

THE CONSTRUCTION OF A HEALTH UNINSURANT: PEOPLE WITHOUT MEDICAL CITIZENSHIP AS SEEN BY SOME SLOVENE HEALTH WORKERS

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The paper deals with medical aspects of migration by first focusing on legal, economic and socio-cultural factors that threaten migrants' health and by then identifying how these factors affect access to medical facilities. Using the case of Slovenia, I will prove that, despite apparently formally regulated access to health services, migrants often remain without health care or without medical citizenship. Because of the frequent inability of migrants to access their formally guaranteed rights, it is crucial to assess how they are perceived by health workers - the second part of the article therefore analyses some of their responses.

Key words: *health care, migrants, access to medical institutions, health workers, medical citizenship, Slovenia*

According to some researchers (Helman 2007; Mladovsky 2007; Bofulin in Bešter 2010), the health of immigrants is generally more vulnerable than that of the rest of the population. This finding is often misused in various racist and xenophobic discourses that stigmatize immigrants as carriers of exotic diseases who hence pose a direct threat to the health of the “indigenous”, “native” population. Perception of the “contagious migrant” stems from the belief that immigrants carry diseases and therefore pose a threat to “native” bodies, vulnerable and susceptible to infection.¹

¹ In Slovenia, we find examples of this in articles published in major Slovenian newspapers between 2000 and 2001, when a large number of asylum seekers was located in Slovenia,

It is obvious that the perception of foreigners (of “non-European origin”) as “contagious migrants” originates in heightened distinctions between “us” versus “others”, and “clean” versus “dirty”. Our “clean” national and European bodies are therefore contaminated with the input of “unclean” elements from other cultures, our individual bodies exposed to “exotic” viruses. The deviatory behavior of migrants allegedly displayed in the area of health (such as illnesses and lack of hygiene) coincides with deviation on a moral level, such as alleged inclination towards promiscuity, sexual perversion and criminal activities (Bassin et. al. 2002:151–159; Lipovec Čebren 2009, 2010b). The perception of a foreigner as a threat to the health and cultural, political and economic welfare of the community, supports the idea of illness as the physical demonstration of an immoral stance, and is as such anything but new. It dates back to the medieval age when etiologic explanations gained popularity (Lipovec Čebren 2008:48–49, 75).

In contrast to the above beliefs, research shows that groups of migrants are often relatively healthy upon arrival, but are afflicted by rapidly deteriorating health thereafter, so reflecting the health levels of the rest of the population after just a few years (Antecol in Bedard 2006; Bofulin in Bešter 2010; Franzini in Fernandez-Esquer 2004; Holmes 2006). At the same time, the prevalence of particular medical problems remains higher when compared to the rest of the population (Franzini and Fernandez-Esquer 2004; Holmes 2006).

Epidemiologic studies surveying the medical condition of the immigrant population reveal a high occurrence of cardiovascular diseases,

provoking xenophobic and racist reactions among some people who were uncritically quoted by the media: “We know that these people come from places where hepatitis, AIDS, Ebola and other infectious diseases are raging... We cannot even walk the dog without a vaccination badge, while they are spreading diseases around town without any supervision, without being vaccinated against any disease” (*Nedeljski dnevnik*, 7. 1. 2001). Certain residents of Šiška (district of Ljubljana), living near the former Asylum Centre and the Centre for Aliens, feared “Ebola and other diseases” (*Slovenske novice*, 9. 1. 2001). Xenophobic discourse intensified in Vidonci, where some residents from Šiška were located, supposedly “infected” with bedbugs. The mayor of Vidonci assured: “We will get rid of them by hook or by crook” (*Slovenske novice*, 22.1. 2001), while his fellow inhabitants added: “If foreigners will not leave Vidonci, we locals will try to starve them. It would be a scandalous affair, but reasonable under the circumstances” (Kuhar 2001).

injuries, contagious diseases, mental problems and various addictions. Miscarriage, premature birth and a high mortality rate of the newborn are also more frequent among this population (Mladovsky 2007; Castañeda 2008; Lassetter and Collister according to Bofulin and Bešter 2010;).

The first part of the article focuses on economic, legal and socio-cultural factors that threaten immigrants' health, as well as describing the conditions arising from the absence of medical citizenship, typical of many immigrants in Europe and worldwide. The first two chapters of the paper are mainly based on current anthropological and sociological research findings, while the second part of this contribution analyzes some data from my dissertation research that took place between 2006 and 2010. This medical anthropological research included, among others, unstructured or semi-structured interviews with 42 health workers and administrative staff from different health care institutions in Slovenia that have frequent contact with the immigrant population.

REASONS FOR HEALTH RISKS AMONG THE IMMIGRANT POPULATION

The reasons for the deterioration of the medical condition in immigrant populations are numerous. Besides factors linked to the process of “general acculturation”, such as adaptation to new living conditions, differences in climate, nutrition habits and the degree of pollution (Helman 2007; Lipovec Čebren 2009; Steffen et. al. 2006 according to Bofulin and Bešter 2010), economic, legal and socio-cultural factors must be considered as well.

