Chapter 11
Discrimination as a Health Systems Response to Forced Migration

Yudit Namer, Canan Coşkan, and Oliver Razum

Abbreviations

MIPEX   Migrant Integration Policy Index
IOM   International Organization for Migration

Introduction: Forced Migration and Health Systems

Health systems' responses to migration can be conceived in terms of entitlement and access to health care. Entitlements and access to health care vary considerably between countries, as shown by the health strand of the Migrant Integration Policy Index (MIPEX) developed by the International Organization for Migration (IOM). Across Europe, 'legal' migrants (those with a residence status) either have analogous health coverage as taxpayers in tax-based health systems or their entitlement is dependent on their residence (they pay into a system they cannot benefit from, should they leave the country). Asylum seekers, on the other hand, have restricted entitlements in most of Europe. Undocumented migrants are invisible to systems and structures, and in many European countries, they risk detention and deportation when seeking care or are covered only with an emphasis on emergency care (Ingleby et al. 2018). As Crawley and Skleparis (2017) put it: "Migration regimes, like all other ordering systems, create hierarchical systems of rights" (p. 51).

Forced migrants have been globally met with punitive measures, from denial of entry or detention upon entry to denied access to services secured by international right-based conventions, as the UCL-Lancet Commission on Migration and Health

Y. Namer (✉) · O. Razum
Department of Epidemiology and International Public Health, School of Public Health, Bielefeld University, Bielefeld, Germany
e-mail: yudit.namer@uni-bielefeld.de

C. Coşkan
Institute for Interdisciplinary Research on Conflict and Violence, Bielefeld University, Bielefeld, Germany

points out (Abubakar et al. 2018) (see also Chap. 13). Several country-based examples illustrate the wide spectrum in entitlement and access: In Germany, 'legal' migrants (as long as they maintain their residency) have analogous entitlements to health care as citizens. Asylum seekers, however, have restricted entitlements in the first 15 months of their arrival, comprising emergency care in the case of acute pain, maternity care and select vaccinations (Razum and Bozorgmehr 2016; Ingleby et al. 2018). In Norway, 'legal' migrants with more than a year's residency permit, as well as asylum seekers, are entitled to health care once they become members of the national insurance system. Undocumented migrants receive only emergency and 'absolutely essential' care with the requirement to pay after care, and health systems may be obligated to report them to the authorities (Huddleston et al. 2015). Spain, on the other hand, has recently reintroduced universal health care for asylum seekers and undocumented migrants (analogous to citizens) and ensures specialised treatment for survivors of trauma among forced migrant groups. Although full access to health care exists in Belgium, Greece, Ireland, Italy and Serbia as well, access is severely complicated by the barriers of language, delayed asylum registration processes, remoteness of refugee accommodations and/or other administrative issues (Asylum in Europe 2017). Overall, politically constructed categories of migration ('legal migrant', 'refugee', etc.) mostly determine the type and extent of entitlements, and access barriers complicate these responses almost everywhere.

Social exclusion, as a result of processes such as discrimination, is considered among the social determinants of health (Wilkinson et al. 2003). Discrimination and social exclusion are in mutual reproduction with poverty, lack of access to education, employment and social and political participation (e.g. Gordon et al. 2017). The duration of exposure to social exclusion is linked to the range and severity of health disadvantages (Wilkinson et al. 2003). Depending on the policy environment, being a migrant limits an individual's choices in the social, economic, political and health-related spheres and thus is also considered a social determinant of health on its own (Castãneda et al. 2015). The two social determinants of health—social exclusion and migration—are intertwined in creating layers of health inequities through discrimination. We follow Crawley and Skleparis' (2017) argument that categories of migrants are political constructs and not necessarily representations of actual migratory accounts. The various labels based on artificial boundaries (e.g. involuntary vs voluntary migration or refugee vs migrant) may serve to homogenise and atomise migration experiences. Moreover, the categories themselves may prepare the ground for 'othering' (the social construction of people as the 'other'), and as such, they are used in health systems as a tool for discrimination.

Discrimination against multiple minority groups lies at the centre of exclusionary and oppressive practices which exist even in today's supposedly multicultural societies. Specifically, discrimination against forced migrants in health care systems constitutes an underspecified example of such exclusionary practices: forced migrants may be subjected to various forms of discrimination in their country of origin (depending on their reason to migrate), during transit (depending on the nature of the journey and the borders crossed) and in the country of destination (depending on the migration policies of the host country). We now consider how

certain constructions of others are institutionalised in ways that perpetuate disadvantage, such as in the case of health systems response to the needs of forced migrants.

First, we discuss discrimination as a health systems response from a sociopsychological and biopolitical perspective emphasising critical approaches that have developed recently. Several empirical contributions in social and political psychology offer intra- and interpersonal as well as intergroup explanations to systematically uncover the dynamics of discrimination. However, few of these contributions provide a macro level analytical frame which also accounts for the politics of life. Biopolitical approaches fill this gap by highlighting power dynamics, sovereignty and population control or discipline. Therefore, in the first two sections, we provide a sociopsychological account of discrimination based on social and political psychological theories and complement the major gap with current explanations from theories of biopolitics and biopower. We then present infrahumanisation, a mechanism employed to derogate and to delegitimise a group perceived as less than human and to justify discrimination of that group (Leyens et al. 2007) and its health care counterpart 'health-based deservingness', as a point of juncture to explain the intertwined dynamics of social exclusion. Next, we provide case examples of how European health systems response to forced migration, and the broader societal response reflected upon its operations have been characterised by discrimination and infrahumanisation. Finally, we suggest an updated ethics of care to counter the social exclusion of forced migrants.

