trusted key figure for every step in the care process potentially doubles the amount of consultations for healthcare workers and patients. However, it can also lead to a more attuned, holistic or patient-centred care, e.g. if these trusted key figures are general practitioners.

The importance of social networks has been described as a source of support in racism studies (Mellor, 2003, Brondolo, 2009), but its role in detouring obstacles in healthcare access has not been taken into account in the candidacy model.

Further, undocumented migrants use a wide range of performative and discursive coping responses, to re-assert candidacy and to plea for understanding their individual situation. In a setting of institutional barriers to health services, the willingness of individual healthcare providers to comply with institutional policies is crucial. Immediate interactions with healthcare workers, allow individuals to shape the attractiveness of the problem they present and to appeal to existing notions of health-related deservingness (Fassin, 2005). Yet, if dialogical coping responses become an important condition for undocumented migrants to access healthcare, this also favours those migrants with linguistic, social and cultural skills, thus reinforcing existing patterns of stratification in healthcare access. Further, the collective use of performative and discursive strategies to influence access to healthcare might have a contradictory effect on candidacy. Initially it might result in easier access for undocumented migrants, but, it also might lead to processes of increased competition and impact on clinical decision-making of health professionals. Suspicions of aggravation or simulation might affect the health professionals’ assessment of illnesses.

Lastly, some respondents mention the use of confrontational responses to cope with difficulties in healthcare access. Amongst others, the persevered bodily appearance can be used as a way to state candidacy. Although this approach apparently advances the situation in some individual cases, this group of responses seems to depresses candidacy, rather than
increasing it. It can also contribute to a progressive securitization of healthcare facilities, thus reducing and impeding direct interactions between healthcare workers and patients.

Most interviewees had tried out more than one response since their stay in Belgium. Respondents also often compared their experiences with practices in their country of origin. Coping responses are obviously shaped by one’s personality, one’s medical situation and needs, and the way healthcare workers denied care. Responses were shaped by their effectiveness in previous experiences and by changes in the perceptions of the available options. This is similar to findings on coping responses in racism studies. Moreover, developing coping responses is the result of a dynamic and diachronic process. The effectiveness of such responses varies depending on the context (Brondolo et al., 2009).

Racism studies show that the choice between different coping responses is influenced by variations in the intensity and nature of the injustice, the perceived degree of intentionality of the harm, the potential consequences of both the maltreatment and the coping response. The choice is also shaped by the appraisal of one’s ability to respond in a particular way (Richeson et al., 2007; Brondolo et al., 2009). Similarly, it is likely that the coping responses of our participants were shaped by their developing responses to a dynamic and diachronic process. Respondents often compared their experiences with practices in their country of origin. Most interviewees had also tried out more than one response since their stay in Belgium. Responses were shaped by their effectiveness in previous experiences and by changes in the perceptions of the available options, personal characteristics, their medical situation and needs, and the way healthcare workers denied them care.

Our methodology didn’t allow us to establish which factors determine the coping strategies chosen in specific situations. Nevertheless, our analysis showed some interesting associations that offer hypotheses for future research.

The longer our respondents had stayed in Belgium, the more likely they had developed detouring or dialogical coping responses to challenge obstacles. Responses also seemed to depend on the professional role of the healthcare worker. Confrontational responses, responses circumventing obstacles and responses of questioning, blaming and shaming seemed more prevalent towards receptionists, administrators and social workers from public welfare institutions. Responses towards refusing clinicians seemed to be more focused on placating and appealing to responsibility. Similar to findings from racism studies (Johnson, 2016) the legitimacy and authority of the health professional seems to play a role in shaping the response in case of rejection. Further, in our sample, differences in response styles were associated with gender differences. Male respondents were more prone to a self-protective or confrontational response style, whereas female respondents mentioned the dialogical and relational coping mechanisms more often in their responses.

(2) Candidacy – further refining?

