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Experiences of Patients and Professionals with Healthcare for Undocumented Migrants

A Qualitative Study in the Context of a Swiss NGO

Master Thesis for the obtainment of a Master of Public Health

Studies of Public Health of the Universities of Basel, Bern and Zurich

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Bern, May 2017

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1. Abstract

This thesis is using a grounded theory approach to explore the ways in which undocumented migrants are included into or excluded from communication related to healthcare. The data was gathered through interviews with patients of a Swiss NGO's medical Contact Point as well as with medical and administrative professionals. The analysis shows that undocumented migrants are mainly included into healthcare by settling in, through the Contact Point and its networks, or by taking out insurance. In cases of exclusion, undocumented migrants use risky strategies to attain health, or leave important health issues untreated. Inclusion remains partial and precarious. This can apply to both financial or administrative aspects, or interactions with medical personnel. Important values concerning healthcare for undocumented migrants, such as continuity, sensitivity to specific needs and individual autonomy and control over health and health care, are not or only partially met. Furthermore, inclusion may often and in various ways have negative consequences for the individual undocumented migrant. Their legal status and exclusion from citizenship, thus pervades undocumented migrants' health and health care.

2. Introduction

AG's hospital visit

January 2016. It is about two months since I wrote an introductory email to the head of an NGO's department, the mission of which is to cater to the healthcare needs of so-called undocumented migrants (the NGO department will henceforth be referred to as the "Contact Point" and the department head as WM). In my email, I explained that I am working on a Master's degree in Public Health, and asked whether there would be a possibility for some volunteering. Since then, I have met WM, and have undertaken some translation work for the Contact Point. Subsequently, she has told me that she could see me accompanying some undocumented migrants on their hospital visits, if I were interested. I am.

Now, WM calls me for the first time for such an accompanying task. The patient, AG, needs an examination at a public hospital in the area. On the phone WM reassures me that, basically, everything should go smoothly with the patient, as he has insurance. AG will take along the contract. But, she warns, he has no insurance card. All in all, she tells me, it would be good to have somebody with AG who "can explain things in a good, broad Swiss accent" (WM).

She had instructed the patient to meet me in front of the hospital one and a half hours before the appointment, because AG has never been to this hospital before and therefore needs to

be registered first. "It's better to be early, just in case..." advises WM and reminds me to call her if there are any problems.

One morning, three days later, I meet AG in front of the hospital. He hands me all the paperwork he has brought along. I find a referral letter, an insurance contract, and some medical results that I avoid looking at. I feel like an intruder into the privacy of a man I do not know at all. We walk to the reception, I show the papers and we are sent on to another desk for registration.

Arriving, I explain that I am here to accompany this patient. I address the receptionist in one Swiss national languages while AG uses another one. The receptionist asks me for the insurance card. I answer that AG does not have one but that he brought along his policy. "Normally we need that card" she says. I do not respond. Then the receptionist asks for the patient's address. I tell her that she can use the address on the insurance policy but she points out that there is only a post-box address on it. She insists that surely the man must be living somewhere. I agree and then reiterate that this is the only address available. I am suddenly uncertain. Would AG really risk anything by giving the hospital his address? I am not sure. Finally, the receptionist says quite sharply: "So, he lives nowhere." "Exactly," I respond drily.

We continue. An emergency contact. Someone is already listed on the policy. Still, the employee needs a phone number. AG gives a number. The receptionist does not understand it, so I translate. A few sentences later, as I continue to translate AG's explanations, she interrupts me, telling me that she understands AG just fine and does not need translation.

Finally, she asks for an identity card. I explain that there is none. She tells me that she has to clarify this with her manager. I am worried about the aggressive tone between us and tell her that I understand this and that she can call the Contact Point for further information.

The woman leaves, returns and says that her manager is fine with it but that she needs to know whether AG is a refused refugee or still in the asylum process? I say that his status has not yet been determined. She accepts this and we are free to leave the desk.

I accompany AG to the waiting area. A doctor shows up to call him in. I say goodbye and leave the hospital.

Outside, I feel relieved and upset at the same time. Many questions arise: What does it mean to AG having to hand over a bunch of personal documents to me and letting me take the lead in such seemingly easy a task as registering in a hospital? Why does he have no insurance card even though he has insurance? And how did he obtain this insurance? Does he face similar difficulties when trying to register for other healthcare services? How does he pay for this insurance? Is he eligible for state subsidies for his insurance, just like low-income Swiss citizens? Why is the Contact Point listed as his address for correspondence? Why did the

receptionist react so emotionally to the missing insurance card and residential address? And why did my reactions match hers in emotionality? I also wonder how his appointment with the doctor might be going.

More questions surface: Do other undocumented migrants face similar situations? Indeed, might some of them not have insurance? What happens then? If they do not know about the Contact Point, do they go to the emergency department?

It is these and more questions that the present study attempts to answer. In this following section, I will outline the background and clarify the research question, before turning to methods of data collection and analysis in section 3. Sections 4 through 6 will analyse the empirical findings of the work, while the concluding section 7 contains a summary of my findings.

Background and Research Question

This study concentrates on so-called undocumented migrants. Lacking the legal entitlements to stay in a country, these are people who are

formally excluded, but physically present within the state's territory.
(Karlsen 2016:136)

Thus, the definition includes visa-overstayers, persons who crossed the border without legal entitlement to do so, as well as rejected asylum seekers (Kotsioni 2016:37). In Switzerland, former so-called 'saisonniers' (see Bilger et al. 2011) also form an important group of undocumented migrants (on Swiss migration politics see: Bilger et al. 2011; Piguet 2013).

Despite obvious difficulties when it comes to counting undocumented migrants, there are some estimates. Worldwide, the International Organization for Migration (IOM) estimates that in 2010 about 10-15% of the then 214 million international migrants were undocumented (IOM 2010). For Europe in 2012, the OECD estimates the share of undocumented migrants at 10-15% of the then 56 million migrants (OECD 2012). Concerning Switzerland, estimates range from 76'000 (Morlok et al. 2015) to 90'000 persons (Longchamp 2005) in studies commissioned by the state, and on the side of activists increase to up to 300'000 (Efonayi-Mäder et al. 2010).

It is though important to keep in mind that being undocumented is not a personal characteristic but a social construct. As Bloch et al. outline, it is

the interplay between restructured labour markets and increasingly complex migration controls and categories [that] created the interstices within which undocumented migrants found space. (2014: 17)

Being undocumented is thus not a property of an individual but a category constructed by a legal framework (see also Zimmermann 2011; Castaneda et al. 2015: 383; Karlsen 2016). Furthermore, it is important to note that being undocumented is not a fixed state, but rather, as Bloch et al. also observe, it "is a process" (2014:26). This means firstly that someone's status can change from legal to undocumented and back again, with accompanying grey areas and unclear transition zones. Secondly, to see being undocumented as a process means to focus on the enactment of the legal status. It shifts the attention on how being undocumented affects people's daily life. The empirical part of this study will both rely on and show the dynamic nature of the migrants' legal status.

Turning now to research about the healthcare to undocumented migrants in the global north as well as their health, several areas can be delimited, namely policy research, health services research, and research about health and its determinants. In my discussion of each of these areas of interest, I will always start with the international perspective. Then, I will explore in how far the focus has been applied to the situation in Switzerland, thus fleshing out what is already known, while also highlighting the gaps in research.

Policy Research

Analysing different countries' laws about access to healthcare, Björngren-Cuadra (2012) identifies countries granting undocumented migrants less than minimum access to healthcare (eg. Finland, Ireland, Sweden), others granting minimum rights, meaning access to emergency care (eg. Germany, Denmark, UK), and a third category granting access beyond emergency care (eg. Italy, Portugal, Spain, France). As Hacker et al. (2015) outline in a review, limiting access to insurance is a common policy barrier, described in three quarters of the reviewed research.

The Platform for International Cooperation on Undocumented Migrants PICUM gives details about laws regulating undocumented migrants' access to healthcare in eleven European countries (PICUM 2007). The authors divide the countries in five categories, ranging from those where "all care is provided only on a payment basis" such as is the case in Austria, to those toying with the idea of "free access to health care to all, including undocumented migrants" (PICUM 2007:8), as is proposed by Spain. Between the two extremes lie countries proposing free access in only limited cases (e.g. Hungary and Germany), and countries offering a somewhat a broader coverage (e.g. the UK). Furthermore, some countries, as for instance France, have put up a parallel administrative and payment system specifically for undocumented migrants (PICUM 2007:8).

In their discussion of the situation in the Netherlands, Sweden, and Denmark, Biswas et al. (2012) show discrepancies between international and national law. While all three countries

have ratified international human rights law, there appear to be important differences in the national laws regulating access to healthcare for undocumented migrants.

Concerning Switzerland, general descriptions of the healthcare system (Rossini & Legrand-Germanier 2010) inform us that health care is organized via an obligatory health insurance for all persons residing in the country for more than three months. The insurance is provided by private companies, which are legally obliged to offer it on a not-for-profit basis. A basic insurance scheme covers primary and secondary care, pre- and postnatal care, reproductive care, psychotherapy if prescribed by a general practitioner, prevention and rehabilitation. Dental care is not covered.

Premiums for this basic insurance scheme differ regionally and depend on exact insurance model. Models where the free choice of doctors is limited, for example, are available at reduced prices. Also, the insured person has to select an annual excess ranging from 300 to 2'500 Swiss francs. A higher excess results in a cheaper premium. On top of the excess, a deductible of 10% of the treatment costs, up to a maximum of 700 Swiss francs is paid out of pocket. Persons in modest financial situations can apply for premium subsidies from the state, the amount of which again varying depending on the region (see section 4 for a concrete example). As Bilger et al. (2011) expand, persons without insurance are still entitled to "assistance when in need" (Art. 12 BV). Whether this encompasses more than aid in life threatening situations is subject to debate.

According to current interpretations, undocumented migrants in Switzerland can and must take out insurance, because they reside in the country (Art. 23-26 ZGB; Art. 1 al. 1 KVV; Art. 13 ATSG). In 2002, the Federal Social Insurance Office issued an order which threatened insurance companies that refused to accept undocumented migrants with sanctions (Federal Social Insurance Office 2002). As consequence of the duty and right to take out insurance, Rüefli & Hügli state as a goal:

For all undocumented migrants, (...) who are legally obliged to have health insurance, to have taken out insurance and to have the same access to care providers and medical services within the scope of basic health provision, as insured people with legal residence. (2011:19)¹

On a policy level, Switzerland would thus seem to be one of the countries granting access to healthcare beyond the minimum of emergency care.

¹ Any quotes from literature not originally in English, will be given in the original language in the footnotes. Here: Alle versicherungspflichtigen Sans Papiers (...) sind krankenversichert und haben denselben Zugang zu denselben Leistungserbringern und Leistungen des medizinischen Grundleistungskatalogs wie versicherte Personen mit legalem Aufenthalt.

Health Services Research

Focusing on the actual delivery of care, Woodward et al. (2013) highlight the difficulties with access. Their scoping review shows that even though in many cases a legal entitlement to care may be given, this does "not correspond with access to care" (Woodward et al. 2013:826). This insight is confirmed by Dauvin (2012), who conducted interviews with healthcare professionals in 16 European countries. Notwithstanding various legal situations, the professionals reported similar difficulties. Access to care was complicated because of unclear legal entitlement, lack of finances, or communication difficulties.

Hacker et al. (2015) relate barriers to healthcare for undocumented migrants on the side of the healthcare system to external resource constraints but also to discrimination and high bureaucratic requirements. On the patients' side, undocumented migrants avoid seeking care because of communication problems, financial restrictions, or out of fear of deportation. As Strassmayr et al. (2012) show, access to mental health resources is a particularly critical issue.

Some qualitative studies in the area of services research take into account both the patients' and the professionals' perspectives about access to and use of healthcare services. Poduval et al. (2015), for instance, analyse patients' and professionals' experiences collected in interviews conducted at a Doctors of the World surgery in London. They report that undocumented migrants are insufficiently aware of their rights. For example, they do not know that they are allowed to register with a general practitioner's office. As a result, undocumented migrants tend to prefer emergency departments. Biswas et al. (2011) apply a similar study design in Denmark. They illustrate barriers to healthcare, but also highlight strategies employed by patients and professionals to overcome them. Receiving help from Danish citizens proves to be a central strategy. Huschke's study (2014) about the situation in Berlin also takes patients' and professionals' points of view into account. She highlights how undocumented migrants frequently need special knowledge, provided by informal networks, to access healthcare.

Concerning Switzerland, Altenburg (2012) shows that there are 14 service providers delivering care to undocumented migrants in the country. Most of the providers are NGOs and charitable institutions. Bilger et al. (2011) and Weiss (2015) confirm this observation. Thus it seems likely that a discrepancy can be observed between the legal entitlement to insurance and care through the mainstream system and the actual delivery of healthcare services to undocumented migrants through NGOs and charities. Turning their attention to one specific condition, pregnancy care and prevention, Wolff & Epiney (2008) show that in Geneva undocumented migrants have less access to such services than legal residents.