The economic factors that pose a threat to the health of the immigrant population are intertwined with legal factors: the European Union's economic system requires the labour of immigrant workers, while at the same time pushing them away from social resources, in order to ensure its own successful accumulation (Walters 2004:240-242; Pistotnik 2009:55). William Walters (2004) calls such policies “domopolitics”, indicating that they are not meant to stop immigration, but to “tame” it. One such mechanism to “tame” the immigrant is the introduction of more restrictive laws that make the acquisition and preservation of a legal status more

difficult, contributing to increase the numbers of illegal and undocumented immigrants (Mezzadra 2006, 2009).

Consequently, numerous migrant workers find themselves in precarious conditions, lacking any opportunity for legal employment or else depending entirely on the acquisition of a work permit that their employer can terminate at will. Being “at the mercy” of employers puts workers in a position of complete subordination (Gregorčič 2007; Woolfson 2007; Castañeda 2008; Basis and claims IWW 2008). In Marxist language, their bodies transform into objects, into the “property” of the employer (Pizza 2007:70-71), which compromises their bodies in many ways: from taking on heavy workloads to accepting the most difficult manual labour and unbearable working conditions (such as work in bad weather conditions without adequate equipment and nutrition), as well as insufficient payment (no social security coverage and health care contributions or reimbursement); from continuous exposure to psychological pressure from the employer to residing in poor living conditions, often reduced to poverty (Brovč et. al. 2008:26–32, Basis and claims IWW 2008; Lipovec Čebren 2010b).

Another set of factors to consider are socio-cultural determinants. When coming to a new country, immigrants are faced with inadequate social networks. Namely, research shows that social networks constitute a source of comfort and trustworthy information in the new environment and are, therefore, of crucial importance for an individual’s health (Helman 2007; Brovč et.al. 2009; Bofulin and Bešter 2010). Furthermore, social networks play a vital role in the perception of health problems, approaches to finding help and in interpreting prescribed therapies (Good 1994; Helman 2007). Cultural factors also determine the relationship between medical staff and the migrant, not only in terms of linguistic barriers (or the lack of linguistic competence) but also in regard to numerous cultural differences stemming from differences in understanding the causes and categories of illnesses, as well as treatment procedures. The staff in medical institutions often do not have much intercultural competence, thus a series of cultural misunderstandings ensue, triggering discriminatory attitudes of medical staff towards migrants. As a consequence, migrants are often not satisfied with the health system in the country of arrival and, therefore, rarely visit a doctor (Koehn, Sainola-Rodriguez 2005:289–311; Ticktin 2006:43–44; Helman 2007:319–330).

All the above factors on the one hand affect the health of the migrant population, and on the other, bear upon access to health facilities. The vast majority of researchers dealing with the health aspects of immigration conclude that immigrant communities have less access to satisfactory medical services, which is one of the key reasons for the poor health status of this population (Koehn and Sainola-Rodriguez 2005:289–311; Ticktin 2006:43–44; Helman 2007:319–330; Mladovsky 2007:9; Castañeda 2008; Bofulin and Bešter 2010, etc.).

The reasons for limited access to health care are mainly legal, as migrants are often offered only a temporary residence permit in the country of arrival or else they are left without any legal status at all. Hence, they often have no health insurance, or their insurance covers only the most basic health services (Holmes 2006; Castañeda 2008). Many economic factors are also related to this problem, as migrants, lacking financial resources, often cannot cover health insurance, while also find it difficult to pay for health services as private patients.

Among the socio-cultural factors that hinder access to quality health care, we must emphasize the lack of linguistic and intercultural skills among medical staff that can lead to a series of stereotypes and prejudices, and the discriminatory attitude of health workers towards migrants (Ticktin 2006:43–44; Holmes 2006; Helman 2007:319–330). Due to cultural and linguistic differences, medical staff tend to perceive migrants as “the Others”, and this perception is strengthened by issues such as foreign citizenship or lack of health insurance (Lipovec Čebren 2010c).

ABSENCE OF MEDICAL CITIZENSHIP

In considering the interdependence of economic, legal and socio-cultural dimensions which are evident in connection with the issue of migrants’ access to medical institutions, the concept of medical citizenship cannot be overlooked.

As defined by Mark Nichter, medical citizenship refers to the policies of entitlement “that articulate what we deem to be the basic rights of a citizen, what human rights are recognized for undocumented immigrants,

and who is excluded or sacrificed when health resources are rationed or restricted” (Nichter 2008:183).