Sociopsychological Perspectives on Discrimination

Stereotyping and Prejudice

Stereotypes are pictures in our heads, beliefs and opinions about the characteristics and behaviours of members of various groups (Hilton and von Hippel 1996). For instance, the stereotype content model (Fiske et al. 2002) suggests that the social strategy of regulating the interactions with the outgroup depends on the ingroup's perception of the outgroup's warmth and competence, which also influences their practices of inclusion and exclusion as well as type and degree of discrimination. Prejudice, on the other hand, is an *attitude* directed toward people because they are members of a specific social group (Allport 1954; Brewer and Brown 1998). Finally, discrimination consists of *treating people differently* from others based primarily on membership in a social group (Sue 2003).

In many instances of social exclusion (such as forced migrants' exclusion from some health systems), these processes are intertwined. Through stereotypes, prejudices and discrimination, social realities are constructed or dismantled by providing them with meaning and consequence; as such, they become embedded in the reproduction of relations of power, inequality and resistance. They mutually amplify each

other through several factors, including perceived threat from the outgroup. Therefore, Dixon (2017) proposes to consider "stereotypes in their wider discursive, historical and political contexts and to recognise their status as forms of social action designed to justify how we treat one another" (p. 21). This also requires acknowledging how certain constructions of others are institutionalised in ways that perpetuate disadvantage, as might be the case in health systems' response to the needs of forced migrants.

From this perspective, categorisations adopted by health systems play a significant part in discrimination against migrants (Scott et al. 2017; Abubakar et al. 2018; Wenner et al. 2019). Migration categories are deeply rooted in states' unique historical representations of immigration and are reproduced in the society even though they do not reflect lived experiences (Scott et al. 2014; Crawley and Skleparis 2017). In Europe, labelling the labour migrants as 'guest workers' implied that host health systems were not responsible for the long-term health of these individuals and their families (Razum and Wenner 2016). The distinction between voluntary and forced migrants or between economic migrants and 'real refugees' prompted the prejudices about the assumed intentions of migrants and served the questioning of the legitimacy of the right to protection from persecution (Crawley and Skleparis 2017). Differentiating between regular, legal and irregular or undocumented migrants and the illegality stereotype used to represent the latter reflect the criminalisation of the act of crossing a border and connote that one group is more deserving of accessing regular services than others (Willen and Cook 2016). Rather than focusing on the unique circumstances of individuals along with the contextual and cultural dynamics of human movements, health systems became fixated on legal status and categories, which often grossly neglect ethics of care discussed later in the chapter.

(Inter-)Group and Social Identity Processes

Intergroup conflicts could be rooted in concerns over collective identity and competition over material resources in social hierarchies (Tajfel and Turner 1979; Turner et al. 1987). For instance, the actions or even the existence of outgroups often lead ingroups to feel as though their group's status is threatened (Branscombe et al. 1999). Intergroup threat is experienced when members of one group perceive another group as intending to cause them harm, thereby inducing a sense of realistic threat (i.e. concern about physical harm or a loss of resources) and/or symbolic threat (i.e. concern about the integrity or validity of the ingroup's meaning system). Accordingly, intergroup threats have destructive effects on intergroup relations, such as between 'host' society members and migrants (Stephan et al. 1999).

Mummendey and Wenzel (1999) suggested that social discrimination results from an ingroup's practices of inclusion and exclusion: Based on superordinate category (e.g. humans with dignity) which would include both the ingroup and the outgroups, the ingroup generalises its attributes to that inclusive category and create 'criteria' for judging the outgroup (e.g. ethnocentrism). If the difference perceived

from the outgroup is judged to be non-normative and inferior, devaluation, discrimination and hostility are likely responses toward that homogenised outgroup, as can increasingly be seen in many European societies' relationship with migration (see also Simon 1992; Fein and Spencer 1997; Brewer 1999).

Social Dominance and Power

The discriminatory practices are themselves mutually constitutive with group-based social hierarchy. According to social dominance theory (Sidanius 1993), discrimination across multiple levels (institutions, individuals and collaborative intergroup processes) is coordinated to favour dominant groups over subordinate groups (such as through providing selectively accessible health services) by legitimising myths or societal, consensually shared social ideologies (Pratto et al. 2006). Hence, hierarchy is normalised to maintain the status quo via asymmetric distribution of values and discrimination (Sidanius and Pratto 1999). The *normalisation of hierarchy* in societal systems also leads the way to discrimination against more than one group.

More elaborative approaches, such as by Turner (2005), reject an understanding of power as the capacity for influence based on the control of resources valued or desired by others (i.e. dependency). They argue that the control of resources (such as access to health care) produces power which is the basis of influence and that mutual influence leads to the formation of a psychological group, also offering a distinction between individual power and group power. The UCL-Lancet Commission on Migration and Health argues that, in their most just interpretation, international conventions protecting the rights of migrants necessitate the signatory countries to secure that no governmental or non-governmental body interferes with migrants' right to health through discrimination. Not only do most nation-states neglect this responsibility; they become the agents of discrimination through restricting entitlements and imposing barriers to accessing existing limited services, thereby constructing a legitimate ground for the social exclusion by controlling the health care resources (Abubakar et al. 2018). Health systems response to forced migration is framed within a discourse of solving the problem (Nyers 2006), which positions refugees "as an anomaly that needs a solution" and connotes the representation of realistic threat (Turner 2015, p. 140). The framing of such a solution implies, however, that any services provided for refugees are "exceptional, temporary and often in legal grey zones" (Turner 2015, p. 140). The emergency-focused, restricted and anomaly-oriented structure of health services provided, coupled with access barriers most migrants face (e.g. in terms of language), suggests that the national priorities are imposed at the expense of needs and rights, thereby creating a hierarchy of rights (as suggested by Crawley and Skleparis 2017) within health systems.

Recently, Sindic (2015) argued that identity is essential to political power, and the latter constitutes the means through which identity and the vision of social life it entails are actualised in practices and institutions. Accordingly, the system of

social relations determines powerfulness/powerlessness of individuals and groups and regulates the dynamics of social inclusion and exclusion. Therefore, not only examining the intergroup relations per se but also considering the cultural and structural settings in which they occur is needed to better account for the interplay between psychological and societal processes of dominance and discrimination without reductionism and to create scientific roads for taking sides and producing strategies for counter-dominance (Reicher 2004).