As reasons for this discrepancy, and similarly to Hacker et al. (2015), Bilger et al. (2011) reported health care professionals asserting that undocumented migrants lack trust in health service organizations and experience difficulties paying for healthcare and/or insurance. Weidtmann (2015) concentrates on barriers to taking out insurance and interviews employees of NGOs and social services, and also two undocumented migrants. She identifies financial and administrative hurdles as the main barriers to taking out insurance. These difficulties are further exacerbated by problems with language, lacking knowledge about the system, and fear on the patients' side.

Qualitative studies with a more encompassing scope, like those by Poduval et al. (2015), Biswas et al. (2011) or Huschke (2014) are missing for Switzerland. As a result, there is no insight as to how the practices of the various players (patients, insurers, medical professionals, administrative staff) interact and result in a (non)delivery of healthcare to undocumented migrants. As Achermann et al. state, in the area of "Migration, Precarity, and Health", there is a need for

research focusing on the treatment of migrants with particular emphasis on the interplay between the various providers of care. (2006:202)²

Undocumented Migrants' Health and its Determinants

A third stream of research focuses on undocumented migrants' health and has drawn attention to undocumented migration as a social determinant of health (Castaneda et al. 2015). Going beyond the discussion of the healthy migrant paradox, this literature shows that being undocumented presents a particular risk. In their 2013 scoping review, Woodward et al. found that undocumented migrants' physical and especially mental health deteriorates after arriving in the host country. In a systematic review, Martinez et al. (2015) identify 30 quantitative and qualitative studies and policy analyses drawing links between anti-immigration policies, barriers to access, and health status. Especially mental health proves to be affected. Kuehne et al. (2015) confirm this insight with a study measuring subjective perception of health in undocumented migrants, which proves to be significantly worse compared to a sample of legal residents in Germany.

Studies originating from medical anthropological research also offer evidence on the link between legal status, access to healthcare, and health. Studying the case of Israel, Fleischmann (2015) distinguishes two kinds of barriers to access to healthcare which in turn appear to function as determinants for health for undocumented migrants. On the one hand, there are barriers directly linked to the migrants' undocumented status, like fear of deportation. On the other hand, there are barriers that are "common among low-income

² Forschung im Bereich 'Migration, Prekarität und Gesundheit' zum Umgang mit betroffenen MigrantInnen, wobei das Zusammenspiel von verschiedenen leistungserbringenden Akteuren besonders beachtet werden sollte" (Achermann et al. 2006:202)

communities but exacerbated" (Fleischmann 2015:89) by the undocumented status, like language barriers. In a similar approach, Laranché (2012) analyses the effects of being undocumented on access to healthcare from the perspective of professionals and patients. She shows how social stigmatization, precarious living conditions, fear and suspicion, which are all directly linked to immigration policies, prevent undocumented migrants from accessing healthcare.

For Switzerland, there exist only some studies investigating specific health issues of undocumented migrants. Thus, Bodenmann et al. (2009) show that out of 125 screened undocumented migrants, 19.2% had a latent tuberculosis infection. Sebo et al. (2011) examine sexual and reproductive health behaviour of mainly young women and assert low use of contraceptives and correspondingly high rates of unplanned pregnancies. Qualitative studies about the health of undocumented migrants and how it is linked to their legal status are widely lacking. An exception is presented by the 2006 study by Achermann et al., which investigates the health, health risks, and health strategies of undocumented migrants and temporarily admitted asylum seekers. Focussing on strategies of self-care, prevention and health promotion, they classify health behaviours of their interviewees along a behavioral scale.

Towards the Research Question: Access Versus Inclusion and Exclusion

On an international level, the question of health and healthcare for undocumented migrants has increasingly been tackled with qualitative research (see also the special issue of *Social Science and Medicine* Nr. 74 2012). Research frameworks that take into account both patients' and professionals' points of view draw a rich picture of the situation. In such frameworks, links between legal status, access to healthcare and health status can be described. For Switzerland, a void concerning such research becomes apparent.

A research question aiming to fill this research void would have to address patients' and professionals' view about healthcare for undocumented migrants. It would thus need to be a question that is answerable within a qualitative framework, using stories as they are told by the actors. Consequently, in order to re-tell stories, the research question would need to be suited to a processual approach. As a result, the question could then be connected to Bloch et al.'s (2014) idea of seeing being undocumented as a process and not a state. Even more, such an approach would also allow us to posit that there are processes of 'obtaining' as well as of 'unobtaining' healthcare.

The concept of access, even if widely used in the medical literature, is not very suitable for such an approach. In the above mentioned studies, access is used in a rather broad and

unspecific way, sometimes focusing on rights and systemic arrangements for access (PICUM 2007; Biffi et al. 2012; Björngren-Cuadra 2012; Biswas et al. 2012), at other times concentrating on concrete administrative aspects (Poduval 2012), or the actual use of healthcare services (Fleischmann 2015), while sometimes addressing and linking several of these aspects (Laranché 2012). In a theoretical paper, Levesque et al. (2013) expand the concept of access to its extreme, using it to encompass the entire process starting from the moment when a health care need is identified, on to what happens along the path to reaching a healthcare provider, and even including the outcome of healthcare interventions. Though this brings them close to a processual approach, the authors overstretch the definition they have chosen to use, describing access as

a way of approaching, reaching or entering a place, as the right or opportunity to reach, use or visit. (Levesque et al. 2013 citing the Canadian Oxford Dictionary)

Access is thus a term that might underestimate the complexity of obtaining health care while getting to the limits of its meaning. And this might be even more the case for undocumented migrants. For instance, Levesque et al. (2013) do not take into account administrative issues as being part of access, though this could, as we have already seen in the introduction to this work, be an important aspect.

Furthermore, the concept of access lacks a suitable counterpart, expressing that once access is achieved, it can also be undone again. Talking about barriers gives the impression that once they are overcome, one has accessed health care on safe grounds. Recently, some criticism about the concept stipulates that it would make more sense to talk about "healthcare pathways" than about access as a "one-off event" (Hanenssger & Proochista 2017).

A framework that is better suited to analyse the complex processes concerning healthcare for undocumented migrants is the sociological dyad of inclusion and exclusion. As Stichweh (2007) shows, there are three different research traditions in sociology relating to this dyad. In France, the discussion dates back to Durkheim and addresses questions of social cohesion. It has widely entered public debate, engaging authors like Foucault and Bourdieu. The British theory of the welfare state operates with the concept since about 1960 when Thomas Humphrey Marshall introduced it. In a German context, the concept is related to Luhmann's system theory (Luhmann 1991), which, in turn, is critically engaging with Talcott Parsons's sociological work. Stichweh continues this tradition and asserts that

the two terms, inclusion and exclusion, designate the way in which social

systems relate to persons in their environment. (2007:2)³

In this framework, social systems are conceptualized as created, stabilized and changed by communication. The approach is constructivist in the sense that communication, as the reality of social systems, is created through communication itself.

A person is included into communication insofar as he or she is more or less addressed by the communication making up the system (Luhmann 1997:620). Inclusion is thus to be differentiated from concepts like integration. Inclusion is about a "connection to contexts of communication" and not about the "integration of people through shared norms and values" (Nassehi & Nollmann 1997:394).⁴

The systems theoretical approach further distinguishes between interaction, organization, and functional systems as main types of social systems. Interactions can be framed by organizations and/or by functional systems. In our case, we will deal with inclusion into organizations like the Contact Point, an insurance company, a hospital or similar. In order to be included in organizations, specific types of communication are necessary. A hospital might, for example, set up an interaction between an administrative employee and a potential patient. Further, within organizations, instances of communication might occur that relate to various functional systems. The payment of an insurance is an instance of communication belonging to the economic system. A patient's interaction with a nurse, in turn, is an instance of communication situated in the healthcare system (Luhmann 1991; 1997).

This approach also allows us to take a closer look at the "links between different forms of inclusion" (Bommes & Tacke 2001:63).⁵ We might, for example, ask how inclusion into insurance connects with inclusion or exclusion into a hospital.

Adding to this, inclusion and exclusion are not seen as fixed states, but are seen as being created and uncreated at every moment of communication where a specific person is either addressed or not. As Stichweh notes:

First and foremost, we must emphasize that inclusion and exclusion are characterized as events. They are executed as operations. (2007:3)⁶

The dyad of inclusion and exclusion thus allows us to formulate an open and process-oriented research question:

How are undocumented migrants included into and excluded from communication related to healthcare?

³ Mit den beiden Begriffen Inklusion und Exklusion [wird] die Art und Weise bezeichnet, in der Sozialsysteme sich auf ihre personale Umwelt beziehen.

⁴ "Anbindung (...) an Kommunikationszusammenhänge" und nicht etwa um eine "Integration von Menschen durch geteilte Normen und Werte"

⁵ Zusammenhänge zwischen verschiedenen Inklusionsformen zu stellen

⁶ Es ist zunächst der Ereignischarakter von Inklusion und Exklusion und damit zugleich der operative Vollzug von Inklusionen und Exklusionen zu betonen.

Four more detailed questions follow. In accordance with the principles of grounded theory, they were developed while the data was gathered and also take into account some of the insights gleaned from the theoretical discussions above. They are:

1. What moments of including or excluding communication are described by patients and professionals?
2. Which preconditions for and consequences of moments of inclusion or exclusion are mentioned by patients and professionals?
3. What are the aspects in relation to which patients and professionals describe inclusion or exclusion?
4. What qualities/values do patients and professionals ascribe to inclusion or exclusion?

The first question allows us to reconstruct the actors' stories of inclusion and exclusion.

The second question enables us to analyse interdependencies between inclusion and exclusion in different organizations and/or functional systems. Insofar it allows us to pick up on the idea that someone's legal status influences their healthcare and health.

The third question helps identify which broader realms of society and communication actors refer to when talking about inclusion. Here, we can for example take into account the literature discussing the financial aspects of access.

The final question allows us to identify qualities/values relevant to the actors when it comes to inclusion and exclusion and thus to characterize in detail the communications which include or exclude undocumented migrants from communication related to healthcare.

3. Methodology and Methods

Data Collection

This research was conducted using grounded theory methodology (Glaser & Strauss 2006 [1967]; Corbin & Strauss 1990). The approach ties in well with constructivist sociological frameworks of communication, as it aims to reconstruct actors' experiences. Grounded theory makes it possible to form middle-range theories out of the empirical material. These theories can be about formal or about substantive aspects (Glaser & Strauss 2006 [1967]:79ff). While the substantive aspect of the present work is the theme of healthcare for undocumented migrants, the dyad of inclusion and exclusion makes up its formal part.

The method used to access the field and become familiar with the situation was participant observation through volunteering at the Contact Point. The volunteering was comprised of translation, child minding, teaching German courses and accompanying patients to health care facilities.

The Contact Point takes care of about 130 patients per year. According to the estimated

number of undocumented migrants in the area, this would mean that the Contact Point sees 2%-4% of the population yearly. About one third of the patients only come to the Contact Point once. Another third attends it episodically, and the remaining third visit it regularly. At this NGO, one nurse, WM who we already encountered in the introduction, is employed as head and carries out operational work together with a second employed nurse (NU). All other professionals related to the facility are volunteers and we will encounter them while re-telling undocumented migrant's stories.

The Contact Point offers drop in consultation hours as well as consultations on appointment. Still, it is not thought to be a doctor's office, as a volunteering general practitioner says:

Well, you see, there are many things we can't offer. I mean, we now have an ECG. But we have no spirometer, we can't fully examine people's hearing and so on. We don't have our own lab. We're only open three half days a week. I don't really give injections, we don't really have the equipment. (RF)

Partly, the scarce staffing and equipment of the Contact Point is due to financial restrictions. On the other hand, the sparseness is on purpose, as the goal of the Contact Point is to serve as a point of "triage into regular care" (WM). Echoing the goal stated by Hügli & Rüefli (2011) to include all undocumented migrants into healthcare via insurance, WM's statement makes reference to the idea of "integrational inclusion" (Stichweh 2007:8). That would mean not separating the healthcare of legal residents and undocumented migrants, but bringing all patients together into the same system.

Non-structured interviews (Spradley 1979) of patients and health-care professionals comprised the main method for data collection.

All patients interviewed were accessed via the one Contact Point. This results in a significant bias, excluding undocumented migrants who might not know about or not need the Contact Point. Furthermore, selection of interviewees was partly dependent on choices made by the Contact Point's personnel (Fleischmann et al. 2015 state similar limitations). Finally, patients who might have had negative experiences with the Contact Point, causing them not to attend it any more, could not be accessed.

Eight patients were interviewed. Age ranged between early twenties and late forties, a span common for the population accessing Swiss Contact Points in general (Bilger et al. 2011:43). Interviews were conducted in German, French and English. This selection was due to language constraints of the interviewer. In some cases, it was the interviewer, in others the patient, and still in others both who spoke in a language other than their mother tongue. For the present work, all statements have been translated into English by the author. Certainly, some linguistic nuances are thus lost. Interviews lasted from 20 to 90 minutes. As an introductory question, patients were asked to talk about how they came to the country and

how things went from then on with their health and healthcare.