The concept of medical citizenship is discussed similarly by Kathryn Goldade (2009) who investigated limited access to the Costa Rican universal health system by undocumented migrants from Nicaragua. She considers the exclusion from medical citizenship to be a consequence of migrants lacking any legal status. In this context, a suffering body is not sufficient to lay claim to health care entitlements, since an individual’s suffering body becomes part of a larger economic and political context that defines the issue of migrant rights, as well as the concept of citizenship (Goldade 2009:487). The author refers to often-quoted Aihwe Ong (2003) who claims that “citizenship is increasingly defined as a civic duty of the individual to ease his or her burden on society (Ong 2003:12)”. In this context, non-citizens (undocumented migrants) are perceived as parasites, taking advantage of the universal right to health care (Goldade 2009:487). Sarah Horton (2004) similarly noted that reductions and limitations in the area of welfare resulted in state health workers in the USA selecting and classifying immigrants’ access to the health care system.

The concept of medical citizenship, therefore, establishes a direct correlation between the political and the health care dimension: exclusion from citizenship status usually entails exclusion from the health system. At the same time, the concept is directly linked to economic factors, since any transformation of medical citizenship cannot be explained outside the neoliberal context, which limits the access of some groups to health care. Most often these groups include the poorest members of society.

MEDICAL (NON-)CITIZENSHIP IN SLOVENIA

The concept of medical citizenship seems an important category in examining the health care aspects of migration to Slovenia. The welfare services that had been available to all citizens prior to Slovenian independence in 1991 were converted into a source of inequality and exclusion after that date (Zorn 2010). The same holds true for the right to health care assistance, which was universally accessible to all residents of the former Yugoslavia, but after Slovenian independence is being

determined more and more by types of coverage and health insurance, as insurance companies have begun to implement stricter controls of medical institutions and have a greater say in the shaping of national health policy (Lipovec Čebren 2010a; Zorn 2010). Health policy has consistently become less socially oriented, as is reflected in increasingly restrictive and selective access to health services – or in other words, restrictive and selective medical citizenship in Slovenia. Similar to other environments (Becker 2004; Goldade 2009; Holmes 2006; Holtz et. al. 2006; Horton 2004), such transformation of medical citizenship has not had the same impact on all sections of the population. The changes have mostly affected redundant workers and workers in precarious employment. Among them are many “erased persons” – people with non-Slovenian citizenship who the Ministry of Internal Affairs erased from the Registry of Permanent Residents in February 1992, thus levelling their status to that of undocumented migrants, i.e. people without any political, economic or social rights, including the right to health care. Prior to Slovenian independence, the “erased” had contributed to health insurance funds in equal measure to other citizens, but due to their new unregulated legal status they later lost their health insurance. As a consequence, they faced great difficulties when in need of medical assistance since they were treated as paying patients, although they were left without legal employment opportunities and therefore without financial resources (Lipovec Čebren 2007; 2010a).

Beside the “erased”, another group of people without medical citizenship are the migrant workers who have been coming to Slovenia on temporary work permits since 1991. In spite of the fact that Slovenian legislation should formally regulate the access of migrant workers to the public health system within the state, the experience of migrants shows that when seeking medical assistance they often encounter a number of insurmountable obstacles (Bofulin and Bešter 2010; Brovč et. al. 2008; Lipovec Čebren 2010b). Let me mention just the most significant ones.

Access to public health care in Slovenia depends on health insurance.² Migrants with a regulated immigrant status are usually insured as employees

² Compulsory health insurance partially covers health care services, whereas voluntary supplementary insurance comes with an additional charge.

(Health Care and Health Insurance Act – Official Gazette of the Republic of Slovenia, Nr. 9/92, 72/06, 114/06, 91/07, 76/08), which means that their health care contributions must be paid by their employer. However, the experience of migrant workers shows that employers in some cases neglect such obligations, leaving workers with health problems without adequate health care assistance (Lipovec Čebtron 2010b). Even those migrant workers who have health insurance report that they are not permitted to choose a personal doctor, which makes it difficult or even impossible for them to access health services (ibid.).

In addition, the Health Care and Health Insurance Act (HCHIA) allows for the free emergency medical treatment of persons without health insurance (Article 7, HCHIA), including “emergency medical services of resuscitation, preservation of life and prevention of the deterioration of the health status of the sick or injured. The urgency of treatment will be assessed by a personal physician or the authorized medical board in accordance with the general Act of the Institution” (paragraph 2 of Article 25, HCHIA). The experience of migrants, the “erased” people and other individuals without health insurance suggests that the interpretation of what constitutes emergency treatment, and what does not, depends largely on an arbitrary assessment by health workers. Therefore, the same medical emergency may be delivered free of charge in one institution, but not in another (Lipovec Čebtron 2007; 2010b).

People without health insurance can either pay for services or use free clinics in Ljubljana and Maribor. Although the free clinic in Ljubljana operates as a “solidarity niche” offering medical assistance to many migrants, many migrant workers still find it too remote or else they are not informed about its existence (Lipovec Čebtron 2010b). The dilemmas regarding migrants’ formal possibilities to access the health system suggest that the attitude of medical staff towards this population is of crucial importance, particularly in view of frequent failure to assert health care rights.