Biopolitical Perspectives on Discrimination

While intrapersonal, interpersonal or (cross-)cultural conceptualisations of norm construction and normalisation in psychology generally underestimate *institutionalised* relations of power, biopolitical approach explains how norms and normalcy as the regulatory mechanisms of the governing powers set the ground for discrimination: the norm determines the normal. The culture is recreated and reproduced on different levels, including the macro level constituted by the sovereign controlling and/or disciplining state. Foucault (2003) ties the norm to *disciplinary power* and argues that the norm "brings with it a principle of both qualification and correction. The norm's function is not to exclude and reject. Rather, it is always linked to a positive technique of intervention and transformation, to a sort of *normative project*" (p. 50). Health is one major area where nation-state politics and sovereignty discourses crystallise through institutionalisation and surveillance.

Current updates on Foucault's conceptualisation of biopolitics slightly diverge from his original formulation (Lemke et al. 2011; Lemke 2016). According to Fassin (2001, 2006), the biopolitics based on *biolegitimacy*, which recognises biological life as the highest (moral) value, simultaneously prioritises human life and includes some groups (e.g. refugees with temporary residence for treatment of diseases untreatable at their home countries) as having (right to) biological life (humanitarian project) and excludes some groups (e.g. political asylum seekers) as not having (a right to) political life. Such a selective permeability of right to life through border politics as well as the praxis of mutating citizenships (e.g. Ong 2006) articulated and regulated by the states create multiple layers of inclusion and exclusion which surpass the lines between the biological/medical, the political and the moral. These layers are frequently intertwined with racism, and the practices of racism in the daily realm of social and health politics constitute an excessive *immunitarian project* of conserving life at the expense of (others' as well as own) life (Esposito 2008).

In Esposito's (2008) formulation, the self and the other's point of contact is the immune system. It has been suggested that migrants, that is, those who have crossed external borders, remind one of the permeability of internal boundaries and are thus perceived as uncanny and threatening (Bohleber 1995). As discussed in the previous section, this is also supported by the sociopsychological account of negative stereotypes constructed upon an imagined threat on the well-being of the 'host' society,

which fuels intergroup conflict (Stephan and Stephan 2000). According to Esposito (2008), when communities are formed on the basis of biologically determined ethnonational terms, defence is conceptualised in terms of immunity against outside threats. In other words, "to affirm the lives of insiders, in terms of the cultural and biological integrity of their identity and the quality of their lives, they must be immunized from foreign contamination" (Bird and Short 2017, p. 308). The health status of forced migrants is used as a rationale for discrimination by the normative and immunitarian project of regulating life through several mechanisms such as surveillance and screening, reproduced through the existing international politics of borders and the health care system, both Foucauldian disciplinary power apparatuses, and its instruments such as humanitarian workers and health professionals (see also Chaps. 7 and 8).

Point of Juncture: Infrahumanisation and Health-Based Deservingness

The simultaneous dynamics of governing life and death are always in play in the discrimination of oppressed minority groups via *infrahumanisation* and *dehumanisation* processes. Dehumanisation is denying victims' identity and community, thereby erasing, respectively, their distinct individuality and their belonging to a network of caring interpersonal relations (Haslam and Loughnan 2014). Infrahumanisation specifically involves considering outgroups 'less human and more animal-like' than the ingroup, which is perceived, in essence, as fully human (Leyens et al. 2007). Both dehumanisation and infrahumanisation delegitimise the social category, the beliefs, the behaviours and the very existence of an outgroup while also legitimising the stereotypes, prejudices and discrimination against that group.

The distinction between dehumanisation and infrahumanisation, despite being blurry, lies on the intensity, or magnitude, and the quality (Leyens et al. 2007). The processes of dehumanisation are representatively coupled with crimes against minority groups, with a dimension of ultimate moral exclusion, including genocide (Opotow 1990), while those of infrahumanisation are generally coupled with many (implicit and explicit) exclusionary and discriminatory practices embedded in daily societal life. To illustrate, racism, which includes ethnocentric discriminatory practices, is socially prohibited in many societies. Anti-migrant attitudes, however, which include stereotypical and prejudicial social stances of not only denial but also neglect of the other, are not met with such prohibition (Abubakar et al. 2018). While overtly racist treatment within health systems would perhaps cause public indignation, anti-migrant treatment by health systems, which endorses social exclusion, perhaps provokes outrage only in some segments of society due to this distinction. As such, the model of infrahumanisation hypothesises that attributed degrees of humanity differ with group membership, and it helps us explain better possible con-

sequences of the wide spectrum of entitlement and access for migrants, hence the *deservingness* conceptualisation much used in academic work explaining the discrimination of migrants in health systems.

Health-Based Deservingness

Willen (2012) introduced the concept of 'health-based deservingness' as a factor intervening with provision of rights. In her conceptualisation, deservingness interferes with right-based approaches and places conditional moral evaluations before the principles of universality and equity. Migrants who are unauthorised, she posits, are portrayed as undeserving in current global political discourses, with labels such as 'parasites', 'freeloaders' and 'criminal aliens' (Newton 2012) used to describe those deemed undeserving.

Often generated by negative stereotypes (e.g. migrants perceived and depicted as less warm—cold—and incompetent and hence labelled as 'less grateful'), enhanced with an imagined 'realistic threat' on the 'host' society's health care resources (e.g. Stephan et al. 1999), such deservingness-based discourses ascribe diverse motives and moral character to those who migrated, meditate on their legality of entry and degree of vulnerability and assess migrants' social closeness to citizens of the host society which are continuously suspected (Willen and Cook 2016). The suspicion and the constant questioning of the legitimacy of migrants' right to health are fuelled by and further contribute to infrahumanisation: As the recipient of humanitarian aid (or of the 'generosity' of host nations), that is, in return of their biological needs being cared for, forced migrants are imposed to be politically undemanding in order to be deserving (Turner 2015). Hence, "by focusing on the correspondence between individual beliefs and the supposedly 'objective' characteristics of others", one risks neglecting the discursive practices through which the social realities, including structural disadvantages are constructed and reproduced (Dixon 2017, p. 4). Deservingness debates maintained by stakeholders, filled with commonly held negative stereotypes, fail to acknowledge the structural disadvantages experienced by migrants. This lack of recognition then serves the purpose of recreating these structural disadvantages and social hierarchies (Willen and Cook 2016), removing health systems even more from an ethics of care.