Professionals were accessed via the Contact Point but also by snowballing and directly taking up contact. Ten professionals were interviewed, with discussions lasting between 30 and 90 minutes. Two interviewees are employed by the Contact Point, four are volunteers related to the Contact Point, two work at a public hospital, one is an insurance employee and one an employee of an NGO caring for HIV positive undocumented migrants. The introductory question for professionals was about how they came to be engaged in work with undocumented migrants and about their experiences with this work so far.

All interviews were transcribed.

The study procedure was not subjected to an extended ethical approval process.

Data Analysis

The patient interviews were the first point of focus for data analysis. Following the conceptualization of being undocumented as a process (see section 1) each of these eight interviews was analyzed in respect of what the interviewees recounted as their core moment or turning point of inclusion into health care. Moments marked with this qualification are moments which patients described spontaneously and in a detailed, animated manner, recalling incidents that helped them to address their health issues, in what they themselves defined as a good and satisfactory way.

Collating interviews, which showed similarity in the core moment of inclusion informed the chapter structure of the subsequent data analysis. One moment related as the most important by one patient, concerns her progress with Settling In (section 4): putting down roots, getting in touch with the local diaspora and finding work are important preconditions in order to be able to live a healthy life and to at least tackle minor health issues. Another recurring core moment for inclusion from four of the interviewees is obtaining healthcare at The Contact Point and its Network (section 5). For the three remaining patients interviewed, Taking out Insurance (chapter 6) was their core moment of inclusion.

It is nonetheless important to note, that the core moments of inclusion mentioned above occur at different time-points in the patients' stories.

Notably, some of the undocumented migrants interviewed have experienced periods of complete exclusion from health care or gone without treatment of specific conditions before reaching their core moment of inclusion. Thus, these moments are told as turning points after periods of struggle, some lasting months, others years, of coping with health issues more or less on their own.

On the other hand, some of the patients identify difficulties as remaining even after having had their most important moment of inclusion.

The longer and more difficult the time before a core moment and the greater the remaining difficulties, the more complex and involved the stories become. The order of the stories within the chapters has been chosen by taking this growing complexity of trajectories into account. Thus, with every story, more difficulties with inclusion to care and more moments of exclusion, but also the strategies for inclusion will appear.

However, inclusion or exclusion are social relations. It is thus not only the undocumented migrants that try to obtain health care, it is also the health care professionals embedded in their roles, organizations and rules that form part of inclusion or exclusion. The point of view of the professionals is important, in order to understand and contextualize undocumented migrants' stories, struggles and successes in tending to their health and healthcare needs. Thus, every time an undocumented migrant's story needs this kind of context in order to be understood, the statements of professionals are brought in.

Moments of inclusion or exclusion were subsequently analyzed according to the three further questions detailing the general research question. Thus, moments of inclusion or exclusion were contextualized with their preconditions and consequences, categorized according to aspects and qualities that analysis fleshed out.

4. Settling In

In this chapter, we will encounter the case of an undocumented migrant whose core moment for inclusion into health care was to settle in. Here we encounter a situation that also tells us much about the preconditions needed for inclusion into healthcare.

Concerning the question as to how common an experience like the one outlined below is, it can be said that, as we have already seen, in a year, about 2%-4% of the total population of the area attend the Contact Point. To this point, there certainly are undocumented migrants in the area who are in rather good health and never attend the Contact Point, maybe knowing, maybe not knowing of its existence. Thus, we can assume that the story in this chapter is shared by some other rather young and healthy undocumented migrants, who, as the Head of the Contact Point confirms, make up an important portion of the population. Over time though, more undocumented migrants might attend Contact Points. Indeed, Achermann et al. (2006:147) state for their study, that out of 18 undocumented migrants, only 6 had never seen a doctor, those mostly being cases who had only been undocumented for a short time.

And as in the case of ZL, it is estimated that most (Bilger et al. 2011:51), meaning around 80%-90% of undocumented migrants are uninsured (Rüefli & Hügli 2011:24). Explaining this brings us a closer look at undocumented migrants' economic and legal situations (see also Achermann et al. 2006), which is an important element of this chapter.

In reference to the economic situation, the head of the Contact Point estimates that an undocumented migrant in the region in question might be able to earn around 800 to 1500 Swiss francs a month, while some may have no income whatsoever. She therefore broadly confirms those authors who estimate undocumented migrants' salaries in various Swiss regions as lying between 600 and 2000 Swiss francs (Chiementi et al. 2003:38; Valli 2003:34; Anlaufstelle für Sans-Papiers 2004: 11; Achermann et al. 2006:113).

In order to contextualise the affordability of health insurance on such an income, we can create an example of a person living in Zurich. Heading for www.comparis.ch, a website that offers comparison of insurances, and looking for basic insurance including accident cover for a 27 year old woman, while going for the cheapest policy with a health maintenance organization and choosing the lowest annual excess of 300 Swiss francs. The cheapest insurance amounts to CHF 395.90 per month (as on 16th march 2017) This constitutes roughly 25% to 50% of an undocumented migrant's monthly income. Furthermore, in case of care needed, 10% of costs, up to 700 Swiss francs, the so-called deductible, have to be paid out of pocket.

Looking at premium subsidies, persons living in reduced economic circumstances may have access to these in Switzerland. Momentarily leave aside the question of how and whether such subsidies are obtainable for undocumented migrants (see Rüefli & Hügli 2011:30ff), as of 2017 a 27 year old woman in Zürich can claim a maximum subsidy of CHF 1'644 Swiss Francs per annum (Sozialversicherungsanstalt des Kantons Zürich 2017). This would mean a monthly premium of CHF 258.9 CHF, which would still constitute 17% to 32% of the monthly income.

By comparison, as the 2016 SGB report shows, Swiss citizens without children and a monthly gross income of CHF 2500 to 5000 Swiss francs spend 8% to 11% of it on health insurance (Lampart et al. 2016). The goal set by the revision of the insurance law was to freeze the spending proportion at 8% (Lampart et al. 2015). Of course, these limits apply to persons otherwise included in basic legal and social security schemes like employment contracts which include paragraphs on sick pay or notice periods, on unemployment insurance, maternity insurance and the like.

To choose an annual excess of 2500 Swiss francs is too great a risk for an undocumented migrant. A patient would have to put aside 2500 Swiss francs on top of 700 Swiss francs deductible, so at least two, at worst four months' salary. In case of non-payment, the patient incurs the risk of being exposed as undocumented.

Another aspect prevents undocumented migrants from taking out insurance: Any contact whatsoever with an organization which might be related to the state, is avoided. Consequently, it is very improbable for undocumented migrants to even to give their address to an insurance company. Furthermore, a person who so far does not have any health insurance in Switzerland, has to provide proof of residence, which is usually handed out by the municipality. An undocumented migrant lacks this proof. And as an insurance employee interviewed states:

A normal administrator just looks at the dossier, is it complete (...) and is there a confirmation of registration from the municipality. If not, he checks with the municipality. (SO)

In most cases, if clients simply forget to enclose the confirmation, or do not have it yet, this violation of data protection rules (KVG 84ff; see also Hügeli & Rüfli 2011:32) has no negative consequences. In the case of undocumented migrants, it can lead to deportation. In addition, a bank account is needed in order to organize financial transactions concerning the insurance. But to open a bank account, one needs a proof of residency in Switzerland.

In terms of health care, this is how, in ZL's story, the Contact Point enters into the picture. This introduces us to the head of the Contact Point (WM) as well as a general physician (RF), a gynaecologist (HU), and another general physician with a specialization in ultrasound, volunteering at the Contact Point.

ZL - "Now, it's just fine"

The interview with ZL takes place spontaneously, as she attends the Contact Point on a drop in morning. ZL is in her twenties and has been living as an undocumented migrant in Switzerland for about four years now. Asked about her health, she says, about her first two years in Switzerland:

Just for me it was a bit terrible and I missed my family a lot and also my daughter and then I cried a lot, almost every day. (ZL)

We will encounter the difficulty of leaving one's family behind in other patient's stories. Here, at the very beginning of ZL's story, we encounter the idea that there might be specific conditions in the life of undocumented migrants that may bring out specific health issues. The head of the Contact Point states that many undocumented migrant's health problems are related to bad living and housing conditions, bad jobs, fear of being caught, missing their family and dependency on the goodwill of others for otherwise most common necessities. But immediately in the interview, WM contrasts these difficulties with the cleverness, good

language skills and independence of some undocumented migrants and refers to them as "survival artists" (WM). Similarly, the general practitioner volunteering at the Contact Point attests to his patients "virtuosity" (RF) in handling their daily lives. And also ZL states, just after talking about how she had cried almost every day: "And yes, now it's just fine" (ZL).

In these statements we can see, that it is important for both caregivers and patients to see undocumented migrants not purely as victims, at the mercy of circumstance, but also as active agents, able to control their own lives. We will see on several occasions later on that the question of doing things and more importantly achieving inclusion into healthcare oneself, rather than having to refer to and depend on others, is important for undocumented migrants. But then, what made things "fine" for ZL after two years of struggle? How did she overcome the pain of leaving her family and especially her daughter behind? She says:

And then I got to know other women here and, yes, this woman helped me so much. With work and so on. [MJ: other women from your home country?] Yes yes. I know two three women. But now they have become good friends of mine (laughs). And these women also work here. And I also work a bit more as a cleaner and sometimes I mind children. (ZL)

We can see in this statement that getting in touch with the local diaspora and getting to work are decisive here for a 'fine' life. Indeed, ZL migrated together with another woman from her country. This and other contacts to compatriots gave her the opportunity to find work. Adding to that, ZL learned one of the national languages.

By working, ZL also has the ability to support her daughter back at home. It thus helps her to address the pressures that come along with her status as an undocumented migrant. As we will see, to be able to support those 'back home' is also an important point for other undocumented migrants. Inclusion into health care often does not concern only a single individual. For ZL for instance, her inclusion into health care is also about caring for those who stayed home.

For ZL, the Contact Point is a place that "I can come to when I have something" (ZL) and thus helps her to create conditions for a healthy living and gives her stability. It was one of her friends who told her about it. At first, she did not attend it as she did not see any need. Then, her friend told her it would be good to have a gynaecological check-up and she dropped in for the first time, her friend translating. On the day of the interview, it is her third visit. She is here for a cough and also for her ear, in which she has been experiencing hearing loss for several years and now it is aching and oozes liquid. For the examination of the ear she will be sent to the Contact Point's network, which we will encounter later on in detail. To her, inclusion into health care is to know that, should she have some more serious issues, she has a place to go to.

Turning now to a closer look at the professional's point of view concerning the routine

gynaecological check-ups, the gynaecologist volunteering at the Access Point states:

Here I don't notice much about their background, except that there's sometimes a language problem. Other than that it's like it was when I was working as a gynaecologist in [a Swiss hospital]. (HU)

For him and the ultrasound expert, concerning the patients that they have seen so far, they state that they would not have been able to tell an undocumented migrant from a citizen.

Knowing that the Contact Point exists, and more importantly, to have a few friends and some work – all these elements allow ZL to reach and maintain good health.

An important element in this is that she can help her daughter and thus address a problem that comes up with her undocumented status. Inclusion into health care for herself means also to be able to care for those left behind. Health and inclusion into health care are thus embedded into and dependent on social relations.

ZL has made herself a situation. She found a place from which to orientate and thus can be an active agent of her own health. This autonomy contributes to her wellbeing.

We see also that from a professional perspective, including undocumented migrants into health care can be quite unproblematic and does not necessarily require specific skills.

5. The Contact Point and its Network

In this section, we look at patients who, unlike ZL, have encountered more serious health issues and for whom the Contact Point and its network have proved to be vital for their inclusion into healthcare.

As we have seen, about a third of the patients attend the Contact Point regularly and another third use the service sporadically. While BS probably tends to belong to the latter category, GL, KF and TG are long term regular patients. During part of their stay in Switzerland, these three patients have also experienced periods of partial or total exclusion from health care. Thus, their experiences during these periods may well reflect those of patients who have some health issues, but do not know about the Contact Point.

Again, a very important actor for inclusion into health care, insurance, is not present in these patients' stories. In the case of BS, the health care needed is not covered by insurance. Furthermore, her story reveals emergency services as another potential point of inclusion that remains unused. BS's statements will be complemented by the perspectives of an administrative employee (BH) and a doctor (AM) working at a public hospital's emergency service. BS's story will further reveal her and the Contact Point's interactions with professionals of the Contact Point's network. For GL and TG, insurance is a background

issue. They have insurance because others have taken on the complete administrative and financial burden of obtaining it for them. Again, the Contact Point and its network are their most important points of reference. TG's story highlights, for the first time, the role of the Contact Point when it comes to taking out insurance for a patient. We will also see what this process involves from the perspective of an insurance employee (SO), thus adding to the analysis of Rüefli & Hügli (2011) who only give a brief overview of the situation. Furthermore, through the perspective of LI, a diabetes counsellor of the Contact Point's network, TG's story will show more closely how the professionals of the Contact Point's network contribute to inclusion. Finally, for KF it is the care at the Contact Point and in its network that proved to be her most important moment of inclusion, insurance being financially out of reach.