Since the issues regarding the experience of migrants have been discussed elsewhere (Lipovec Čebtron 2010b), I will examine below how persons without health insurance are perceived by health workers, particularly with respect to their understanding of the situation of migrants.

Although there are no precise figures as to how many migrants without health insurance live in Slovenia, the experience of migrants suggest that they are often without health insurance either temporarily or for longer periods of time (ibid.). In addition, investigating how health workers perceive people without health insurance reveals that medical staff tend to develop a multi-faceted relationship with regard to migrants. When reading the text below, it is necessary to keep in mind that these perceptions do not refer to all immigrants and that they represent only the opinions of a small number of medical personnel in Slovenia, but they seem meaningful nonetheless.

HOW PEOPLE WITHOUT HEALTH INSURANCE ARE PERCEIVED BY HEALTH WORKERS

The text that follows is based on my dissertation research, which took place between 2006 and 2010. The analysis includes groups such as the “erased”, migrants and health workers in Slovenia. It covers the part of my research that was conducted among health workers and administrative staff in Ljubljana and in the Slovenian part of Istria, and who were employed in different health care institutions and had the most frequent contacts with the immigrant population. My survey included 42 persons: unstructured and semi-structured interviews were conducted with 13 specialist medical doctors, 4 general practitioners and 6 nurses. We received responses to the questionnaire from 5 specialist medical doctors, 3 general practitioners and 11 administrative workers from health care institutions.

Based on the answers from medical personnel, a construction of persons without health insurance can be discerned that indicates some specific characteristics. In the subsections that follow, these characteristics will be analyzed, though it must be noted that not all respondents and interviewees explicitly discussed these characteristics. Namely, the construction of the uninsured person appears only in a fragmentary manner, whereas nearly half of the respondents did not address it at all.

A) DENIAL OF THE EXISTENCE OF PEOPLE WITHOUT HEALTH INSURANCE: "THERE ARE NO SUCH PEOPLE IN SLOVENIA".

Despite the fact that recently a lot of attention has been paid to the problem of people without health insurance worldwide, a public debate about these issues is almost completely absent in Slovenia.

Alja from the Clinic for people without health insurance in Ljubljana notes:

"We often hear in the media that there are no uninsured people in Slovenia, that such a problem doesn't exist. But this is not true, it does exist. We are the living proof that this problem exists!" (Alja, social worker, 37 years).

I came across a similar understanding of the problem when I was trying to explain the purpose of my research to my potential interlocutors in medical institutions. Many of them refused to participate in the research, claiming that such a problem does not exist or that it is negligible. Initially, almost all interlocutors denied the existence of people without health insurance, although some of them changed their point of view later in the interview. It appears that denial or the diminishing of this problem offered a psychological mechanism allowing them to avoid problematizing existing health care provisions, at least "publicly" - in front of me and a recording device.

At the same time, when going through the process of remembering, they acknowledged the presence of people without health insurance sometime later in the interview, indicating the possible presence of cultural anesthesia (Zorn 2003). Cultural anesthesia is a mechanism of "concealing unpleasant and contradictory feelings and experiences of the cultural "Other" (...) It silences experiences and feelings which, if they went public, could begin to undermine the normative, tacit assumptions of everyday life and the legitimacy of authority" (Feldman according to Zorn 2003:101-102). The concept of distancing ourselves from a problem, whereby we push the suffering of others into the subconscious, is similar to the concept of cultural amnesia. The process of "distancing" was analysed by the medical anthropologist Paul Farmer in his study of AIDS patients, in

which he claims that “distancing” is associated with exoticizing suffering, since it is difficult to comprehend the suffering of people who are not close to us, due to geographical, gender or cultural differences (Farmer in Pizza 2007:101).

B) PEOPLE WITHOUT HEALTH INSURANCE ARE FOREIGNERS WHO CAME FROM “ELSEWHERE”

U: "Who are people without health insurance?"

E: "They are foreigners, from elsewhere. They pay because they don't have it sorted out. It's the same for us – when we go to Croatia or Serbia we have to pay as well, right?" (Erika, nurse, 37 years).

M: "Most things are governed by conventions in other countries. If a person is not insured in the country of residence or if he/she does not know where he/she is coming from and where he/she belongs, then we assume that they do not know how to take care of themselves" (Miro, medical doctor, 61 years).

R: "There were only some cases in which the basic health insurance coverage was missing. In one case, we could not check health insurance data – they all claimed that they had health insurance coverage, however, the computer terminal did not work after 10pm at that time. There are other foreigners who do not live here, they have temporary visas and did not get the European health insurance card before coming here: in such cases, solving their problems must be solved through insurance companies in their homeland and their costs are reimbursed later. I am not sure about the others; I was not paying attention" (Rok, medical doctor, 35 years).