Health-based deservingness discourses are in turn internalised or utilised by migrants. Huschke (2014) showed that, even when undocumented migrants access health care provided by humanitarian organisations (which will not report them to the authorities), they felt the need to display performative expressions of deservingness. These expressions included lengthy explanations of pain and demonstration of suffering, appearing in poverty when seeking care while performing 'normalcy' in everyday life or silence when faced with disrespectful treatment in order to overcome infrahumanisation by themselves and to justify access.

Discrimination as Health Systems Response to Forced Migration: Case Examples

Hostile Environments

Health services themselves assume the role of discriminating agents by building hostile environments through the implementation of legal entitlement restrictions and the failure of removing barriers to access (recreating the hierarchy of rights) even if this violates the principles of ethics of care. This affects forced migrants in different ways: They may choose not to seek care when in need of care, because of fear of deportation, criminalisation and/or institutionalisation, or they may need to prove at length that they deserve health care. In many places, separation of children from parents, detention and deportation are real threats for undocumented migrants (Doctors of the World 2017). The burden of living with such fear, anxiety and the real adverse consequences often lead to negative physical and mental health, which exacerbate the vicious circle of barriers to access, ill health and barriers complicated by worsened health status (Abubakar et al. 2018) (see also Chap. 8).

In the United Kingdom (UK), the 'hostile environment policy', which was implemented through the Immigration Acts of 2014 and 2016, became known to larger communities in 2017, when access to health care was denied to the Windrush generation, who arrived in the UK from the Caribbean countries in the 1950s (Liberty 2018). This policy also affected migrants without an explicit right to remain and asylum seekers whose cases were deemed 'complicated', since the passing of the Immigration Acts. Such service users were billed up front for health care and were denied continued and emergency care unless they could pay for services beforehand (Bulman 2017; Abubakar et al. 2018). Following the Immigration Acts of 2014 and 2016, the UK's National Health System further agreed to share confidential personal data with the Home Office, which meant that the immigration enforcement could contact people suspected to be undocumented or whose application for asylum was rejected, if they were to seek health care (Liberty 2018). Considering the care with which citizens' personal data are protected across Europe, as reflected by the Data Protection Act of 2018, such lack of concern regarding noncitizens' data implies first a normalisation of hierarchy and second an infrahumanising stance based on the sovereign's assumed legitimacy of control and discipline.

Surveillance

Surveillance characterises nation-states' relationship to forced migration. Health systems play a crucial role in surveillance, specifically when they classify "migrants as potential sources of infection and disease" (Scott et al. 2014, p. 11), that is, as infrahumanised subjects who are biopolitical threats to the immunitarian project. Scott et al. (2014) argue that migrants are classified in order to keep the national

boundaries impermeable and thus invulnerable. The discourse of forced migrants as carriers of disease serves the purpose of reinstating nation-states as holders of (bio) power and promoting immunity, thereby justifying the existing hierarchy and social dominance relations through legitimising myths. There is empirical evidence supporting the mechanism: Murray et al. (2017) documented a positive relationship between perception of disease threat and moral vigilance, an increased sensitivity to moral violations. This relationship was not only correlational; when the threat of diseases was made salient to participants, they made harsher judgments regarding moral violations.

Denial of entry or deportation on the grounds of infectious diseases, non-communicable illnesses and/or cost of care is not performed in Europe. However, some high-income countries such as the USA and Canada have health-related eligibility criteria for entry and/or residency (see also Chap. 7). In the USA, persons with communicable disease considered to have 'public health significance' are denied entry. In Canada, permanent residency is dependent on a health status that does not pose a threat to public health or safety, or the nation's immunity (Abubakar et al. 2018). Such residency restrictions, which do not apply to citizens, and entry restrictions which apply to select countries communicate that migrants are less (human) than citizens or that bodies are threatening to the ingroup's immunity only when they come from certain parts of the world, contributing to the infrahumanising discourse.

Harper and Raman (2008) further argue that public health research contributes to the infrahumanising 'foreign body' discourse of migration and disease. They posit that epidemiological research continues to utilise the phrase 'foreign born' as an epidemiological signifier in tuberculosis research, which then leads to health systems efforts in the forms of pre-migration and border screenings to keep the foreign bodies out. Within the already prejudicial and infrahumanising discourse, forced migrants are considered as not only a danger to themselves but a threat to society.

Screening

Surveillance and thus implementation of biopower also take the form of screening. Screening of asylum seekers for tuberculosis is performed in all European states in one way or another with the rationale of protecting the majority population (Dara et al. 2016) despite evidence that prevalence of tuberculosis in subpopulations born outside of Europe has no significant impact on native-born subpopulations in Europe (Sandgren et al. 2014) (see also Chap. 10). The effectiveness of some existing screening policies is further questionable, missing latent infection with no systematic follow-up (Pareek et al. 2011; Aldridge et al. 2016; Dara et al. 2016). Health workers in Germany involved in mandatory tuberculosis screening of asylum seekers and refugees residing in mass accommodation solely cited the disease control law when justifying screenings (Kehr 2012). In other words, they used legalism to normalise the social hierarchy. Kehr (2012) argues that screening, done superficially,

based on administrative categories or without attention to the social and political realities of the individuals, misses the complex health needs of forced migrants, complicating their access to the care needed. This may function as providing rational basis for reinforcing the prejudices against forced migrants by homogenising the outgroup.