As the Contact Point and its network are the core professional actors in this chapter, it is important to note that, as WM puts it, the Contact Point is positioned in a "relationship of dependency" (WM) to the professionals in its network. Indeed, they often work extra hours, spontaneously and for reduced pay. It is not easy to build up such a network and specific motivations from professionals are needed. For example, the general practitioner volunteering at the Contact Point states that he has often worked with socially vulnerable patients. The gynaecologist and the ultrasound-expert whom we met in ZL's story, have both worked in hospitals in so-called developing countries. The head of the Contact Point describes the work with the network as time-consuming. She always needs to arrange

very binding deals, but with individuals. Because, we don't really have any [formal] agreements. (WM)

This is echoed by the other nurse working at the Contact Point:

We're always dependent on there being people with a good heart, or that someone feels, yes, we really must help these people. (NU)

BS - "they always find a solution"

BS is a woman in her thirties, who has been living in Switzerland for about four years. Concerning health matters, her situation was initially quite comparable to that of ZL. Echoing statements from the previous chapter, BS initially portrays her life as an "adventure" (BS). Interestingly, a few moments later in the interview, she starts to muse that God keeps undocumented migrants healthy because they "already have to bear all the weight of the adventure" (BS). Her adventure should thus not be misunderstood as a purely hedonistic undertaking. The "weight" is always present and, as with ZL, causes physical and mental symptoms:

So if one has, (...) a headache, perhaps because from time to time one is in a state of depression when thinking about the family. (...) Because I spent the whole night thinking, thinking about my people, thinking about my family. (BS)

Again similar to ZL, BS gets to know about the Contact Point early when she arrives in Switzerland through the local diaspora. The community also provides her with housing and some child minding jobs. As she says:

Some people already know how to get things done, as we are in an irregular situation and then also we don't have any work so we can't take out any health insurance. So this way we are informed. (BS)

BS gets registered at the Contact Point with her age, name and birthdate. A short while after, she gets a toothache to the point where she feels that she needs treatment:

I needed to be given care immediately. Because there were already infections. (BS)

She decides to call WM. In the following, BS describes in great detail, with precise naming of days and hours, how WM organizes a same day after-hours appointment at a dentist's, accompanies her there as she does not know the city yet and assures translation. WM then sets up an urgent appointment for BS with a surgeon at the dental surgery the next morning at 7am. For BS this unbureaucratic and quick aid and treatment is a core moment of inclusion. This is confirmed at the end of the interview when, asked what she would like to add, she says:

That in Switzerland er, at the Contact Point there are wonderful people who don't defer until tomorrow the things they can do today. Because it was an emergency. So, they always find a solution when facing an emergency. (BS)

This moment is the starting point of a longer treatment of BS's teeth in the Contact Point's dentistry network, inclusion thus gaining stability. As the patient herself explains, the surgeon, showing professional interest, found out that she has a tendency to lose teeth easily. Further, there seemed to be some teeth that had grown in wrong, due to a specific morphology of her jaw. After having several teeth removed by the surgeon and consequently losing her ability to masticate food correctly, she needs an implant. The head of the Contact Point, having obtained the radiography showing her state after surgery, organizes a series of appointments with another dentist recommended by the surgeon. Asked more closely about these appointments, BS says they were all set up by the head of the Contact Point. However, she stresses having gone there "on my own and they would tell her what had been done" (BS). Again, BS stresses the importance of the professional's interest:

In the beginning (...) it was a bit difficult. Because when she saw the state

of my mouth (...) 'Why is it like this? What can we do?' But knowing her profession, she found a solution. And for her, it was also a challenge. (BS)

To have seen BS's morphology as a challenge and a possibility to stretch one's professional practice seems to play an important part for a lasting inclusion in BS' view. She reports that her face's shape changed during treatments and she had some issues accepting it, but states that she is very happy with it now. She still visits the dentist who did the implants for check-ups.

Turning now to the professional's point of view, one of the first questions that comes to mind is why BS never considered attending an emergency unit despite having such urgent problems with her teeth. Her response:

Well, the first thing they ask for is your identity card and you don't have any documents on you. (BS)

According to the interviewed hospital staff, BS's fear of being asked for an identity document is groundless. The administrative employee says: "We couldn't care less about the legal status" (BH). The doctor agrees:

I don't really get notice of it [whether a patient is an undocumented migrant]. Most of all, I don't know (...) what an undocumented migrant looks like, right. (...) We are not trained for that, and (...) I mean, it wouldn't change anything. (AM)

Still, it seems BS is lacking this knowledge. The fear of being exposed and subsequently deported when attending emergency care becomes clear, when she tells of an acquaintance who had an ectopic pregnancy. The undocumented migrants around her brought her to a hospital at the last minute, when she was already having convulsions and her limbs were going cold. They did not call an ambulance. Before driving, they called a Contact Point and asked what they could do. BS knows that no one will be left to die and that in life threatening circumstances care will be given first. Still, she assumes that inquiries about identity will be made:

They will first take care of you before asking you from where you are, what's your origin. (BS)

But, and this is the other side of her story, BS is again amazed at how well her acquaintance had been taken care of:

If you consider our hospitals many would already be dead, but in Switzerland, people (...) give their time for others. And, if I may say so, almost for free. For free. That's a great thing. It's great. Because [at home] for everything that is done you need to offer an incentive. But that's not the case here. (BS)

BS compares and contrasts her country of origin with Switzerland, and highlights the fact that delivery of care is independent of financial exchange or bribery. As we progress, we will encounter other examples of patient's valuing the predictability of a system free of corruption. With this in mind, it must be said that BS is right when she says that the care in such an urgent case is 'almost for free.' More drastically, the general practitioner volunteering at the Contact Point says:

Even when we send someone to an emergency department, they immediately check: is he able to pay? (RF)

Indeed, as the administrative employee at the hospital confirms, if a patient can be talked to before care is given and the administration becomes aware that costs are not covered, staff try to obtain a deposit of 500 Swiss francs. If this is not possible, care is given anyway:

We do inform the doctor that the patient can't pay the deposit. And then the doctor simply takes the history, carries out diagnostics and provides treatment. But on a level where he assesses, well, whether things can be postponed until the finances are sorted. Or whether we have to [do something immediately], in which case we do it. (BH)

If patients however give out an address, they are pursued for payment. An undocumented migrant would therefore either have to pay for the care, give a false address, or deal with being pursued, risking exposure once again. The canton on his side does not, as the administrative employee informs the interviewer, refund costs for treatments of patients without insurance.

If a patient says to be without insurance but to live in the hospital's canton, the administrative staff makes him or her sign a form that will reach the canton's responsible for social insurances. This responsible will then attribute the patient to an insurance. The head of the Contact Point though knows that in these situations, undocumented migrants will sometimes give a wrong address, causing an futile administrative process.

Turning to the Contact Point, we have seen that it plays a key role in further inclusion. To some extent this role follows through all the way, with WM receiving medical reports and organizing all appointments.

The reason for this is the dependency of the Contact Point on its professionals, already mentioned in the introduction to this section. Also in the case of dentists, it is not easy to find professionals willing to work extra hours and for reduced fees. BS says that both dentists caring for her had previously worked in areas experiencing civil war and in developing countries. WM adds that for her, it is easier to motivate dentists who themselves have a migration background, to help. Again, personal engagement and goodwill is needed. For the Contact Point, the resulting lack of formal agreements prompts it to closely monitor

professionals' interactions with patients, in order to quickly mediate in case of difficulties. One cause of difficulties can be that undocumented migrants may not be very reliable at keeping appointments. As the head of the Contact Point says:

Especially with the dentists I'm really pedantically careful, I accompany almost every single person. Only when I see that people are really reliable (...), only then do I tell them they can go on their own (WM)

As the other nurse says, at the Contact Point itself, flexibility is needed:

Overall, I had to learn to deal with that, people either attend or they don't. For whatever reasons, maybe they are working, or they forgot, or they couldn't afford the train fare. (...) You know, we're not like in a hospital, where you then go, well they didn't attend this time, we may as well not take them next time. That's not how it is here. We say hey, we are here for these people and if they don't attend, they will have their reasons. (NU)

For instance, BS says that she might not always be reachable, as, when childminding she sometimes stays in another city for some weeks and cannot leave during that time. Certainly, the professionals of the Contact Point's network are not always willing and not always able to offer such flexibility.

Another point BS doesn't spontaneously address is the financial aspects of her treatment. Asked about her contribution to costs, she says she can make it up with her little jobs and again mentions WM as first interaction partner for these issues.

The Contact Point has a fixed budget of 500 Swiss francs per year and patient. A first strategy to try to counter this financial precarity, is to make patients contribute towards the costs of their treatment. But for the personnel of the Contact Point, there's no clear procedure how to assess a patient's financial capacity:

I have to negotiate with them each time. And there is nothing I can refer to. (WM)

The head of the Contact Point says she has developed "a feeling" for these things, and attempts to "take people at their word." She wants them to understand that "everything is not for free" (WM). In the case of dental care, patients should pay at least one quarter of the total costs in installments. Sometimes, money can also be reallocated from patients who have not incurred high costs. And sometimes, it can happen that patients defraud their way into care:

Well, I have also been tricked by some, in that I sent them to the dentist and they never returned. (laughs) Yeah, of course, that money, I never saw again. (NU)

As we will see further on, for various reasons, patients sometimes obtain healthcare through fraud and lies. In these cases Inclusion is achieved through being marginalized.

BS's story firstly confirms insights we reached through ZL's account: that for inclusion into healthcare to happen, there needs to be inclusion into a community. There needs to be inclusion into a system of paid work in order to establish a good living situation, but also in order to be able to contribute towards the costs of care. For BS, inclusion into health care at the Contact Point and its network has very positive consequences, as it allows for stable inclusion and lasting care for her dental problem.

Furthermore, the unexpected quick and non-bureaucratic aid and organization of appointments proved to be very important for a lasting inclusion into treatment. The negative flip side of this becomes clear when BS is talking about emergency care. Here she conflates the idea of exclusion from treatment, with administrative exclusion due to lacking legal status. In the case of emergency care, therefore, the condition of being undocumented in itself excludes people from it. Furthermore, financial aspects of inclusion are also difficult to achieve and may put undocumented migrants at risk of deportation, should they be pursued for costs. Thus, difficulties with financial inclusion increase the likelihood of patients being excluded from emergency care.

Listening to the two nurses working at the Contact Point, we can also start to see that quick and non-bureaucratic aid and professional engagement are in fact the result of an ongoing effort by the professionals' side. This effort especially involves the setting up of stable agreements, in a situation where goodwill, personnel engagement and organizational flexibility are particularly needed. Also, financial insecurity bringing with it the risk of exclusion from health care, is partly transferred from patients to the Contact Point, thus intensifying its dependency on the goodwill of individuals.

The engagement and interest shown by professionals were important conditions for inclusion for BS. Such qualities would probably also have been mentioned by patients from the wider population, demonstrating that inclusion into treatment need not, in the case of BS, address her legal status. Another important value when talking about inclusion is more specific to BS's situation: The Contact Point's dependence on the professionals in its network has the consequence of requiring a certain passivity from BS's, on the flip side, BS's statements show that she values the act of attending appointments on her own. So, it seems, that it is important for her to maintain a degree of autonomy whilst achieving inclusion.

GL - "these people are now like my family"

In 2016, 13'526 people were denied asylum or temporary admission in Switzerland, corresponding to 51% of all asylum seekers (SEM 2017:16). If not appealing to the administrative court, leaving the country, or going into hiding, rejected asylum seekers live on

so called "emergency assistance" (see Suter 2011). They are undocumented migrants insofar as they have no right to stay in the country. If not housed by friends, they live in emergency accommodations, where they also get food. Some of them are given 56 Swiss Francs a week, others are handed vouchers. Rejected asylum seekers do have a health insurance plan, provided by a special scheme, which is also given to asylum seekers in process. Health care can then be accessed via the asylum center's staff and is covered by the insurance. Rejected asylum seekers sometimes live in this situation for years and are under the constant threat of being deported.

GL, a man in his thirties, is one of these rejected asylum seekers. Adding to the rejection of his application for asylum, his identity documents have been confiscated during the asylum assessment process. He consequently has no documents at all relating to his identity.

At the start of the interview, he explains that he left his country after having been tortured during an eight-month imprisonment. Migration included a difficult stay of several months in Greece, from where he finally, with some additional financial help from his family, reached Switzerland in a truck. Arriving in an initial asylum camp about mid 2011, he tells personnel there that

I have health problem. When I [was] in [my home country] they too much (...) tortured me. (...) And sometimes I feel very bad. I (...) think that maybe tomorrow I die. (GL)

Being then moved to a transit center and thereafter to a cantonal center, he repeats his problem, but still is not given any care in this respect. During these times, GL also has difficult experiences with a general practitioner:

[I said] 'I have a problem.' He asked 'why do you come here so often?' [I came] one week two times or three times because (...) my health was very bad. When I go [again he asked] 'why are you here?' I say 'you don't know anything.' (GL)

The same doctor diagnoses GL with a stomach problem and subsequently sends him for surgery at a hospital. But apparently he does not recognize, or can not adequately react to GL's mental health problems. Inclusion into health care therefore remains fragmented.