Such explicit and unequivocal association of people without health insurance with “foreigners” was not a common feature in the interviews. Numerous health workers did not want to relegate such people to specific categories of the population or else they classified people without health insurance in different categories, as “foreigners”, migrant workers, as well as homeless people and/or Slovenian citizens. However, Rok's, Erika's and Miro's position seems to be meaningful.

Their perception of people lacking health insurance as “foreigners”, cultural Others who are not a part of the civic “body” of the Republic of

Slovenia, implies that such persons neither have access to civil rights nor to health care benefits. This overlap between the status of a citizen and the status of a medical citizen reveals that in the case of non-citizens or medical non-citizens, "homeland" or "country of origin" is defined through an undefined phrase: "from elsewhere". It seems that we are dealing with an unspecified, "loose" geography that resembles Farmer's concept of the "geography of blame" (1993). In this "loose geography", a mechanism of transfer of responsibility can be detected: once a person is defined as a citizen of "some other" country, his/her civic rights and medical entitlements are transferred outside Slovenia. As a consequence, no one bears responsibility for such people's health.

This is obvious from Miro's and Rok's emphasis on "conventions" and the "European health care card" that cultural "Others" have to arrange "in some other place" in order to benefit from medical entitlements in Slovenia. The status of a "medically stateless person" is therefore not foreseen.

It seems that the perception that institutions abroad are primarily responsible for "foreigners" has a significant impact on medical practice, and it allows us to observe xenophobic and discriminatory attitudes towards those people.

This is clear from Fadila's experience:

F: "Then a doctor came and asked me: 'Will you go back to Bosnia or will you stay here after you leave the hospital?' I said I would stay here. Then he immediately discharged me from the hospital. The doctor who performed the surgery didn't behave like that. He was on his annual leave and this other doctor was filling in for him. I thought this was so horrible, why did he ask me that? He didn't care if I was going to live, all he cared about was where I would live. This is what I think."

U: "How did he ask you about this?"

F: "He asked me how I felt. I said I could not lift myself out of bed. I would only use my potty, and then go straight back to bed. He said: 'You are pampering yourself!' No one pampered me. My life has been so cruel; no one has ever pampered me. Then he discharged me. I said I was in pain."

U: "Do you think he discharged you because you said you wanted to stay here?"

F: "I have no idea what he wanted to achieve. Why did he ask whether I wanted to be here or in Bosnia? I really don't know! Then he discharged me and my husband came to pick me up from the hospital and the very next evening I was barely alive, so he took me back to the hospital. This wound was infected, which was clear even if you only touched it and he still discharged me" (Fadila, 59 years).

C) PEOPLE WITHOUT HEALTH INSURANCE AS IRRESPONSIBLE INDIVIDUALS

U: "Some can't afford to pay... for their health insurance."

S: "They all can. If they are unemployed they sort this out via the employment agency, and if they are not registered with the employment agency, they can obtain health insurance through the municipality" (Magda, nurse, 59 years).

Magda's trust in the general accessibility of the Slovenian health system rests on the conviction that lack of health insurance is an individual's fault. This notion was very common among health workers and administrative staff who participated in the survey. The wide currency of such convictions is demonstrated in a survey that was carried out among 19 employees in two medical institutions. Respondents answered the following question: "What is the reason that some people do not have health insurance?". They could choose among different answers. The selected reply was most frequently: "Because they do not take care of it, although they could" (14 replies). The second most frequent reply was: "Because they don't have (financial or other) means to arrange it" (10 selections). The fourth option: "Because they are trying to take advantage of our health care system" was selected 7 times; while the option "other reasons" was selected just once, and no one chose the reply: "Because they were not informed". The highest frequency of the first reply, connected to some extent with the fourth reply, reflects the neoliberal ideology of individualization, as I will prove later.

Gay Becker notes that in the USA it is a common assumption that everyone who seeks medical attention will be assisted. The same author

shows that, on the one hand, this false assumption undermines endeavours encouraging citizens to demand universal health insurance, and on the other hand, this type of neoliberal discourse, based on the ideology of individualism and self-responsibility, shows a tendency to turn health policy errors into an ideological success, thus maintaining the illusion that the poor are adequately taken care of (Becker 2004:271).

The perception of what constitutes “individual responsibility” varied among my respondents, as is clear in many aspects that I will deal with separately, although it formed a single interpretation of the discourse on persons without health insurance.

D) PEOPLE WITHOUT HEALTH INSURANCE VIEWED AS DISORDERLY AND UNCLEAN

Most health workers and administrators participating in the research described people without health insurance as disorderly. Although this term was primarily associated with lack of health insurance, it often occurred in other segments of the research on the perception of uninsured persons.