This application of the candidacy model allows us to suggest some refining of the model. The candidacy model tends to view the interaction between the healthcare worker and the patient as a dyadic matter between two individuals. Mackenzie (2013) pointed to the need to study more explicitly how candidacy can be depressed organizationally and politically in health services. Our findings – and specifically the coping responses by non-professional navigators and external social support – suggest that research into how candidacy is influenced by the relational and social networks of the patients is also necessary.
Our overview of coping responses also gives more insight in the ways and stages by which patients can shape candidacy. Self-protective reactions in response to unsuccessfully asserting candidacy depresses the identification of future candidacy. Dialogical and confrontational coping responses mainly seem relevant when asserting candidacy. Detouring coping responses seem to impact different elements of candidacy: they are relevant to understanding the navigation of services, the permeability of services, the adjudication by professionals and the local production of candidacy.

Studying the coping responses also shows how the different elements of candidacy are sometimes interconnected ambiguously on a micro-level. For instance, detouring coping responses, by adjudication, interact ambiguously with permeability of services. The initial increase of candidacy, associated with this coping response, can lead to increased selectivity, thus depressing candidacy in the longer term. Similarly, the collective use of dialogical coping responses to influence access to healthcare might have a contradictory effect. When employed repeatedly and by a multitude of patients, they can lead to more suspicious reactions amongst healthcare workers and thus depress candidacy.

(3) Coping responses, or agency?

Dixon-Woods (2005) suggested that both patients and providers have some degree of agency in negotiating access to healthcare. On the other hand, Chase (2017) suggested that precarious status migrants have little agency in negotiating access to healthcare due to the power differentials between the patient and the professional. These opposing views resonate with ongoing theoretical discussions in the structure-agency debate, including different understandings of agency. As noted in the introduction, the conceptualization of coping responses in racism studies, implies a deliberative choice between different strategies. Some respondents refrain from further action in response to difficulties in healthcare access. However, our interviews illustrate that many undocumented migrants do take action when confronted with obstacles to health services. This raises sensitive questions about agency. Dixon-Woods (2005) suggests that both patients and providers have some degree of agency in negotiating access to healthcare. On the other hand, Chase (2017) suggested that precarious status migrants have little agency in negotiating access to healthcare due to the power differentials between the patient and the professional. In this regard, the described coping responses could be understood as a form of agency, i.e. a capacity to act intentionally and strategically when dealing with barriers to healthcare. Agency is a capacity-concept. It expresses the capacity for self-reflective decision making and action (Hutchings, 2013). However, assuming individuals’ agency can also be normatively problematic as one’s actual possibilities to act are also constrained by structural or contextual factors (Squire, 2017).

The relevance role of dialogical and relational aspects in understanding and transforming existing practices of healthcare access of undocumented migrants has so far largely been ignored. A possible explanation could be that approaching these coping responses as a conscious action or carefully considered process unwantedly might affirm assumptions about undocumented migrants illegitimately performing illness and ‘patient likeability’ to mislead gullible or naive healthcare workers, and to instrumentalize or even misabuse care relations. The way committed care relations allow circumventing institutional limitations in healthcare access has also been critiqued as arbitrariness, clientelism, or activism of the healthcare workers (Author, 2019). The positionality of undocumented migrants and the
potentially unruly character of care relations interact with attempts to regulate their access to healthcare legally or administratively. Presenting undocumented migrants and/or healthcare workers as intentional and strategic actors easily slips into a wider struggle to legitimize or delegitimize (health) rights of undocumented migrants.

One view will claim that actions and responses of individuals are produced by group membership to a non-voluntary social group (Mackenzie, 2018) and through operations of power and socio-economic circumstances. In this view, performative responses of undocumented migrants can be understood as unconscious responses shaped by internalized representations. Engaging in committed relations is interpreted as a matter of survival in a hostile environment and is inextricably linked with notions of dependence or victimhood. In this light coping responses, are considered as the result of adaptive preference and behaviour formation – the phenomenon that patients who are deprived from care unconsciously adapt their behaviour to the circumstances and refrain from preferences that can’t be met (Veltman, 2014).

However, these accounts ignore the deliberative capacities of individual undocumented migrants. A second view will consider the coping responses of undocumented migrants to be a form of agency. The use of different relational and dialogical coping responses can be seen as a form of non-violent resistance and resilience of people who stand up for themselves to resist harmful and unjust policies. It can be considered an intentional response of people taking a conscious decision to bend certain laws to serve higher objectives such as health (Willen, 2012). However, this account may also reproduces assumptions that undocumented migrants take decisions to migrate more or less free from constraints (Squire, 2017). It also forgoes that illness impacts on one’s abilities to adapt to constraints.