Again, the interactions with healthcare staff in the hospital and the surgery itself were good experiences. GL reports having been well informed and treated. During the interview, he explains in detail how the endoscopy was explained to him. He reports having had fear:

You know in my land, sometimes some people having endoscopy, (...) they have much pain (...) and then they say, 'ah you may change completely (...) it's not good.' (GL)

Laughing, he says that after the surgery,

when I woke up, they said 'ok it's finished.' I thought that maybe they start now. They say 'it's finished.' I say 'What? Ah it's finished.' (GL)

Still, his mental health problems remain untreated as his application for asylum is rejected and he is transferred once again. For GL, every transfer means an unannounced and unexpected disruption, it is difficult to rationalise. Also, in the interview, it is not easy to precisely follow all the different places he was transferred to. The hospital's doctor confirms that this is also a difficulty for healthcare professionals: "In Switzerland you don't know how the patient did at his last placement" (AM). At his next placement, an emergency accommodation, GL still does not get adequate consideration of his problems:

They give us too much medicine. 'You use this one, this is very good, you use this one this is very good.' (...) But I think (...) I have another problem. And they give me another medicine, because 'ah, we have a sample here.' (GL)

Adding to his difficulties, there is the insecurity associated with life as an undocumented migrant, at the constant mercy of the authorities. This is well illustrated by GL's account about an encounter with police at a time when he already had treatment in the Contact Point's network:

We [GL and a friend] were in a car and police came and they [stopped] us and they said: 'What is this?', and I say: 'No no no' and then they caught me and one night I was [in prison]. I told them that I (...) have a doctor. They say no. The next day a translator came and they say: 'Why you are not going back to your country?'. I say that I have problems there. They said: 'It's better for you to go back.' The next day, another of these guys came with me to a big police station. (...) They took my fingerprints again and then they said: 'Now you are released.' And every time, when you see the police you are afraid. If they catch you or if they [stop] you then you have problems again. (GL)

As the police does not take GL's reference to his doctor in the Contact Point's network into consideration, he is left with no other option than to try to explain why he does not want to go back to his home country. He is therefore reduced once more to his status as refused asylum seeker, while having to undergo, once again, the typical steps of an asylum procedure like giving fingerprints. The way GL relates this episode shows how helpless he feels during the interaction with police. He concludes:

You know I left [my country] to have my life safe (...) but here it's the same situation. Every time I'm afraid (...) when police [stop] me. (GL)

GL is put in touch with the Contact Point via an NGO counselling undocumented migrants, at the beginning of 2013, one and a half years after his arrival in Switzerland:

First, when was here, when I sleep, I see everything that happened with me in my land. And I cannot sleep well and I cannot eat and everything is very bad, and then I came here and then they gave me treatment and slowly slowly I am better. (GL)

Inclusion at the Contact Point is a double turning point for him. First, he is referred from there to ambulatory psychiatric care. This therapy, he says, is doing him a lot of good, finally being included into health care for this specific issue. Again, he stresses the importance of continuity of treatment:

Because, [the psychiatrist] knows me very well (...) and he knows my situation he treated me very slowly slowly (GL).

GL's 'slowly slowly' marks a contrast to the haste and disruption he describes in his life as a rejected asylum seeker. On the other hand, the Contact Point is an important place to help him address some of the problems his legal status is causing him. Echoing ZL and BS, he talks about the difficulties he has with being unable to help his family. He gets very sad at this point of the interview, but at the same time relates how the Contact Point addresses this issue:

I cannot do anything for my family. (...) And I am very thankful to [the head of the Contact Point] because (...) she asked me: 'Why are you worried?' I said: 'My mother is very sick.' And she said 'ok don't worry. You bring me all the reports.' (...) And after she looked at it and also discussed it with doctors and she gave me medicine I'm sending my mother. (GL)

The Contact Point here gives GL the ability to act upon a health issue he would not otherwise be able to address. A bit later, he says about the Contact Point:

You know now these people are now like my family. Because, I don't have other family. But, it's a long time with these guys and (...) when I have any problem, then I discuss [it] with these people and sometime I feel happiness and also I discuss it with these guys. (GL)

We can see here that for GL, the role of the Contact Point and the meaning of inclusion into health care are quite broad. The Contact Point's professionals are described as a family, otherwise lacking but essential to GL's health and wellbeing. The statement at once expresses the turnaround the Contact Point and psychiatric treatment have provided and the loss of social ties and securities GL has experienced. The statements also show that for GL, inclusion into health care cannot be seen as fixed within one locality or person. It seems that his health is embedded in a wider context, encompassing family left behind and new ties built up in an immigration context.

These kind of challenging situations, though, are a vital part of their motivation for the Contact Point's professionals. The head stresses her interest for transcultural care and sees

her work as being at the nexus between culture and health. For her, this means identifying a patient's needs and his or her way of communicating them. Starting out with listening to patients,

it's almost as if you use [their concrete health problem] as a stepping stone to gently approach the much more complicated problem, that of their legal status. (WM)

The nurse NU again contrasts the Contact Point with ordinary care organizations:

It's not at all like care as you know it from a hospital, or an old age home, or [home care services]. (...) They come here with everything and they bring along the most complex stories. Not all of them, but things become quite complex very quickly when their health is impaired in some way. (NU)

A further important quality of inclusion for the professionals, is to build up trust with the patients. As the general practitioner states: "Even as an NGO, you don't just have their trust" (RF). The nurse echoes the sentiment:

When I work as a nurse in hospital, and I enter the room in my white uniform, people (...) assume my good intentions. Here, it's not like that. (NU)

This again essentially means a need to take time for patients:

I think, our advantage here is that we can take our time in most cases, or we invite someone to come in a second time. And I think for our patients that's extremely important. They feel taken seriously, they feel respected. (NU)

Certainly, GL's main remaining problem concerning his health is the threat caused by his status, excluding him from the most parts of civil life. Living now most of the time at a friend's place, he is however never sure he won't be transferred again, or even deported. His inclusion into healthcare thus remains precarious, while he has developed some problems with his blood pressure and heart. For instance, in the last center he stayed in, he could go to a general practitioner who "treat me very well and regularly and also he's very nice, very very nice guy" (GL). Still, after his latest, recent transfer, he again doesn't know to which doctor he is allowed to turn to.

GL's story shows the difficulties even insured undocumented migrants can have with inclusion into health care, for specific conditions. The reason that accessing the Contact Point is the most important moment for inclusion, is not only because it leads to finally addressing this specific problem through adequate therapy, but also because it provides an opportunity to talk about problems that directly stem from his legal status. We have seen with BS's story, that administrative aspects of inclusion sometimes have to be adapted to the

specific circumstances of undocumented migrants. With GL's story, we start to see that in some cases the care process itself has to take specific needs into account, such as talking about lacking perspectives, fear of deportation, or issues such as caring about a family left behind. This in turn enables the patient to actively confront health issues, to take an active part in his own care.

We can see that, on the other hand, for specific physical conditions and the treatments they require, inclusion into health care can be quite unproblematic and the interaction between medical personnel and patient does not require special measures. Here, GL's statement echoes those encountered in ZL's and BS's story.

Importantly though, GL's account shows the difficulty for continuity of inclusion both during and after the asylum assessment process. Being moved from one center to the next not only contributes to the insecurity of patients, but also cuts existing ties to health care professionals. They consequently cannot get to know their patients and, instead of coming to recognize more hidden health issues with increased patient familiarity, end up being overstretched, themselves adding to patient exclusion from health care.

KF- "I was in bondage but I didn't know"

At the Contact Point, about 90% of the patients do not have health insurance. As we have already seen, for the general population of undocumented migrants in Switzerland, this percentage is estimated at a very similar 80%-90%. It is unknown how many of the undocumented migrants present conditions that would need medical treatment, though given these numbers, the case of KF may well be an experience shared by at least some of them. Also, other patients without insurance that manage to access the Contact Point and get treatment through its networks may share some of KF's experiences.

KF, a woman in her thirties, fled political upheavals in her country of origin. She was imprisoned in her home country and gave birth to her son during migration. Arriving in Switzerland in 1997, she was treated in a psychiatric hospital for about two to three years. Though her memory of the time has become blurry, she does her best to explain her condition:

It was like I was dying. No life in me, I just know that I'm still living. For years (...) I was having stiff neck. (KF)

Upon her release from the hospital around 1999 to 2000, her request for asylum is turned down. But because she has just married a man with a Swiss residency permit, she is allowed to stay. Her son is naturalized. However, because she and her son are treated very badly by her husband, she decides to get a divorce, in the knowledge that she will lose her right to

stay. Because she does not dare work on the black market, she also loses her health insurance.

Some time passes and she becomes engaged to be married with a new partner around 2008. But this marriage is not recognized by the authorities. The procedures to legalize her stay are still ongoing, and have, in her view, taken on Kafkaesque dimensions:

I had to appeal to the state. The state refused. Then my lawyer said there's another one again, it's called federal. Then they refuse. (...) So, I appealed the immigration, the state and the federal three times. So I do the appeal nine times. So it cost my husband more than 20'000 Swiss Francs. (KF)

She reports that the immigration authorities tried to deport her several times but could not execute the deportation order. She describes the fear this has caused her:

If they want to deport you, they will come to your house early in the morning. So then after they attempted and they couldn't succeed, I became afraid. Even in the night (...) if I should hear a car, I would get off the bed to go and look if it's police. (...) So it was really a terrible experience. (KF)

She highlights another important aspect, which also impacts other undocumented migrant's health, as we will see later:

I'm ashamed to tell people my story. (...) Because people sometimes they will laugh at you when you tell them you have a problem. I always keep everything inside, keep everything inside. (KF)

Finally, she directly relates some of her increasing health problems at the time to her legal status: "I develop blood pressure because of this paper problem" (KF). But the situation is such that she cannot address this problem. She understands that with all the money her husband is putting into the legal process, he cannot afford health insurance for her on top of that.

With her legal situation remaining unresolved, KF's health goes from bad to worse during a period of seven years from 2005 onwards: "So my blood pressure was high, I was sick, you know it started slowly slowly" (KF). But it is not only the blood pressure. A whole cluster of symptoms build up in severity during these times:

That tiredness. (...) I cannot describe it. (...) I should raise my hand (...) it's a big job for me. My heart is beating fast [for a] small thing. I don't enjoy anything, I don't enjoy my body, I don't enjoy anything. Just to sleep and cover myself. Two weeks to my menstruation, I'm in another world. Two weeks after my menstruation is like war for me. I cannot even describe the pain. The pain is even more than punishment. (KF)

She knows of medication that would help address her blood pressure, but it requires a prescription. Fraud becomes her seemingly only option:

Sometimes I just have to go and lie in the pharmacy because I don't have insurance. That I want to send this to (...) my mom. (KF)

This way, KF sometimes obtains medication to treat her high blood pressure. Other times, she is not that lucky and is only given herbal remedies. Later in the interview, she explains how her success at obtaining effective medication depended on the pharmacy's staff:

Because they used to have different people at the pharmacy. So there's a man [he] would always sell it for me. But if it's just this lady, she will tell me 'ah no'. (KF)

Again, we encounter the dependency on goodwill, but also the dependency on people's willingness to bend the professional rules. Her attempts at inclusion marginalize her and also bear a certain risk for the professional involved. For her many other problems, KF's only option during that time is Dafalgan, a brand of paracetamol: "I'm taking Dafalgan like fruit" (KF).

KF gets in touch with the Contact Point in 2012, through the same NGO as GL. From there, she is first referred to be examined at a lab and by a gynaecologist in the network. Of both places, but especially the gynaecologist, KF reports very good and humane treatment and adds: "I even didn't have to pay" (KF). Again, the fact that there is no connections between money and care appears to be surprising and contributes to a positive experience. KF is diagnosed with fibroids in her breast and uterus, the latter causing the heavy menstruation. Also diagnosed are anaemia, low iron, high blood pressure, and depression.

She is given a prescription for adequate blood pressure medicine at the Contact Point, her low iron is treated at the lab, and her depression is also addressed. As a result, after over seven years, she regains an awareness of the difference between good and bad health. It is her most important moment of inclusion into healthcare until now:

You know after sometimes you don't know what is normal and what is not normal. Yeah. You see before, when I wake up with this headache, after some time, my body is like ah, it's normal life, to get up with headache. But like three months after the treatment I started to feel good in my body. Then I started to say 'oh God, so this is how I am supposed to live.' So is like before I was in bondage but I didn't know. I know but I don't really know that I can be free. So I don't know that this suffering is free suffering. I thought ah, that is how I will live. That is how it is. But the day that I started to get better is like my eyes opened and I'm in another world. (KF)

At one point, KF addresses the recorder directly, as if willing it to pass a message to an audience:

I thank [the Contact Point] one million times. (...) Because maybe I could have been a stroke patient. (...) I appreciate their good work. If God bless

me in life and give me a job I will join to support them. They see illegal people as human beings. (KF)

KF's statement for sure honours the work of the Contact Point and echoes GL's sentiments, but, at the same time, it highlights KF's dependence on the charitable organization.

