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Performing deservingness. Humanitarian health care provision for migrants in Germany

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A B S T R A C T

In this paper, I critically investigate humanitarian aid for migrant populations in Germany. I aim to enhance the existing literature on migrant deservingness and humanitarian aid by focusing on the performative aspects of concrete face-to-face interactions between physicians/volunteers and patients. I argue that despite efforts of volunteers to provide non-discriminatory care, the encounters between patients as aid-receivers and volunteers/physicians as aid-providers are inevitably shaped by power inequalities. These immanent power inequalities may lead patients to perform their deservingness, that is, to present themselves as helpless sufferers rather than empowered subjects. Simultaneously, patient-solicitants are prevented from feeling and enacting a sense of entitlement. Those patients who do not heed to the social mechanisms of humanitarian aid, such as being thankful and humble, cause disenchantment on the side of some medical professionals who provide care as part of humanitarian networks and subsequently, they may be turned away.

The research project focused on the migration trajectories and illness experiences of undocumented Latin American migrants and their access to healthcare. The analysis draws on my long-term ethnographic fieldwork with 35 Latin American migrants in Berlin (2008–2011), 22 interviews with healthcare providers, and my experience as an activist/volunteer for a Berlin-based humanitarian NGO (2008–2012).

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1. Introduction

In this paper, I critically investigate humanitarian aid for migrant populations in Germany. My analysis builds on the literature on the health-related *deservingness* of migrants, which has been defined as "migrants" shifting and historically produced experiences of socio-political exclusion from their countries of residence, often leading them to be portrayed as unwanted, undesirable, and unworthy of services" (Castañeda, 2012: 830). Despite a growing scholarly interest in this topic, the academic literature is still relatively sparse (cf. Willen, 2012). Recent ethnographic studies have documented the construction and treatment of undocumented migrants as undeserving of public health services for example in France (Larchanché, 2012), Israel (Willen, 2012; Rosenthal, 2007), the U.S. (Heyman et al., 2009), Costa Rica (Goldade, 2009) and Germany (Castañeda, 2009; Huschke, 2013). In the literature, the process of constructing deservingness is contrasted with *entitlement*, the formal and legal stipulation of a right to receive medical care (Fassin, 2001; Willen, 2012: 813–4). This juxtaposition of deservingness and entitlement is central for analysis of the interactions between volunteers/physicians and patients in humanitarian encounters developed in this paper.

In my analysis, I focus on the performative aspects of giving and receiving humanitarian aid to highlight the intersubjective, dynamic ways in which deservingness is enacted in the encounter between patient-solicitants and physician-patrons or volunteer-patrons. The role of the patient's performance and the enactment of deservingness have not yet received much attention within social science and medical research. I therefore draw on literature regarding welfare distribution more generally which shows that docile, passive and shameful clients receive preferential treatment compared to demanding ones (e.g. de Swaan, 1988; Will, 1993; Yoo, 2008). By using the terms *patient-solicitant* and *physician-patron* (or volunteer-patron, depending on the context) in my discussion I aim to stress the relevance of the power inequality between patients and physicians/volunteers that is codified in the humanitarian healthcare provided to migrants: the patient presents a plea for help which is assessed by the volunteer and/or physician and that can be granted or denied in any given interaction. Humanitarianism

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is founded on an inequality of lives (Fassin, 2010) and inevitably implies the discursive and interactional construction of deservingness. Humanitarian practice constitutes a "*voluntary* expression of human decency and solidarity in the face of suffering" (Stellmach, 2010: 2, emphasis added), and thus, the question of who should receive what kind of care is continuously negotiated and defined in the concrete humanitarian encounter. Consequently, humanitarianism – as a form of charity – "is always discretionary" (Fassin, 2001: 469).

The importance of a solicitant's performance in humanitarian spaces of care and control has been addressed for example by Ticktin in her analysis of undocumented migrants' struggle to obtain legal status based on their illness in France. Ticktin points out that "a face-to-face encounter allows for performances on both sides, and if one does not perform in the desired manner, one may be penalized and excluded" (Ticktin, 2006: 43). Furthermore, Larchanché (2012) investigated undocumented migrants' access to health care in France, and draws out how "intangible factors" such as social stigmatization and an atmosphere of fear created by restrictive migration regimes contribute significantly to migrants' self-perception and their (lack of a) sense of entitlement on one hand, and on the other hand, lead government officials in charge of handling migrants' claims to perceive them as undeserving. Although these authors mention the importance of a solicitant's performance, they are predominantly concerned with the question of how socio-political *constructions* – or categorizations – of more or less deserving migrants as well as predominant stereotypes about different migrant groups shape clinical practice (cf. Jubany, 2011; Grove and Zwi, 2006; Fox, 2001: 282). Their focus lies on the discursive construction of deservingness prior to or outside of the actual interaction between a state official or a physician and the patient.