The relationship between biopower and infrahumanisation is illustrated by another example Kehr (2012) provides: Roma patients diagnosed with tuberculosis in France are at risk of deportation upon hospitalisation despite negotiations between public health professionals and immigration enforcement. They are then forced to abandon treatment due to the threat of or actual deportation, running the danger of multi-resistance. This then leads to the doctors' decision of not treating Roma patients in the first place as they are likely not to complete treatment, deeming Roma patients more vulnerable to be seen as 'disease holders'. Surveillance then becomes problematic when it serves the immunitarian conceptualisations of who should be inside and who should be outside.

If diagnosed following screening, "the same body that is subject to a systematic colonisation by bio-medicine and the state often seems to be one of the very few tools left through which protest, resistance and despair can be articulated" (van Ewijk and Grifhorst 1998, p. 255). When treatment is refused, and the bodies are used as sites of resistance (by negotiating privileges within accommodation in return of treatment adherence), health professionals morally ascribed patients' refusal to ignorance, irresponsibility or deviance. These ascribed qualities were in turn attributed to refugees' 'culture', such as a relative ease with the concept of dying, an infrahuman quality in the age of biolegitimacy (van Ewijk and Grifhorst 1998). In line with the establishment of health-related prejudices against migrants, Taylor (2013) argues that migrant non-compliance and moral irresponsibility especially in the case of multidrug-resistant tuberculosis as assigned to migrants are part of the disease identity of tuberculosis in Europe.

Depending on state policies, health status could be utilised to document that a person's existing health status puts them at even further risk in detainment conditions, that their health status has deteriorated in detainment or that their experiences of torture or mistreatment in their country of origin are medically valid. Medical professionals at such facilities increasingly voice the ethical dilemma they find themselves in: their refusal to intervene would mean people in need may not receive care, whereas their participation in documenting health status enables such practices. Avoiding to ascribe uniquely complex human emotions to patients, that is, one form of infrahumanisation, is a strategy also employed by health professionals to protect themselves. Those more likely to infrahumanise patient suffering (in terms of ascribing basic emotions not uniquely human) were less likely to report exhaustion or decreased work engagement and professional inefficacy (Vaes and Muratore 2013). Christoff (2014), however, strongly questions the ethics of 'effective' infrahumanising and dehumanising strategies and argues that a more acceptable strategy would be "to relieve the person in power of the decision-making responsibility and to place it where it rightfully belongs", with the patient: a clear sign of relational autonomy (p. 4).

Strategy for Social Inclusion: An Updated Ethics of Care

Discrimination is first legitimised by the border politics of nation-states; this legitimisation is further reproduced in health systems. This chapter presents only a limited snapshot of this legitimisation in health systems on both structural and individual (intergroup or interpersonal) levels. Specifically, we suggest that using migrant status and health status in health systems as a rationale for discrimination contributes to societal infrahumanising discourses, discrimination and social exclusion in mutual reproduction. Both statuses exist in contrast to the biolegitimised social identity of the 'healthy citizen', thereby serving the twofold function of 'protecting and defending' the citizens by the nation-state. Based on the sociopsychological and biopolitical literature reviewed, we propose to consider the discursive, historical and political context of discrimination (Dixon), to remember that identity is constructed through institutionalised power (Sindic) and to take sides by reflecting on how to produce strategies for counter-dominance (Reicher). We acknowledge that those who work in the health care systems or in voluntary organisations in relation to forced migrants are first and foremost care workers. As structural and individual levels are intertwined, we also argue that social change could and should be pushed forth by those who are within the (health) system and that health care workers could be the agents of this change. We accordingly suggest an updated account of ethics of care integrated with intersectional and anarchist approaches for health care workers and diverse parties in the health system as a possible strategy for the elimination of infrahumanisation and discrimination and the prevention of social exclusion of migrants in health systems, on both structural and individual levels.

We mainly follow Hankivsky (2014) who has critically elaborated on the feminist ethics of care approach (Tronto 1993) and suggested an intersectional understanding of care ethics. Intersectional ethics of care considers perspectives of gender, race, sexual orientation, geographic location, immigrant status, ability and class "and a more expansive and accurate portrayal of the interlocking and mutually enforcing axes of power that affect the operationalisation of care on a global level" (Hankivsky 2014, p. 255). Efforts to apply intersectional ethics of care can create space for self- and group reflexivity upon the master statuses which built the dominating social identities (Reicher 2004). Seeing through the eyes of the other (Hurtado 2018), thereby, can allow to overcome tendencies of social dominance and act in solidarity (not for but) with the oppressed. Still, as neither the nation-states nor the private sectors are willing to prioritise intersectionality in providing the most equitable and efficient distribution of health needs and resources of forced migrants, the intersectional ethics of care can be complemented with values of autonomy, responsibility, solidarity and community (anarchistic values, according to Scott 2018). This approach to health care can reclaim health as a common good that cannot be subject to instrumentalisation or compromise (Rogers 2006; Harvey 2007). This would entail counteracting the commodification of health, a consequence of excessive immunitarian project which excludes the other even to the point of self-/group destruction in Esposito's terms, through corporeal relation of care as a form of political relatedness (Hoppania and Vaittinen 2015).

The dismantling of infrahumanisation, discrimination and thus social exclusion of migrants can be possible by rejecting commodification (of health) in health systems and by recognising the crucial role of health workers as *homines curans* (caring people, Tronto 2017). On the structural level, this would require a framework of laws and regulations that avoids entitlement restrictions and actively removes access barriers to health care (Razum and Bozorgmehr 2016). Informed by a descriptive and transformative intersectionality-based policy analysis, such a framework also needs to emphasise developing non-hierarchy within and consensus among all parties and participants of the care relationship, practicing reflexivity and prioritising social justice and equity (Hankivsky et al. 2012).