Importantly, the fibroid causing her heavy menstruation requires surgical intervention. Unfortunately, such a procedure is impossible to finance without insurance. KF is resigned:

It will take a miracle. (...) But I just pray that the immigration should answer me. Quick. So that I can get a job. (KF)

Thus, even though KF has been freed from the 'bondage' she did not know she was in, she is still far from free from it. The fibroid, but also her difficulties concerning her legal status, have now been weighing on her for a very long time.

Theoretically, she and her partner could chose to cease their legal efforts and use the money to pay for insurance instead, but, that would terminate any hope of regularizing her legal status, of living a life without fear, and of gaining legal employment. As the head of the Contact Point puts it, "we are all born with this insurance" (WM). Indeed, Swiss citizens are included into healthcare from birth by virtue of their citizenship and later by work. Furthermore, if Swiss residents cannot afford health insurance, they can rely on social welfare. With KF, we are now for the first time confronted with a case where these prerequisites become explicit, because they are lacking.

And once more, like in the case of BS, in the background of at least partial and precarious inclusion, professionals work under constant financial pressure. To send uninsured patients to further care outside the Contact Point is

always problematic. Well, I should say, almost always. (...) It's immediately a question of money. (...) In my surgery I was used to being generous, like everything that was a potential diagnosis was checked in the lab. Here, we can't do that. So I have to restrict myself to what is really important to know. (...) It's a constant balancing act. How much risk can we shoulder ourselves, and when has the line been reached where (...) a more detailed examination or a specialist or the like is indispensable. (RK)

KF adds to the doctor's statement when she recounts her first visit to the lab:

I think the lab they made a mistake. (...) The doctor here said I should do like two or three test. So they did like ten test for me (laughs) by mistake. So (...) they find out that I'm having anaemia. (KF)

For KF, this was a lucky accident. For the Contact Point though, such mistakes can rapidly turn into financial problems:

A young woman had a broken finger, and I wasn't sure whether it was broken or just badly bruised. So I sent her to [a hospital] with a referral for an x-ray. But there, she was seen by an orthopaedic surgeon, who then immediately operated on her. From a medical perspective, perfect. But in terms of cost, something like six or seven thousand Swiss francs. And then, afterwards, the discussion: 'Hey, we'd only asked for an x-ray.' That got very complicated. (RF)

The close monitoring of the interactions between healthcare professionals in the Contact Point's network and its patients, like the one we we encountered in BS's story, takes its reason also in the wish to avoid situations like the ones just described.

Again, for the professionals of the Contact Point, the patients' financial difficulties are mirrored and doubled by their own restrictions. Asked about how they think the Swiss healthcare system is doing with regard to care for undocumented migrants, the volunteering general practitioner says: "What seems very problematic to me, is how much of it is tied to money" (RF). The nurse working at the Contact Point wonders why it is that most healthcare for undocumented migrants is provided by NGOs. For her, the best would be to

incorporate this into a regular structure like they exist for other things in a canton. Because then we would have funding and also some structures. (NU)

We have seen in BS's and ZL's accounts how settling in helped with their inclusion into healthcare. KF's story illustrates just how difficult inclusion into insurance and subsequently into healthcare can be when there is no income because there is no inclusion into the job market, even if it is just that of a parallel economy. In order to keep at least a very small margin of control over one's health, engaging in fraud while depending upon someone's complicity is an option. Marginalization is the consequence. Another aspect is that a sense for what being in good health feels like is lost over time. The contrast KF describes between her state before and after her inclusion at the Contact Point and in its network, shows this very well.

Together with GL's story we get a clearer sense of the mental pressures that weigh on undocumented migrants living at the mercy of the immigration authorities. At the same time, we see the importance of inclusion addressing these specific issues and giving room to talk about what otherwise must remain widely silenced.

Still, while marking a turning point in KF's story, the health care she gets via the Contact Point also highlights her dependence on this charitable organization. Taking together KF's and BS's story, we now have a clearer picture of how financial restrictions and dependence on goodwill are transferred between patients and the Contact Point.

Finally, a further interesting point with KF's story is the paradoxical 'choice' between inclusion

into healthcare and harming one's health. Inclusion into an official economy and job market, and into social welfare is an unspoken prerequisite for inclusion into healthcare. It appears that in this case, and we will encounter others similar, inclusion into healthcare and harming one's health are linked. Whatever KF does for inclusion; she worsens her health at the same time. If she decides to take out insurance, she has to give up on her legal efforts for legalizing her stay. This worsens her health by completely eliminating hope to ever get out of her situation of being undocumented. Conversely, if KF decides to continue her legal efforts to legalize her stay, she worsens her health by leaving her fibroid untreated. To a certain extent, such paradox interactions may also exist for citizens in precarious financial situations. Still, they appear here in a force and brutality hardly imaginable for people who can still rely on social welfare.

TG - "I had no place to go"

The Swiss law on asylum states that

asylum seekers must state any serious health problems of relevance (AsylG Art. 26 al. 1)

during asylum procedures. Usually, requests for asylum on purely medical grounds are quickly turned down. However, in some cases asylum seekers are granted a residency for one year with an F permit for the unique reason that in their emigration countries

a needed treatment is not granted or not granted sufficiently and the return would result in a rapid and life threatening deterioration of health. (Der Schweizerische Bundesrat 2016)⁷

In 2015, 201 persons were granted a temporary residency exclusively for health reasons. This amounts to 4% of the F permits granted that year (Der Schweizerische Bundesrat 2016).

It is 2016 and TG had been granted an F permit for medical reasons only weeks before my interview with him takes place. Had the interview happened later, he would probably have cited this as his most important moment of inclusion into healthcare. But as the event is so recent, TG concentrates on the time before. Indeed, he has already been in Switzerland for eight years at the time the interview takes place.

TG's story starts with the deaths of his two brothers, both suffering, as he himself, from a

⁷ wenn eine notwendige Behandlung im Heimat- oder Herkunftsstaat gar nicht oder nicht ausreichend zur Verfügung steht und die Rückkehr zu einer raschen und lebensgefährdenden Beeinträchtigung des Gesundheitszustandes führt.

mixed form of diabetes type I and II. His sister advises him to leave his home country. The family starts selling its cows and TG can afford a safe trip to Switzerland in 2008. However, on his journey he has no means to care of his diabetes. At the time of his arrival in Switzerland, he is immediately hospitalized:

The doctor checked my sugar and it was ouh, very very very serious. So, immediately they took me out to the hospital. I stayed there maybe one or two weeks (...) because the diabetes was very ouh, no insulin (...) you know. (TG)

From this time onwards, TG enrolls in an asylum process. His request is rejected by the authorities for the reason, as they say, that diabetes can be treated in TG's home country. It is the year 2010 and TG decides to go into hiding. Other than BS, KF and ZL, he does not have any contacts in Switzerland. Trying to get some work, especially while suffering from untreated diabetes does not even seem worth considering. In this situation, TG adopts strategies to take care of his health or even survival that harm his health further:

I eat everything, which is not allowed you know. But I don't have no choice. (TG)

With no access to insulin, he takes up walking in an attempt "to get the sugar down" (TG) and states that this caused a lesion on his foot that does not close up. For TG, this wound presents a severe physical problem, and, in light of the circumstances of his brothers' deaths, is also a source of a very existential fear for his life:

The foot was also a very big problem for me because my brother was having it in my country and he couldn't make it. (TG)

After some months, TG's next attempt for inclusion into healthcare is to file for asylum a second time:

It was very very difficult for me, I don't have medicaments, so I was sick. So people advise me: 'You have to make another asylum because you are sick.' And this is very dangerous. (TG)

We will see later, when discussing PI's story, that in certain very serious and urgent circumstances undocumented migrants may engage in an asylum process for purely medical reasons which also means facing an increased risk of deportation. TG, however, does not see any other possibility to handle his rapidly worsening diabetes and he reports that he was again sent to hospital immediately. He reports that at the end of treatment he was sent away with "a lot of medicine" (TG).

During the previous and the following phases, the conditions for TG in Switzerland are similar to those in his home country. For him, it is very hard to understand how it comes that in a

country with such a good healthcare system, there is no possibility for him to receive healthcare:

It was even a surprise for me you know. I said wow, I am here but I have no help. Yeah, I always think about this you know. I said not the paper, but I am a human being. The paper they can forget about it, but for my life, you know. (...) I was thinking that maybe if I came here, it would be better. But (..) not like that ah. Not like that. (TG)

Finally, some months later in 2011, an acquaintance tells him about the Contact Point. When TG attends it for the first time, he travels there by public transport without a valid ticket and risks being caught by the conductor and thus discovered. Given TG's state at that moment in time, it becomes easily understandable that the care provided at the Contact Point and through its network present a turning point in his story:

This means that if I don't (...) see these people so quickly, then it would have been too late. (TG)

Like GL, he describes a slow process of building a relationship, of getting to know and trust each other: "We started you know not very quick but slowly slowly knowing each other" (TG). This process results in decisive events for TG's inclusion into healthcare. Given his very precarious social situation, the Contact Point makes an exception and finances his insurance. For TG, the insurance itself thus is less of a decisive or visible moment and he only mentions it at the very end of the interview.

Much more important for him is that he is taken care of by a diabetes counsellor of the Contact Point's network. She will become an important person for TG, opening up other possibilities of inclusion, thus substantially contributing to his health.

But still, inclusion sometimes remains difficult. For instance, due to complications, TG sometimes needs to access emergency services. One night, still being homeless, he has a very bad stomach ache:

So I don't know what to do (...) I have no money to call the taxi. I don't (...) contact ambulance because if (...) I contact the ambulance what can I do? I have no paper I have no insurance card nothing. So, I said, these people in the hospital know me (...) I have to go by myself. So that night I walk until to the hospital from [a place about one hour walk to the hospital]. (...) I have to walk with height [holding himself upright], because of police. When I walk I have to sit I walk I sit, oh, (...) that day I was thinking that I'm going to die. (TG)

The lack of a document to show to the ambulance drivers is here contrasted with the fact of knowing people in the hospital. The statement thus stresses again the felt importance of and dependency on personal relationships for inclusion. The emergency unit itself will take care

of him as he has insurance; there is no doubt about this for TG in this moment. But the lack of an insurance card makes him walk for an hour in the night and in a pretty critical health state to the next hospital. Fear of being stopped by police accompanies him all the way.

Not having an insurance card can raise professionals' suspicions about coverage of costs and thus foster exclusion. TG reports that he had to remind doctors that they would be paid to treat him, as despite being an undocumented migrant, he did have insurance. Only the reference to the Contact Point made them "relax" (TG). It seems that, from TG's perspective, he had to handle the professionals' fear of uncovered costs, even though he was the one in need of help and support. He contrasts this with the situation at the Contact Point where "people (...) don't care if I have paper or not" (TG). As the diabetes counsellor says about TG:

He has always received treatment. Because he had insurance and then it depended a bit on the individual people. (LI)

She states that sometimes there were "reservations" or language problems, on other occasions though, people took extra care because they knew the patient was an undocumented migrant.

Certainly, receiving care and being able to sometimes obtain it on his own was a big step forward for TG. Still, bringing us back to his social situation, he says of the Contact Point:

I give them a tough time you know. Because (laughing) I have no choice you know. When I knock the door and this lady opened the door and saw me she said 'oh my God (laughing) it's him again.' Yeah because she knew that at the moment I get inside I just start to complain. You know, I was a headache. I had no place to go, no place to go. (TG)

With regard to the social situation of undocumented migrants, TG presents an extreme but also paradigmatic case of what happens when inclusion into healthcare remains very haphazard due to a combination of multiple exclusions.

We can elaborate this point further by turning closer to the professionals' point of view. TG's diabetes counsellor says that with the insurance, she was able to prescribe insulin, needles, and syringes for him, "just like for a Swiss patient" (LI). But it was difficult for the homeless TG to store the insulin. He says that he sometimes used a place in a little stream where he could cool it. Sometimes he also stored the insulin with some colleagues who lived in a nearby centre for asylum seekers. He is proud of himself for having found ways to help himself even in difficult situations. But in the end, the insulin "didn't help him much because he had nothing to eat" (LI). LI further reports that she has not been able to really adjust TG's

medication because he was always afraid he might go hypoglycaemic in public and then be found out by the police.

Together with a doctor at her hospital, LI reports that they had done much “social work” in order to improve TG’s situation. She mentions the following activities: organizing housing, organizing money for podiatry, accompanying TG and showing him the place where he can obtain orthopaedic shoes, forwarding bills to the Contact Point, giving financial guarantees, figuring as a contact person for other hospitals and informing them about TG’s health status and medication, informing TG about appointments, organizing surgery for his foot and eyes, giving her private phone number to TG. However, even her resources are not limitless. For instance, when her colleagues from the hospital call her to inform her that TG has nowhere to go after he wakes up from anaesthesia, she cannot help either. Together with the hospital doctor and the head of the Contact Point, LI always tried to find a way to maintain “a small pot of petty cash” reserved to help TG. She concludes:

We can do an amazing job. (...) Yet, I’ve never gone home with a clear conscience because you just know everything else doesn’t work, and then the best healthcare is useless. (LI)

For the professionals, this creates a paradoxical situation:

Sometimes we were almost happy when he had another episode. Then he could go back to hospital for three or four days, and he had something to eat, a shower, a warm bed. (LI)

The doctor working at the emergency unit of a hospital confirms this by telling the interviewer that in winter patients sometimes attend the unit also because they have no place to sleep. He says:

I don’t think our hospital is set up for this. (...) There are no real [associated] social services like I know it from other countries. (CR)

The asylum structures were used to gain inclusion into healthcare at the beginning of TG’s story, now the healthcare structures are used to obtain some minimal social inclusion. This social inclusion in turn makes healthcare interventions more efficient.