Many researchers of nationalism, xenophobia and racism (Jalušič 2001; Kuzmanić 1999; Bassin et.al. 2002:151-159), who analysed media discourses regarding refugees with temporary asylum status and asylum seekers in the first decade of Slovenian independence, indicated that the concept of tidiness and cleanliness was a key concept in such discourse.

The concept was thoroughly researched by Mary Douglas in her well-known book “Purity and Danger” (2004 [1966]), in which she defines “unclean” as everything that escapes classification in an orderly system and thus every attempt to systematize entails the removal of inappropriate and “impure” elements. Since “foreigners” or migrants, lacking citizen status, can be considered representatives of such impurity *par excellence*, this alleged impurity is mirrored in many aspects:

"These are people who came to Slovenia, often without documents. They are beggars, they have no insurance...they are not tidy. They cause a lot of trouble, they don't stick to rules, they have all kinds of diseases and they stink. They come here 10 times and take advantage of the system. Then he throws himself on the floor, soils his pants, and I have to pick him up, give him a bath, he's all dirty and scruffy.

We, nurses, have organized and we give them baths, wash them, we collect clothes for them so that we can clothe them. We pull them back together. The big problem is where to send them from here, because there are no institutions which they can be sent to, this is not regulated" (Erika, nurse, 37 years).

From Erika's account it becomes obvious that impurity is not limited to the lack of health insurance, but it is used as an umbrella term for numerous aspects: from "untidiness" in hygiene terms ("stink", "dirty", "scruffy") to medical terms ("they have all kinds of diseases"), as well as in legal terms ("no documents"), existential claims ("beggars"), behavioral patterns ("Then he throws himself on the floor, soils his pants"), social sense ("The big problem is where to go, because then there is no institution to which they can be sent to") and deviation from rules of behavior in medical institutions ("they don't stick to the rules"). Furthermore, Erika's description also indicates a paternalistic discourse that reveals elements of the objectification of needy persons ("We pull them back together").

The continuity and overlap of the aspects described above seem meaningful, but the cause-and-effect link between these phenomena cannot be deduced from Erika's words only. However, such overlapping of the legal, behavioral and social sphere is not new and is revealed in the perception of "contagious migrants" as noted in the beginning of this paper. Such representation can be observed in European health policy trends, as well as in the tendencies of health care practices or in the discourses of individual institutions (asylum centers, immigrant centers).

Similar parallels between medical and socio-political discourses were pointed out by Sarah Horton and Judith C. Barker (2009) in their study of the perception of Mexican immigrants in the U.S.A. According to their study, hygiene, with its connotations of civilization and morality, has long served as a mean for measuring the proper moral conduct of immigrants and as a yardstick against which non-whites' "fitness" for citizenship has been assessed (2009:784-5). Similarly, Aihwa Ong (Ong 1995 according to Horton and Barker 2009) reports on the perception of American officials that immigrants have different hygienic habits, which resulted in explicit demands for heightened personal hygiene in immigrant centers (including elimination of personal body odours, bathing, use of deodorant and mouth

wash). Adherence to norms of hygiene becomes the criterion according to which health professionals assess whether individuals are “fit” for citizenship, and thus establishes the demarcation line between “sanitary” and “unsanitary” subjects (Ong and Briggs according to Horton and Baker 2009:789). Norms of hygiene thus serve as a rich symbolic catalogue on the basis of which national purity and pollution can be established, while also representing an index of civilization that serves to demarcate the boundary between Mexico and the United States, between “internal foreigners” and “Americans” (ibid.: 785-9). During the first wave of immigration into the U.S., cleanliness was associated with patriotism and served as a symbol of Americanization (Molina and Shah according to Horton and Barker 2009:796), whereas nowadays public health educators conceive personal and domestic hygiene in terms of neoliberal ideology, i.e. as an ability to practice self-restraint. The aforementioned authors point out that while trying to ensure hygiene standards, health workers fail to consider the socio-economic and political obstacles that immigrants face, such as low income, lack of nutrition, bad housing conditions, inaccessibility of health care services, etc. (ibid. 2009:789, cf. Holmes 2006). Such views are related to Farmer’s previously mentioned concept of “the geography of blame”, a notion that serves to downplay structural obstacles (such as inaccessibility to health care), while pinpointing a certain region as a source of unhealthy behavioral patterns (such as Mexico). By accepting the presuppositions of “the geography of blame” certain facts can be obfuscated, such as evidence that immigrants changed eating habits only after arriving in a new country, and thus their eating habits cannot be viewed as a consequence of “Mexican habits” (Farmer 1993; Horton in Barker 2009:789).

Such lack of consideration of the socio-political and economic reasons influencing deviation from the norm of “order” and “purity” was a common feature in most conversations with health workers. Many negative attitudes can be linked to the neoliberal ideology mentioned above, according to which an individual is considered fully responsible for lacking health insurance, as well as for all other kinds of “untidiness” and/or “impurities”. At the same time, such attitudes mostly ignore all the structural factors that impede the acquisition of crucial social, political, economic and health care entitlements.