On the individual level, we suggest understanding responsibility through continuous self-reflexivity, enhancing autonomy, creating solidarity and empowering community. This would firstly require all care workers and potential agents of social change to engage in continuous self-reflection upon one's own privileges, social advantages and critical roles in the system and to recognise the specificities of needs in those intersecting axes of power. Second, Scott (2018) proposes conceiving "autonomy …[as] truly self-determining and support[ing] an individual in pursuit of that person's life projects and health as a good" (p. 219). Applying this to the health needs of migrants would mean co-creating space for the capacity of migrants' self-determination of movement as well as of health care along with an attempt to redefine the relationship with the other, hence mutually developing relational autonomy (Braidotti 2006). More importantly, health care workers who engage in daily interaction with forced migrants can adopt a patient-centred approach which would enable care workers to avoid the dehumanising effects of institutionalisation and infrahumanising tendencies of dominating social identities by thinking more creatively about patient need (Scott 2018). Finally, as also suggested by Dutt and Kohfeldt (2018), a liberatory care for the community can be built which would help care workers and community members to interrogate the power relations and to redefine health needs in terms of common goods for the inhabitants of this world (instead of individual or group commodification). This does not only build a line of solidarity and prepare the ground for mutual empowerment, but it also establishes care as the centre of a new definition of the economy (Schmitt et al. 2018).

References

Abubakar, I., Aldridge, R. W., Devakumar, D., Orcutt, M., Burns, R., Barreto, M. L., et al. (2018). The UCL–Lancet Commission on Migration and Health: The health of a world on the move. *Lancet, 392*, 2606. https://doi.org/10.1016/S0140-6736(18)32114-7

Aldridge, R. W., Zenner, D., White, P. J., Williamson, E. J., Muzyamba, M. C., Dhavan, P., et al. (2016). Tuberculosis in migrants moving from high-incidence to low-incidence countries: A population-based cohort study of 519 955 migrants screened before entry to England, Wales, and Northern Ireland. *Lancet, 288*, 2510–2518. https://doi.org/10.1016/S0140-6736(16)31008-X

Allport, G. W. (1954). *The nature of prejudice*. Reading, MA: Addison-Wesley. https://archive.org/details/TheNatureOfPrejudice

Asylum in Europe. (2017). *Reception conditions*. Retrieved April 3, 2019, from https://ec.europa.eu/home-affairs/what-we-do/policies/asylum/reception-conditions_en

Bird, G., & Short, J. (2017). Cultural and biological immunization: A biopolitical analysis of immigration apparatuses. *Configurations, 25*, 301–326.

Bohleber, W. (1995). The presence of the past - Xenophobia and Right-wing extremism in the Federal Republic of Germany: Psychoanalytic reflections. *The American Imago, 52*, 329–344.

Braidotti, R. (2006). Affirmation versus vulnerability: On contemporary ethical debates. *Symposium: Canadian Journal of Continental Philosophy, 10*, 1–18. https://doi.org/10.5840/symposium200610117

Branscombe, N. R., Ellemers, N., Spears, R., & Doosje, B. (1999). The context and content of social identity threats. In N. Ellemers, R. Spears, & B. Doosje (Eds.), *Social identity: Context, commitment, content* (pp. 35–58). Oxford: Blackwell.

Brewer, M. B. (1999). The psychology of prejudice: Ingroup love and outgroup hate? *Journal of Social Issues, 55*, 429–444.

Brewer, M. B., & Brown, R. (1998). Intergroup relations. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *The handbook of social psychology* (pp. 554–594). New York: McGraw-Hill.

Bulman, M. (2017). Thousands of asylum seekers and migrants wrongly denied NHS healthcare. *Independent*.

Castañeda, H., Holmes, S. M., Madrigal, D. S., Young, M. E. D., Beyeler, N., & Quesada, J. (2015). Immigration as a social determinant of health. *Annual Review of Public Health, 36*, 375–392. https://doi.org/10.1146/annurev-publhealth-032013-182419

Christoff, K. (2014). Dehumanization in organizational settings: Some scientific and ethical considerations. *Frontiers in Human Neuroscience, 8*, 748. https://doi.org/10.3389/fnhum.2014.00748

Crawley, H., & Skleparis, D. (2017). Journal of ethnic and migration studies. *Journal of Ethnic and Migration Studies, 44*, 48–64. https://doi.org/10.1080/1369183X.2017.1348224

Dara, M., Solovic, I., Sotgiu, G., D'Ambrosio, L., Centis, R., Tran, R., et al. (2016). Tuberculosis care among refugees arriving in Europe: A ERS/WHO Europe Region survey of current practices. *The European Respiratory Journal, 48*, 808–817. https://doi.org/10.1183/13993003.00840-2016

Dixon, J. (2017). Thinking ill of others without sufficient warrant?' Transcending the accuracy–inaccuracy dualism in prejudice and stereotyping research. *The British Journal of Social Psychology, 56*, 4–27. https://doi.org/10.1111/bjso.12181

Doctors of the World. (2017). *Falling through the cracks: The failure of universal healthcare coverage in Europe*. London: European Network to Reduce Vulnerabilities in Health.

Dutt, A., & Kohfeldt, D. (2018). Towards a liberatory ethics of care framework for organizing social change. *Journal of Social and Political Psychology, 6*, 575–590. https://doi.org/10.5964/jspp.v6i2.909

Esposito, R. (2008). *Bios: Biopolitics and philosophy*. Minneapolis: University of Minnesota Press.

Fassin, D. (2001). The biopolitics of otherness: Undocumented foreigners and racial discrimination in French public debate. *Anthropology Today, 17*, 3–7.

Fassin, D. (2006). La biopolitique n'est pas une politique de la vie. *Sociologie et sociétés, 38*, 35–48.

Fein, S., & Spencer, S. J. (1997). Prejudice as self-image maintenance: Affirming the self through derogating others. *Journal of Personality and Social Psychology, 73*, 31.

Fiske, S. T., Cuddy, A. J. C., Glick, P., & Xu, J. (2002). A model of (often mixed) stereotype content: Competence and warmth respectively follow from perceived status and competition. *Journal of Personality and Social Psychology, 82*, 878–902.