In this paper, I aim to expand these investigations of humanitarian encounters and analyses of migrant deservingness by focusing on the concrete face-to-face interactions between physicians/volunteers and patients, thereby providing an in-depth discussion of how a patient's *performance* in the humanitarian space of migrant health care contributes to her/his perception as deserving or undeserving. I argue that despite efforts of volunteer-activists to provide non-discriminatory care, the encounters between patients as aid-receivers and volunteers/physicians as aid-providers are inevitably shaped by power inequalities. These immanent power inequalities may lead patients to perform their deservingness, that is, to present themselves as helpless sufferers rather than empowered subjects. Simultaneously, patient-solicitants are prevented from feeling and enacting a sense of entitlement. Those patients who do not heed to these social mechanisms of humanitarian aid cause disenchantment on the side of some aid-providers and subsequently, they may be turned away by medical professionals or hospital staff collaborating with humanitarian NGOs.

My analysis is grounded in ethnographic fieldwork on healthcare for undocumented Latin American migrants in Berlin as well as in my experience as a volunteer for one of the humanitarian organizations providing medical assistance to migrants. The implications of the dual role are discussed in more detail below. First, however, I will describe the humanitarian organizations working in the field of migrant health and the migrant groups they attend to.

2. Research background

The vast majority of people living in Germany are covered by health insurance (Statistisches Bundesamt, 2008), which in turn facilitates access to comprehensive medical care. When seeking medical assistance in a private practice or a hospital, patients are asked for their insurance card before seeing the physician. Everyone residing in Germany is legally required to be insured, and social benefits for legal residents with low or no income include statutory health insurance. Out-of-pocket payments for treatments are uncommon. Undocumented migrants, however, cannot sign up for health insurance because they usually lack a passport with a valid visa, proof of address and/or an official registration with their local registry office. Consequently, undocumented migrants usually cannot access Germany's 'universal' healthcare system. Addressing this exclusion, various humanitarian organizations started providing healthcare to this underserved population in larger cities in the mid-1990's. The two main organizations providing healthcare for undocumented and uninsured migrants are the so-called *Medibüros* or *Medinetze* (meaning "medical office" or "medical network"), and the *Malteser Migranten Medizin*, the migrant clinics of the Catholic Order of Malta. The former are non-governmental, donation-sponsored projects, run by volunteers, many of them medical students or physicians. The volunteers do not treat patients directly but refer them to cooperating physicians, hospitals, and other healthcare providers who offer their services free-of-charge or at a very low rate. *Malteser Migranten Medizin* is a faith-based charity organization funded by the Catholic Order of Malta. Patients are treated directly by one or more doctors who work voluntarily or as employees for the NGO. In addition to these walk-in clinics, the organization also cooperates with hospitals and specialists.

This kind of humanitarian aid has significantly expanded over the last decade. New branches of these NGOs have opened up in many German cities, and the number of patients treated has increased notably. For example, the Berlin branch of the Malteser Migranten Medizin, which started off with just over 200 patients in 2001, treated 11,000 people in 2012 (Malteser Migranten Medizin Berlin, 2012). Furthermore, these NGOs attend to an increasingly diverse population of uninsured migrants. While they originally catered mainly to undocumented migrants, including for example denied asylum seekers and labor migrants without a valid residence permit, they now also treat documented (legal), yet uninsured migrants from within the European Union (EU), particularly migrants from Eastern EU member states such as Romania and Bulgaria. In Berlin, approximately one third of the Medibüro patients and more than half of the patients of the Malteser Migranten Medizin are EU citizens (Medibüro internal statistics; Malteser Migranten Medizin Berlin, 2012: 5).

This new development can be explained with the mismatch between theory and reality in regard to the inclusion of EU citizens in the German healthcare system. First of all, it is important to clarify that EU citizens enjoy freedom of movement within the European Union, thus, their stay in Germany is by definition not illegal. In order to have access to healthcare while residing in Germany, EU citizens can either obtain a European health insurance card (EHIC) from their national insurance or apply for health insurance in Germany. The main problem with the implementation of these regulations appears to be that EU migrants are not necessarily insured in their country of origin, which in turn bars them from obtaining the EHIC. This is particularly the case for migrants from Romania and Bulgaria, Eastern European countries which only joined the EU in 2007, but may also apply to migrants from other EU countries. A significant percentage of citizens in Romania and Bulgaria are not covered by health insurance, for example due to the lack of documents needed for registration, such as a birth certificate (Loewenberg, 2006). Low levels of education and high levels of illiteracy furthermore prevent some of these recent Eastern European migrants from accessing statutory health insurance in Germany (Vladu and Kleinschmidt, 2009: 204). Access to private health insurance is equally difficult, as many of the recent labor migrants from Romania and Bulgaria are self-employed, and their

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