Yet, this agency dilemma (Khader, 2011), notably the question of whether coping responses are some kind of agency or not, might not be that as relevant as it seems. Recently several feminist scholars have pointed to the unproductive nature of such debates. Both attributing agency and not doing so can be politically and normatively problematic (Squire, 2017). By equalizing agency with resistance, we focus on the ‘doer’, and not on the actual act and its effects (Mahmood, 2006; Hutchings, 2013) Undocumented migrants making coping responses are not necessarily to be seen as “exemplary political subjects” nor as “passive victims” (Squire, 2017). The coping responses are situated in immediacy and don’t aim to change a policy at a future date. Nevertheless, the collectivity of these actions can have transformative effects, even if these actions are not identical to the academic definition of collective agency. As Squire (2017) argues, undocumented migrants may act in strategic ways, but these acts are not necessarily predefined as such. The daily negotiations between undocumented migrants and health professionals about the needs that qualify for care may have a transformative effect on candidacy and health service delivery, albeit often in unintended ways. Therefore, we should not simply focus on conscious strategic action, but mainly on its effect, more precisely on how these coping responses reproduce or transform existing practices of healthcare access and candidacy.

Limitations and implications of the study

Since all participants had accessed or tried to access healthcare services at least twice, the sample was subject to a selection bias. Yet, to strive for as much variety as possible during the recruitment process, we recruited undocumented migrants through different channels and
from different subgroups in terms of healthcare utilization, ethnic background and living conditions.

The candidacy model provides a useful conceptual framework to study how healthcare access is negotiated within a social interaction. So far, operationalizations of the model have criticized it for overlooking the embeddedness of micro-level interactions in organizational and political contexts. These critiques focused on the power differentials between individuals and service providers and considered the interactions not as ‘true negotiations’ (Mackenzie, 2013; Chase, 2017). However, in doing so, they abandon the strength of this model, notably providing a tool to analyse how individuals respond to shifts towards more restrictive health policies and, by dynamically doing so, change provision of healthcare services and potentially shape future policy changes. Our findings show the importance of paying greater attention to how candidacy is influenced by relational and informal social networks, as well as by discursive and performative coping responses of the patients. This does not detract from the need to research the impact of structural constraints to healthcare access, but is rather complementary to it.

More research is needed to understand whether different coping responses lead to different health outcomes. In racism studies, self-protective coping mechanisms are associated with poorer mental health outcomes (Mellor, 2004). Gaining greater insight into the association between specific coping responses and aspects of social identity beyond migration status, such as race, gender and level of education also seems important. Lastly, given the interactional nature of candidacy construction, studying the perceptions of healthcare providers of the coping behaviour of undocumented migrants is important.
References


Endnotes

1 All real names have been replaced by pseudonyms or codes (C) for reasons of privacy.
2 In this study undocumented migrant refers to anyone who stays in Belgium without a valid residence permit.
3 Belgium’s healthcare system is a publicly funded public healthcare system. A characteristic of the system is the importance of the patient’s free choice. They can easily switch between healthcare providers and patients can freely access first, second and third line services (Coene & Raes, 2009).
4 This is just one possible conceptualisation of agency. Agency has also been defined as a more collective capacity of people to resist structural violence (Madhok et al., 2013). Others have challenged the western liberal conceptualization of agency, equating agency with choice, liberation and resistance (Mahmood, 2006). Mahmood advocates that agency can also be understood as the way people make themselves fit within certain structures.
5 Positionality: The occupation or adoption of a particular position in relation to others, usually with reference to issues of culture, ethnicity, or gender (Oxford dictionary). Here we refer to it as to the active process of adapting or performatively shaping one’s appearance in front of a health professional.

Agency is considered as a capacity concept. It expresses the capacity for self-reflective action (Hutchings, 2013).

Coping is described here as actions that serve the purpose of avoiding or reducing the impact of perceived obstacles to healthcare services.

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