TG’s social situation and his possibilities to contribute to his health and healthcare himself improve only when he is granted an F permit. NGO employees and healthcare professionals have helped him file the application this time round. It is accepted because the immigration authorities recognize that, unlike the diabetes itself, the long-term effects of TG’s illness cannot be treated in his home country. It is thus the undersupply in health care for TG in Switzerland, his initial exclusion from healthcare, that finally makes the application at least for the temporary permit successful. Exclusion from healthcare makes TG’s political inclusion and thus his inclusion into healthcare beyond an NGO’s charitable support possible.

Given his very precarious social situation, it is not surprising that TG does not spend a lot of thought on how his insurance is organized and paid for. Still, in the background, numerous institutional and organizational arrangements and efforts have to be undertaken, especially in the interaction between the Contact Point and insurance companies, in order to include undocumented migrants into insurance.

In TG's case, the Contact Point first of all provides an address for all correspondence concerning the insurance. The Contact Point's staff also finds a person with a Swiss permit organizing financial flows via a Swiss bank account. But on the insurance company's side too, special arrangements have to be made. The insurance company employing SO has created a special department that deals exclusively with asylum seekers and undocumented migrants as clients. These employees

deal with the more delicate cases (...) and nobody else does. Because only very few have that level of training. (SO)

The specific training and sensitivity needed mainly concerns the verification that the applicant indeed has his or her residency in the country. It must be avoided that insurance employees contact the municipality for this verification. Furthermore, it is important that the staff of the insurance company know how to react adequately to inquiries by municipalities:

When someone calls from the municipality and makes enquiries about somebody, then we ask them why they're calling and we tell them that we're not permitted to give any information. In those moments we're very unapologetic and very unrelenting because they're just determined to get their hands on this data by all means necessary. (SO)

All the prerequisites on the Contact Point's and the insurance company's side in place, the application for insurance has to be filed in a pretty unusual way:

[A regular application] is seen by umteen people, from the scanning centre to the internal mail clerk, everybody can look at it because the document is open. And later we also read it into the system, electronically. And all of that we aim to avoid by saying that (...) for our department, with a code number indicating that it's about an undocumented migrant. With those [NGOs] that we have [this] agreement with, that works. And also, [using this system] no applications are lost. [You see], that is the risk when someone just applies [by themselves], there's a real risk that the application ends up just anywhere. (SO)

Not all insurers are trusted by the Contact Point to guarantee this level of data protection and exactitude. Once more, specific arrangements and personal contacts are needed to build up a relationship of trust, this time between organizations, in order to include undocumented migrants. Also here, personal investment, this time on the side of insurance employees, is needed:

What I personally think is very important is the personal [attitude] and awareness that these people really have nothing here, they didn't choose this situation. (SO)

From a patient's perspective, all these special arrangements and the need to use someone else's address and bank account details make them heavily dependent upon others in order to be included into healthcare.

Finally, there is there the question why TG has no insurance card. Indeed, this is quite a common problem for undocumented migrants. We have already encountered it in the story about AG's hospital visit (section 2). In order to issue an insurance card to an undocumented migrant, the insurance has to put in a request for an AHV number, the Swiss social security number. This procedure is rarely undertaken by an insurance company but for example also required for foreign diplomatic staff. But as the insurance company employee states:

Insurers tend to be reluctant to issue [insurance] cards, especially for undocumented migrants, because one doesn't know what do they want to use it for, are they going to get medicine and so on. That said, I must say our insurance is not like that. (SO)

The suspicion of misuse thus makes the difference between diplomatic dignitaries and undocumented migrants, and results in insurers not or only very unwillingly issuing cards. For the patients though, the card may be very important in order to be included into healthcare. From the perspective of administrative staff of organizations delivering healthcare, the absence of the card can create suspicion about financial coverage:

You try going to the pharmacy with just your insurance policy document in hand and try to get medication. In the best case, they [the pharmacy staff] feel suspicious and so they just refuse the customer. As a rule, they always want the number of the insurance card so they can validate it electronically. (SO)

The important point about the insurance card for the organizations delivering healthcare is to validate the patient's information about the insurance with a second source of information. The hospital's administrative employee mentions this same aspect. He says that for people having an AHV number, he can check it in a register and he can also check whether patients are registered with a specific insurance company. The problem when a patient shows up with neither a card nor an AHV number is that:

We don't find these people in our searches. And then it gets difficult. Because we know he's insured but we can't verify it. And in our processes, well we verify that kind of thing. (BH)

The Contact Point sometimes provides a letter of guarantee to reassure the healthcare organization's administrative employees that the costs are indeed covered. The Contact

Point's remit may even include

advocacy: for example, to speak for a patient, to protect him, or to elicit the best possible outcome for him or her. (NU)

At the same time and stressing again the active part of undocumented migrants, the nurse adds:

We only advocate when necessary. I mean, our people are extremely resourceful and most of them are good at getting what they need. I think it's important that we're here and that we help them. But you also need to let go. I mean, you don't want to make them dependent on you. (...) We don't want to see our patients as victims. Of course, they are to a certain extent but if you see people only as victims you lose sight of what they are actually capable of. It's kind of a fine line. (NU)

TG's story offers numerous insights into the question of how undocumented migrants are excluded from and included into communication related to healthcare. First, it shows what kind of strategies for inclusion are adapted when chronic conditions worsen without inclusion at the Contact Point. Health threatening self-care strategies are adopted. Inclusion is not sought via emergency care but via a risky, and futile asylum process allowing inclusion for a short period only. Still, the strategies employed while being excluded from healthcare also show a will to stay proactive when it comes to one's health.

The short moment of inclusion into healthcare provided by the asylum application process is again contrasted with the description of care at the Contact Point and in its network, which offers a more lasting option.

Behind the turning point of TG's story, we see that once more, administrative aspects of inclusion into healthcare, here taking out insurance, need specific arrangements. Patients are again dependent on the financial support and specialist knowledge of an NGO and a willing insurer. Then, with TG's story we can see how inclusion can remain difficult, even once insured. The problems with the lacking insurance card highlight again the high importance of administrative aspects, even on such a basic level as an undocumented migrant's ability to make their way to a healthcare facility with an ambulance. Even more, it shows the tight entanglement of prejudice against undocumented migrants from the insurer's side, suspicion and fear by administrative and medical personnel about uncovered costs and subsequent difficulties for inclusion. Like with KF, we can see that inclusion is dependent upon professional's goodwill, even if the Contact Point can be relied on in interactions. Still, we can see that not only patients but also the Contact Point's healthcare professionals stress the importance of giving patients the space to be active about their inclusion.

TG's story also supports the idea that inclusion of undocumented migrants into healthcare has to take into account their specific needs. The importance of handling appointment-scheduling, taking care of family members, and making space to talk about problems

otherwise well-hidden has come up in BS's, GL's and KF's stories. TG's story brings these aspects to their extreme, showing the limits of capacity of professionals in balancing the consequences of exclusion from citizenship.

Finally, linking up to KF's story, we see again that inclusion into healthcare and harming one's health interact in paradoxical ways in TG's case. Ironically, getting papers legalizing his stay is in his case only possible by exclusion from health care, harming him physically to a point where deportation cannot be executed. TG literally has to get sick enough in order to get his status legalized and healthcare financed by the state. Swiss healthcare requires, as we already saw with KF, a certain inclusion into economic or welfare systems as prerequisite. Inclusion and exclusion start to operate paradoxically when these prerequisites are not met. In the case of undocumented migrants these paradoxes result in lasting scars on concrete human bodies.

6. Insurance

In this final empirical section, we will encounter patients who identify reaching out to an insurance as their most important moment of inclusion into healthcare.

We have already seen that compared to the total of patients taken care of at the Contact Point and in comparison to the estimated total of undocumented migrants, patients with health insurance represent a minority of around 10-20%.

Concerning the professional's perspective, OT's story will bring us again to the Contact Point. It will also pick up to the question of the actual start of insurance coverage and thus bring us back to the interview with the employee of the insurance company (SO) and also to an employee of an NGO that provides care for HIV-positive undocumented migrants (MC). PI's and AG's stories will offer good insight into how valuable insurance is to undocumented migrants. AG's case in turn will show more about emergency healthcare in case of accidents. His story is complemented by the hospital's administrative employee (BH).

Since insurances play such an important role in this section, it is worth reminding ourselves of the reasons why such a very small fraction of undocumented migrants is insured (see also Rüefli & Hügli 2011). Besides the important financial reasons and administrative difficulties, there is at least one other, more fundamental reason, which leaves insurers reluctant to offer their services to undocumented migrants. As we have seen, TG's insurance cover was set up at the very moment there was an actual need. This is also the case for OT, PI and AG. The insurance employee says:

Of course an insurance company is not interested in insuring people who

cause a lot of write-offs because [their] costs are simply not covered by their premiums. (SO)

This argument is not compatible with the idea that an insurance provider balances costs versus income not at an individual but at a population level. However, only taking up insurance in a moment of need, is not quite in the spirit of things either. Companies react with different strategies:

Of course, now they bring forward all sorts of reasons as to why they won't insure him, for example, they claim that 'this was the wrong form you used'. Or, in the beginning, a lot of applications just went missing. (WM)

WM relativizes this statement by saying that it is not always "bad will" that causes lost applications but also the fact that sometimes the somewhat unusual applications of undocumented migrants do not fit in the "insurance apparatus" (WM). But the insurance employee confirms that there may be something more systematic to 'losing' applications:

And some insurers simply kick those applications into the long grass. As in, you've gone to the insurer's office three times, and you say 'I have your stamp here, you have received' – 'We have nothing.' That [application] ended in someone's rubbish bin or similar. (SO)

Sometimes, the Contact Point uses legal council to push applications through. But as the general practitioner volunteering at the Contact Point puts it: "Some of them [insurers] make things so complicated, at some point you just give up" (RF). For those insurers who cooperate, it is a tightrope walk between the willingness to insure and not wanting to become too attractive for NGO's taking out insurances. The insurance employee sometimes initiates a conversation:

Well if there is a bit of a connection we sometimes just address them [NGOs] directly and ask if maybe one or the other case, if they're in very bad health, well, we just have a frank conversation. We state that in general we are not interested. 'We are obliged to insure them, you know that. But you have to also see our side (...) wouldn't it be possible to insure this client somewhere else [with a different insurer]?' (...) Of course they're not happy about this either, but there are indeed some who, as a result, switch insurers on an annual basis. (...) For us, of course, this would be ideal, if we could all take turns a bit, that way all insurers are a bit involved. (SO)

An employee of an AIDS Advisory Charity bureau, who also obtains insurance coverage for HIV positive undocumented migrants confirms this practice. She was contacted by an insurance employee who "asked me whether we insure all of 'them' at their insurance" (MC). Whether by complicating the registration process or by talking, when asked directly whether this can be said to be a kind of risk selection, the insurance employee answers:

What you say is correct, there is a strong selection process. (...) That's the competition of course, everyone wants to grow, everyone wants to keep their losses as low as possible. (SO)

And while when it comes to asylum seekers, cantons distribute them amongst different insurers depending on the insurer's size, "with the undocumented migrants you can't do anything but talk. Because you can't control [at which insurer they register]" (SO).

OT - "Sometimes, I have a friend"

OT is a woman in her forties. Entering Switzerland in 2011, she gets in touch with a relative who tells her that there is no way to get any healthcare without papers in Switzerland. However, when she starts to earn her livelihood as a sex worker, she is informed about the Contact Point by an NGO's social worker. As she goes there to register, the general practitioner ascertains that there is a large lump in her breast. The mother of six says that she has had this lump since breastfeeding her fourth child.

However, soon after, the lump starts to hurt and the breast oozes liquid. OT returns to the Contact Point. Echoing BS, she describes having been given a hospital appointment immediately. The exams show that she has breast cancer. The dense passage in which she explains this reveals her most important moment of inclusion, which is immediately put in jeopardy:

He said you have breast cancer. So then I started to cry because (...) you know in [my home country] almost everyone who has this illness their only end is death. So, from then on then they started to treat me. And then I made the mistake. Because they [the social worker's NGO] had been paying for my health insurance, I was told I should file for asylum. (OT)

OT did not file an asylum request, her relative telling her that there would be no chance. She regrets this today, as the NGO subsequently stopped paying her insurance and she still has to "live in the shadows" (OT). The realization of how important the insurance was and is for her health and healthcare thus comes to OT retrospectively. From this moment on, she decides to pay for it herself as an aging sex worker.