Foucault, M. (2003). *Abnormal: Lectures at the Collège de France* (Graham Burchell, Trans.). New York: Picador 50 1974-1975 SRC-BaiduScholar FG-0.

Gordon, S., Davey, S., Waa, A., Tiatia, R., & Waaka, T. (2017). *Social inclusion and exclusion, stigma and discrimination, and the experience of mental distress*. Auckland: Mental Health Foundation of New Zealand.

Hankivsky, O. (2014). Rethinking care ethics: On the promise and potential of an intersectional analysis. *The American Political Science Review, 108*, 252–264. https://doi.org/10.1017/S0003055414000094

Hankivsky, O., Grace, D., Hunting, G., Ferlatte, O., Clark, N., Fridkin, A., & Laviolette, T. (2012). Intersectionality-based policy analysis. In O. Hankivsky (Ed.), *An intersectionality-based policy analysis framework* (pp. 33–45). Vancouver, BC: Institute for Intersectionality Research and Policy, Simon Fraser University.

Harper, I., & Raman, P. (2008). Less than human? Diaspora, disease and the question of citizenship. *International Migration, 46*, 3. https://doi.org/10.1111/j.1468-2435.2008.00486.x

Harvey, D. (2007). *A brief history of neoliberalism*. Oxford: Oxford University Press.

Haslam, N., & Loughnan, S. (2014). Dehumanization and infrahumanization. *Annual Review of Psychology, 65*, 399–423. https://doi.org/10.1146/annurev-psych-010213-115045

Hilton, J. L., & von Hippel, W. (1996). Stereotypes. *Annual Review of Psychology, 47*, 237–271.

Hoppania, H. K., & Vaittinen, T. (2015). A household full of bodies: Neoliberalism, care and "the political". *Global Society, 29*, 70–88. https://doi.org/10.1080/13600826.2014.974515

Huddleston, T., Bilgili, Ö., Joki, A.-L., & Vankova, Z. (2015). *Migrant integration policy index 2015*. Barcelona: CIDOB and MPG.

Hurtado, A. (2018). Intersectional understandings of inequality. In P. L. Hammack (Ed.), *The Oxford handbook of social psychology and social justice* (pp. 157–187). Oxford: Oxford University Press.

Huschke, S. (2014). Performing deservingness. Humanitarian health care provision for migrants in Germany. *Social Science & Medicine, 120*, 352–359. https://doi.org/10.1016/j.socscimed.2014.04.046

Ingleby, D., Petrova-Benedict, R., Huddleston, T., & Sanchez, E. (2018). The MIPEX health strand: A longitudinal, mixed-methods survey of policies on migrant health in 38 countries. *European Journal of Public Health, 29*, 458–462. https://doi.org/10.1093/eurpub/cky233

Kehr, J. (2012). Blind spots and adverse conditions of care: Screening migrants for tuberculosis in France and Germany. *Sociology of Health & Illness, 34*, 251–265. https://doi.org/10.1111/j.1467-9566.2011.01415.x

Lemke, T. (2016). Rethinking biopolitics: The new materialism and the political economy of life. In S. Wilmer & A. Zukauskaite (Eds.), *Resisting biopolitics: Philosophical, political, and performative strategies* (pp. 57–73). New York: Routledge.

Lemke, T., Casper, M. J., & Moore, L. J. (2011). *Biopolitics: An advanced introduction*. New York: NYU Press.

Leyens, J. P., Demoulin, S., Vaes, J., Gaunt, R., & Paladino, M. P. (2007). Infra-humanization: The wall of group differences. *Social Issues and Policy Review, 1*, 139–172. https://doi.org/10.1111/j.1751-2409.2007.00006.x

Liberty. (2018). *A Guide to the Hostile Environment: The border controls dividing our communities – and how we can bring them down*. Retrieved from https://www.libertyhumanrights.org.uk/policy/policy-reports-briefings/guide-hostile-environment-border-controls-dividing-our-communities-%E2%80%93

Mummendey, A., & Wenzel, M. (1999). Social discrimination and tolerance in intergroup relations: Reactions to intergroup difference. *Personality and Social Psychology Review, 3*, 158–174.

Murray, D. R., Kerry, N., & Gervais, W. M. (2017). On disease and deontology: Multiple tests of the influence of disease threat on moral vigilance. *Social Psychological and Personality Science, 10*, 44–52. https://doi.org/10.1177/1948550617733518

Newton, L. (2012). "It is not a question of being anti-immigration": Categories of deservedness in immigration policy making. In A. L. Schneider & H. M. Ingram (Eds.), *Deserving and entitled: Social constructions and public policy*. Albany: SUNY Press.

Nyers, P. (2006). *Rethinking refugees: Beyond states of emergency*. New York: Routledge.

Ong, A. (2006). *Neoliberalism as exception: Mutations in citizenship and sovereignty*. Durham: Duke University Press.

Opotow, S. (1990). Deterring moral exclusion. *Journal of Social Issues, 46*, 173–182.

Pareek, M., Watson, J. P., Ormerod, L. P., Kon, O. M., Woltmann, G., White, P. J., et al. (2011). Screening of immigrants in the UK for imported latent tuberculosis: A multicentre cohort study and cost-effectiveness analysis. *The Lancet Infectious Diseases, 11*, 435–444. https://doi.org/10.1016/S1473-3099(11)70069-X

Pratto, F., Sidanius, J., & Levin, S. (2006). Social dominance theory and the dynamics of intergroup relations: Taking stock and looking forward. *European Review of Social Psychology, 17*, 271–320.