Lack of critical thinking about such obstacles among my interlocutors led them to frequently perceive people without health insurance as “undisciplined” patients who (in Erika’s words) “don’t stick to the rules” or do not behave in accordance with institutional policy or professional instructions. This type of “untidiness” is exposed in the accounts of doctors Bojana and Tina, while Tina’s opinion also contains elements of “the geography of blame”:

T: "I had a patient (...) she was uninsured and I arranged for her to be admitted to the clinic, although she didn't have any health insurance. She never went. For example: you arrange some medical tests for her, free ultrasound and she never comes. The responsiveness of patients varies. A lot depends on a patient – you have a different attitude towards a patient who is interested and who shows up, you engage fully, too. You know there can be no success with the ones who neglect themselves, don't show up to change bandages (...) Some neglect treatment and you have a lot of problems trying to tell them that they should take the medicine, as many refuse treatment. You spend a lot of energy getting through to these people, trying to tell them how important the treatment is. They give up taking medicine."

B: "I (...) have noticed that it is easier to work in Slovenia as a doctor because patients generally have more confidence in a doctor. If you establish good contact, they comply and don't ask questions. If we go south, to Croatia and further down, things get worse. Those who come from the south do not comply" (Tina, doctor, 53 years and Bojana, doctor, 60 years).

It seems that ignorance or indifference to the structural obstacles that people without health insurance are often confronted with leads to, maintains and strengthens the construction of the health insured as an “undisciplined” patient. But at the same time, health and social workers with deeper knowledge of the living conditions of these people are able to interpret their behavior within a broader social context:

U: "It is often said that these patients are disorderly..."

A: "I know, doctors say that a lot. Not all of them, though. They get angry at them, but do they ever consider that this person may be in distress, that he/she has no ticket for the bus, no one to take him/

her home, maybe he/she lives far away and is without any means of transport. Then they don't even show up, or they show up late and don't say why...people are ashamed. They are proud. They tell me things in secret" (Alja, social worker, 37 years).

The discourses and practices of some health workers suggest that the middle-class citizen is the criterion for "orderliness" (Horton 2004:479). Sarah Horton calls this criterion "an ideal for attaining health" that an "average" person, a representative of the middle-class, can satisfy, as opposed to people representative of the poorer lower-class who are confronted with major economic and social obstacles when trying to achieve this "ideal". In her opinion, patients who are identified by health workers as incapable of achieving the ideal (either because of incorrect assessment by a health worker or because they do not behave according to doctor's instructions or general health policy) are often treated as patients with "high health risks" and are often refused treatment (ibid. 478-9).

E) PEOPLE WITHOUT HEALTH INSURANCE VIEWED AS IRRESPONSIBLE PEOPLE

"Everyone with an income should have basic health insurance coverage. I would have all the possessions seized of those who bend the rules of the system. Such people moonlight and refuse to pay for insurance as citizens – this is not an expense. Can we support irresponsible people? I don't think so.

(...)

People who don't pay health insurance should be ashamed. They are not ashamed to be a leech on the system, and the system allows it. It makes me sick. I don't consider those who can't pay problematic; I only blame those who consciously neglect to pay – since society will take care of it anyway."

U: "Are there many such people?"

"I think so. If we are talking about unemployment – everybody can find work! There are many people who wouldn't touch certain kinds of work. I know a few such people personally.

(...)

Speculators! They think that nothing can touch them, that someone

will show solidarity and pay for them as there are so many loopholes in the system, and they carry on not paying for insurance.

(...)

There are people who are not insured through their own fault, not working through their own fault - people who are unable to keep any job. Take the Strojans³, for example, they got everything for free. I think we're dealing with social pathology here – people who constantly live on income support and refuse to work.

Regardless of what nationality, be it the “erased” or not, Slovenes, Serbs or Muslims, who grafted all the time and now feel betrayed. There is a need to determine who is responsible for his/her own misery. Those who are completely responsible and were given every opportunity, yet didn't take it, they should pay the price. Within their means.

(...)

Those who worked hard all their lives have a fundamentally different attitude to their health from those who chose not to finish school, live as tramps, drink too much, are drunks – such people do not take responsibility for their own health seriously."

U: "So there is a difference between working and non-working people?"

"Hardworking people may also be unemployed, but everybody can find work" (Rok, doctor, 35 years).

This long excerpt from an interview is quoted here to summarize in a radical and dramatic way numerous points made previously regarding the construction of a person without health insurance, since it is representative of many xenophobic and nationalist conceptions about the uninsured. From the quotation and the entire fragment it can be concluded that the key word for this physician is “responsibility”. “Responsibility” is always associated with work and employment, while hard work appears to be the criterion for selecting between “responsible person/ (non-)citizen / medical (non-) citizen”. In a country where “everyone can find work” the attitude towards health is based on the attitude towards work:

³ Here he refers to a Roma family who was forcefully relocated by local residents (with the support of Slovenian authorities) from its home to a former refugee center.