Razum, O., & Bozorgmehr, K. (2016). Restricted entitlements and access to health care for refugees and immigrants: The example of Germany. *Global Social Policy, 16*, 321. https://doi.org/10.1177/1468018116655267

Razum, O., & Wenner, J. (2016). Social and health epidemiology of immigrants in Germany: Past, present and future. *Public Health Reviews, 37*, 4. https://doi.org/10.1186/s40985-016-0019-2

Reicher, S. (2004). The context of social identity: Domination, resistance, and change. *Political Psychology, 25*, 921–945. https://doi.org/10.1111/j.1467-9221.2004.00403.x

Rogers, W. A. (2006). Feminism and public health ethics. *Journal of Medical Ethics, 32*, 351–354. https://doi.org/10.1136/jme.2005.013466

Sandgren, A., Sañé Schepisi, M., Sotgiu, G., Huitric, E., Migliori, G. B., Manissero, D., et al. (2014). Tuberculosis transmission between foreign- and native-born populations in the EU/EEA: A systematic review. *The European Respiratory Journal, 43*, 1159–1171. https://doi.org/10.1183/09031936.00117213

Schmitt, S., Mutz, G., & Erbe, B. (2018). Care economies—Feminist contributions and debates in economic theory. *Österreichische Zeitschrift für Soziologie, 43*, 7–18. https://doi.org/10.1007/s11614-018-0282-1

Scott, N. (2018). Anarchism and health. *Cambridge Quarterly of Healthcare Ethics, 27*, 217–227. https://doi.org/10.1017/S0963180117000561

Scott, P., Odukoya, D., & Von Unger, H. (2014). The classification of "migrants" as a discursive practice in public health: A sociology of knowledge approach. *Discussion Paper SP III 2014–601*. Berlin: Wissenschaftszentrum Berlin für Sozialforschung.

Scott, P., Von Unger, H., & Odukoya, D. (2017). A tale of two diseases: Discourses on TB, HIV/AIDS and im/migrants and ethnic minorities in the United Kingdom. *Social Theory & Health, 15*, 261. https://doi.org/10.1057/s41285-017-0026-5

Sidanius, J. (1993). The psychology of group conflict and the dynamics of oppression: A social dominance perspective. In S. Iyengar & W. J. McGuire (Eds.), *Explorations in political psychology* (pp. 183–219). Durham, NC: Duke University Press.

Sidanius, J., & Pratto, F. (1999). *Social dominance: An intergroup theory of social oppression and hierarchy*. Cambridge: Cambridge University Press.

Simon, B. (1992). The perception of ingroup and outgroup homogeneity: Reintroducing the intergroup context. *European Review of Social Psychology, 3*, 1–30.

Sindic, D. (2015). Power by the people and for the people: Political power and identity in the separation and integration of national states. In D. Sindic, M. Barreto, & R. Costa-Lopes (Eds.), *Power and identity* (pp. 140–161). Hove: Routledge.

Stephan, W. G., & Stephan, C. W. (2000). An integrated threat theory of prejudice. In *Reducing prejudice and discrimination* (pp. 23–46). Mahwah, NJ: Lawrence Erlbaum Associates. https://doi.org/10.1002/9780470672532.wbepp139

Stephan, W. G., Ybarra, O., & Bachman, G. (1999). Prejudice toward immigrants. *Journal of Applied Social Psychology, 29*, 2221–2237. https://doi.org/10.1111/j.1559-1816.1999.tb00107.x

Sue, D. W. (2003). *Overcoming our racism: The journey to liberation*. San Francisco: Wiley.

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup relations. In S. Worchel & W. G. Austin (Eds.), *The social psychology of intergroup relations* (pp. 33–47). Monterey: Brooks-Cole.

Taylor, R. C. R. (2013). The politics of securing borders and the identities of disease. *Sociology of Health & Illness, 35*, 241–254. https://doi.org/10.1111/1467-9566.12009

Tronto, J. (2017). There is an alternative: *Homines curans* and the limits of neoliberalism. *International Journal of Care and Caring, 1*, 27–43. https://doi.org/10.1332/2397882 17X14866281687583

Tronto, J. C. (1993). *Moral boundaries: A political argument for an ethic of care*. London: Routledge.

Turner, J. C. (2005). Explaining the nature of power: A three-process theory. *European Journal of Social Psychology, 35*, 1–22. https://doi.org/10.1002/ejsp.244

Turner, J. C., Hogg, M. A., Oakes, P. J., Reicher, S. D., & Wetherell, M. S. (1987). *Rediscovering the social group: A self-categorization theory*. Oxford: Blackwell.

Turner, S. (2015). What is a refugee camp? Explorations of the limits and effects of the camp. *Journal of Refugee Studies, 29*, 139. https://doi.org/10.1093/jrs/fev024

Vaes, J., & Muratore, M. (2013). Defensive dehumanization in the medical practice: A cross-sectional study from a health care worker's perspective. *The British Journal of Social Psychology, 52*, 180–190. https://doi.org/10.1111/bjso.12008

van Ewijk, M., & Grifhorst, P. (1998). Controlling and disciplining the foreign body: A case study of TB treatment among asylum seekers in the Netherlands. In K. Koser & H. Lutz (Eds.), *The new migration in Europe* (pp. 242–259). Basingstoke: Palgrave Macmillan.

Wenner, J., Namer, Y., & Razum, O. (2019). Migrants, refugees, asylum seekers: Use and misuse of labels in Public Health Research. In A. Krämer & F. Fischer (Eds.), *Refugee migration and health. Challenges for Germany and Europe*. Cham: Springer.

Wilkinson, R., Marmot, M., & World Health Organization. (2003). *Social determinants of health: The solid facts* (2nd ed.). Copenhagen: Centre for Urban Health, World Health Organization.

Willen, S. S. (2012). How is health-related "deservingness" reckoned? Perspectives from unauthorized im/migrants in Tel Aviv. *Social Science & Medicine, 74*, 812–821. https://doi.org/10.1016/j.socscimed.2011.06.033

Willen, S. S., & Cook, J. (2016). Health-related deservingness. In F. Thomas (Ed.), *Handbook of migration and health* (pp. 95–118). Cheltenham: Edward Elgar Publishing.