"Those who worked hard all their lives have a fundamentally different attitude to their health from those who chose not to finish school, live as tramps, drink too much, are drunks – such people do not take responsibility for their own health seriously."

In Rok's moralistic discourse, work represents the measure of civic as well as medical responsibility, coinciding with medical-anthropological research among undocumented migrants. Researchers noticed that health workers (like Rok) classify immigrants into those "deserving" vs. those "undeserving" access to medical services. The former are associated with diligence and civic responsibility and the latter with indolence, irresponsibility, and various health risks (Becker 2004:260; Horton 2004:478). Such a selective principle is used to justify unequal access to health services, further supported by the view that they, as unproductive and irresponsible individuals, "burden" health insurance funds. The construction of the immigrant as a "burden" is possibly one of the most frequent elements of a xenophobic, nationalistic and racial discourse, discussed extensively by many researchers analysing attitudes towards "foreigners" in Slovenia (Jalušič 2001; Kuzmanić 1999; Bassin et. al. 2002:151-159).

As "saving" becomes an essential vision in the context of neoliberal health policies, the notion of "burden" acquires more important connotations. While Ong (2003) claims that citizenship is increasingly defined as the duty of each individual to reduce his or her burden on society, the "medical citizen" specifies a self-responsible individual as one whose "risk-free" behavior requires very little medical attention. In the case of people without health insurance, this "shifting of the burden" to the shoulders of an individual is particularly problematic, since the main reason that they are perceived as a "burden" is precisely their inability to "shift the burden" themselves.

The view that people without health insurance are a burden to the health system was common among many medical personnel in Slovenia. Rok and Miro argued that these individuals had not contributed anything to the health system:

"Well, in this case our health insurance programme is not exactly friendly. But I understand this unfriendliness entirely; it's like throwing money away. Why?"

These people have not contributed anything to this system in the past, but they then demand certain rights. It is true that these people do not demand much. Generally they are not very demanding" (Miro, doctor, 61 years).

"Everyone with an income should have basic health insurance coverage. I would have all the possessions seized of those who bend the rules of the system. Such people moonlight and refuse to pay for insurance as citizens – this is not an expense. Can we support irresponsible people? I don't think so" (Rok, doctor, 35 years).

Within this individualized neoliberal discourse both physicians obviously consider that responsibility lies solely upon the person without any health insurance who is apparently seeking to exploit and undermine the health insurance funds. It is interesting to note that they do not consider the employers who avoid paying health care contributions for their employees as equally responsible, nor those who do not provide adequate working conditions and are thus directly responsible for the consequences evident in the health of workers (Goldade 2009:495).

CONCLUDING THOUGHTS...

Contrary to populist, racist views about the “contagious migrant” which allege that migrants bring diseases “with themselves”, this paper aims to show that immigrants are usually threatened by difficult, often insurmountable obstacles in the country of arrival. In the case of Slovenian health legislation, I have tried to prove that the seemingly regulated access to medical services still often deprives migrants of medical entitlements. Due to their frequent failure to assert health care rights, it is very important for migrants how health workers perceive them. Based on the comments of some medical professionals, it can be concluded that their views of people without health insurance mirror neoliberal health policies: they perceive them as “foreigners” who should be taken care of in other countries, as disorderly, “impure”, incompetent people who represent a “burden” for the Slovenian health system.

Such perceptions, labeled here as “the construction of a health insurant”, are not only present in the field of health care, but pervade all levels of social life, thus acting as a restrictive and selective mechanism in society. Such a mechanism first seems to exclude mostly non-citizens and vulnerable groups, while it later starts to affect the rest of the population who experience a gradual diminishing of political, social and economic rights.

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PREDODŽBE O NEOSIGURANICIMA: LJUDI BEZ MEDICINSKOG
DRŽAVLJANSTVA PROMATRANI OD STRANE SLOVENSКИH
ZDRAVSTVENIH RADNIKA

Članak se bavi medicinskim aspektima migracije i prvo propituje pravne, ekonomske i sociokulturne faktore koji ugrožavaju zdravlje migranata, a zatim identificira načine na koje ti faktori utječu na pristup medicinskim institucijama. Koristeći primjer Slovenije, pokazati ću kako, usprkos naočigled formalno reguliranom pristupu zdravstvenim ustanovama, migranti često ostaju bez zdravstvene skrbi ili bez medicinskog državljanstva. Zbog česte nemogućnosti migranata da koriste svoja formalno zagwarantirana prava, važno je bilo promotriti kako ih doživljavaju zdravstveni radnici – stoga drugi dio članka analizira neke od njihovih odgovora.

Ključne riječi: zdravstvena skrb, migranti, pristup medicinskim institucijama, zdravstveni radnici, medicinsko državljanstvo, Slovenija