Still, and importantly, the insurance makes it possible for her to receive treatment for her cancer. She gets surgery and chemotherapy during 2012-13. OT describes the treatment as good for most of the time, with medical staff acting in a caring and professional way towards her. She has a general practitioner who has been attending her since 2014 and tries, as best as she can, to take care of her health herself. Asked what good healthcare means to her, she says:

It's my health. So I have to take care of it. Yes, it's my health. It's my life after all. (OT)

When she feels bad, she tries to use preventative measures at home before attending a healthcare facility. She goes for walks, as her general practitioner recommends, having recently been diagnosed with diabetes. As the doctor volunteering at the Contact Point says, a general practitioner might be an important professional for an undocumented migrant. The Contact Point helps its patients to get in contact:

Well we have some GPs where we can place, them so to speak. Yes, it is rather important that they [the GPs] have some experience with undocumented migrants and are a bit aware as to what kind of problems that entails. (RF)

Interestingly enough, he again mentions professionals stemming from the Contact Point's network.

Generally, as soon as patients are insured "we are no longer responsible [for them]" (RF). Still, as we have already seen with GL and TG, patients tend to return

because they have found they trust us, they still return [to us] with one or the other problem, or to ask us to explain something. (RF)

That's also the case for OT. She says, echoing statements made by GL:

I didn't hide anything from [the head of the Contact Point]. When I have a little problem I come and I explain to her. Sometimes, she even tells me when someone has dropped by with some clothes, (...) and I come and sort them and (...) I send them to the children. (OT)

For OT, it is also important that she is accompanied by either the social worker or the head of the Contact Point whenever she has chemotherapy, or when attending doctors that do not speak the national language she can speak. All these elements contribute to her inclusion into health care.

On the other hand, OT recalls an episode where, after a session of chemotherapy, she returned to hospital because she had started to feel very bad. A medication error had happened. She says:

I don't even know anymore how I got out of the house to (...) take the tram and go to the hospital, but still, I arrived there. (...) All these parts [points at her arms] were already numb, I didn't feel my feet anymore. They kept me there for eight days. (OT)

What is striking, in parallel with TG's and BS's accounts, is that OT does not mention the option of calling an ambulance either.

Still, OT's main problem is paying the insurance premiums. The Contact Point has found a possibility to make premium reductions available for its patients. (see section 2 about premium reductions). On the other hand, administrative difficulties prevent them from having access to the cheapest insurance packages. For OT in turn, her quite serious illness certainly did not make it any easier to carry out her work in order to earn money. Asked about how she manages to pay the premiums, she says: "Sometimes, when I have a friend I explain to him. Yes, he gives me something" (OT). As the head of the Contact Point explains,

The high premiums that they have to pay for with their [low] or even inexistent wages well, (...) especially women enter into highly dependent relationships. (...) Even so, a good third to a half of our people are in some way or another involved in sex work. With the corresponding illnesses.
(WM)

The statement, taken together with OT's account about how she manages to pay the premiums, shows again that undocumented migrants are sometimes forced to engage in practices and that may in themselves compromise their health, in order to be included into healthcare.

Still, coming back to the moment OT's insurance was first taken out, for such a costly treatment it is very important to have an insurance that actually covers costs from the very beginning. Inclusion has to happen at the right time. And even if it might seem obvious that when taking out insurance it should cover costs, this is again not always evident in the case of undocumented migrants. Usually, as the administrative employee of the hospital explains, people immigrating into Switzerland have the obligation to organise insurance during the first three months of their stay. If they receive care during this time, while an insurance is not yet in place, costs are retrospectively covered. The insurance in turn, will fix the start of the contract at the moment the person registered at a municipality.

But in the case of undocumented migrants, it is not possible to know when the person entered the country. This bears, for the insurance provider, the risk of making contracts with clients who only entered the country in order to get treatment, in which case the insurance company can refuse the contract. Because of this, the insurance employee states, the company is "very sensitive to the fact, if there's a recent hospital admission" (SO) just after a contract has been taken out. On the other hand, it also might be that the insured undocumented migrant has already been in the country for years. For this:

there's an article [in law] that states – this applies specifically to people who are in Switzerland, who are in a bit of a, let's call it a grey area – that, in those cases, we can rely on that the date that counts is the date on which we receive the insurance document. (...) So, nothing is done retroactively.
(SO)

Indeed, the KVV states that if a person registers later than three months after their arrival, the insurance starts at the moment of the registration (Art. 7 al. 1). Also, the insurance can demand a supplementary premium (Art. 8 KVV). The head of the Contact Point relates a case where an insurance company made a patient pay a month's premium as supplement, but without covering expenses that had arisen during this time: "You pay an empty premium" (WM). In this case, the Contact Point ended up paying the uncovered care costs of 400 Swiss francs - 4/5 of the annual budget for one patient.

The employee of the NGO caring for HIV positive undocumented migrants says that this practice is rather recent. In order not to generate uncovered costs, she on her part asks doctors not to start HIV therapy as soon as the diagnosis is made, even if there is some urgency, especially when the HIV is already in a progressive state. Rather, doctors should wait until the insurance is certain to be valid:

We informed [the doctors] that their medical standards and the actual possibilities do not always coincide. (MC)

The most salient aspect of OT's story about inclusion into health care via insurance is the difficulties this inclusion brings with it. Once more, an undocumented migrant is included into health care by harming her own health and by being heavily dependent upon other people. And while such difficulties might also affect Swiss citizens, being undocumented exacerbates these problems, due to the absence of any legal, social and working security entitlements. Thus, to play an active part in financial inclusion, is foremost a huge burden for OT. Her situation is such that even if she still tries to actively care for her health, her margins for action have become very small, the spectre of despair and hopelessness pervading the whole interview.

The debate about the exact start of insurance coverage shows once again the dependence undocumented migrants have on the Contact Point, in order to assure administrative procedures are carried out correctly. These are again closely tied to financial aspects of inclusion into health care and the care process itself within the interaction with medical personnel. Having important treatments postponed might be a consequence of this close entanglement between financial, administrative and care aspects of inclusion.

And while OT's treatment of her breast cancer is certainly very important to her health, difficulties remain with aspects of inclusion concerning physical access in emergency situations. Further, OT still depends on the Contact Point's or other NGO's help, in order to be included.

Also, just like GL, KF and TG, OT stresses the importance of the Contact Point in assuring health care in a wider sense, despite having a family doctor who sees her.

PI - "I can just make an appointment"

PI, a woman in her late twenties, has now been living in Switzerland for about twelve years. At the time of her arrival, like TG and KF, though in better health and still a minor, she enrolled in an asylum process. During this time, she learned a national language, which she now speaks fluently. She then also had a family doctor at her side who regularly examined her one remaining kidney. She lost the other one in her home country, while undergoing surgery because of a kidney stone:

And then they said, now there's nothing we can do. This kidney we have to, the right one, so this side, they removed everything. (PI)

PI's asylum request is turned down in 2007, but she decides to stay in Switzerland. She reports having been with compatriotes during migration and from the very beginning on of her stay. Via this diaspora community, she finds a cleaning job, enabling her to afford housing and food. Concerning health, PI helps herself with some paracetamol when she has pain. She expresses concerns about this kind of self-medication:

I also have stomach pain, many, and I have always taken medicine, but that's not good either, no? I don't know if I can just take this medicine, or, I don't know. And then I still have such strong pain. (PI)

Then, in 2012, she falls pregnant. Having had no examinations during pregnancy, she decides, towards the ninth month, to undergo a second asylum process:

Because, it's difficult. When you are illegal in Switzerland and getting children, you have to pay much, and you have to work much, or so. That's why I made a second request. (PI)

PI explains that she only felt safe to be in contact with the asylum system because she was so highly pregnant that she was sure she would not be deported. At the end of this second asylum process, she and her new-born child go into hiding again.

It is during her second pregnancy in 2015 that PI finally gets pointed to the Contact Point by a friend. All pregnant patients attending the Contact Point are urged to take out insurance. Even more, as the head of the Contact Point stresses, she does not want a "parallel universe" (WM) of health care for undocumented migrants and deplors any situation in which a patient remains without insurance. PI did not even know she was entitled to take out insurance, but once it is established is very satisfied to have it. Being in a financially less precarious situation than OT, she stresses most of all its organizational and administrative advantages. She can go "to the women's clinic, just normal." She continues:

Now that I pay the insurance every month and when I have pain somewhere, then I go, then is no problem. (...) Then I have no worries, right. When I have pain or something, I don't have to think, ah, what should

I do or something. I can just make an appointment. Is easier and much better. (PI)

The value of the insurance to PI is again stressed in the following statement, comparing her current situation to that in her home country:

When I go to hospital or the like [in my home country], I always heard them talking, they wanted money. We have to give something, right. And then they do it. But if we don't give anything or so, then they didn't want to. No, that is different, right, here in Switzerland they don't do this, right. When I go to hospital, I give money to nobody. (PI)

We see here a similar point of view to BS's explanation, when she talked about not having to motivate every medical action with money. PI also stresses this decoupling of paying for care and obtaining care. Paying for and receiving care are social relations enacted at different time-points and in relation to different organizations. The insurance makes her inclusion into health care independent from individual goodwill or corruptibility. It takes her into a procedure where personal negotiation and bargaining are not necessary.

Asked about the financing of the insurance, PI just says that she has to "work a lot" in order to pay the premiums. Her two children are not insured, but get some basic care at the Contact Point. And even PI, who is at this point able to handle much of the interaction with healthcare organizations herself, states that the Contact Point gives the hospital a call before she goes there, "so then they don't ask too many questions" (PI).

With PI, we have encountered a case which, although a bit more turbulent than OT's, shows well how much space for autonomous inclusion undocumented migrants can open up and how much they value this autonomy. For PI, it seems, the insurance gives her a sense of having a certain right to exist and to be recognized in Switzerland, if not as citizen, then at least as patient. Again, the contact to the diaspora and the inclusion into a labor market, however precarious, allow PI to obtain healthcare almost on her own.

On the other hand, PI's case shows once more what kind of inclusion undocumented migrants obtain when remaining excluded from charitable organizations and insurance. To file an asylum request is a marginalizing and risky strategy for inclusion into health care.

AG - "I know I have to pay because I know why"

AG came to Switzerland in 2003 after abandoning studies in Germany for financial reasons. He always thought that maybe he could earn enough money to get his studies finished, but never was able to put anything away on the side. Still, of the interviewed patients, he's financially probably the best off. He works in agriculture and on building sites and says:

I know maybe ten or a good fifteen people, sometimes I work with people like that. Sometimes he says no, this time there's no work, but I call you. So sometimes they call. (AG)

Getting to talk about health, AG's first experience in Switzerland with health issues is directly related to one of his jobs. Working on a building site, while not yet having taken out insurance, he has an accident with his knee:

There was a lady (...) she says, mister mister hello what's up, and I say listen, I fell, I don't know what's up. She said, my husband is ambulance driver (...) and she called and he came with the ambulance and he put a thing like this, like ice. (AG)

Despite getting this first aid, AG does not let the driver take him to hospital. He instead says he wants to go home, as it is already late. Adding to that, as he repeats twice, he "doesn't know anybody" (AG) in the hospital. The fear of going to an emergency unit, because of not knowing anybody, echoes the dependency on personal connections already stated by other patients. Again, it seems that undocumented migrants have to rely so heavily on personal and informal relationships, that they don't dare to interact with organizations where no such connections exist. Only the next day, when the knee has swollen even more, AG is willing to go to the hospital. His boss picks him up in a car, drives him to the unit and pays for the care given.

For AG, things stay calm after this incident, until his sight starts to be impaired. Still not insured, he is examined by an ophthalmologist. He starts to talk about it by saying "I paid him for nothing" (AG). The doctor tells him that there's nothing wrong and that he just should get new glasses. AG continues about this episode:

I said 'listen, I tell you the truth. I trust you. I don't have papers here in Switzerland. How much does this cost?' He said 500 francs. I said (...) 'can you, can you wait a little moment, for example, some days, a week?' He said 'listen, you have to pay now.' (...) Maybe he is stressed, maybe he thinks I won't pay. (AG)

AG therefore has to pay 500 Swiss francs for a diagnosis he suspects to be wrong and as the doctor wants the money at once, he bargains with an employer in order to get an advance on his salary.

AG then turns to another professional, who tells him that he indeed needs a surgery on his eyes and should take out insurance. We will come back to the details about how AG reaches out for and manages this insurance. For now, with the contract taken out in 2010, he can get surgery for his eyes. He says he was afraid during the first surgery, reminding us of GL's statements. He describes how the hospital personnel calmed him and informed him about every step taken. He is very happy with the results and for the operation of the second eye "I

go there easy and hop hop, no problem" (AG). Like PI, he values the insurance a great deal:

The insurance, that works very well here, that helps a lot. (...) And I know I have to pay because I know why. (AG)

He does his best to punctually pay the premiums. When things get tight with money, he can sometimes get an advance from one of his employers and "sometimes I don't eat" (AG). On one occasion he ends up calling the insurance company:

Once I called them, they sent me a letter if you don't pay – police. I said 'listen, I'm not like you. You have a salary, I don't. I work a bit here and there and then I don't work for two or three months, it depends.' Ah he understood. 'Listen, when I have delay (...) I pay it anyway.' (AG)

AG again stresses the importance of insurance in his next statement, though adding at the same time a vicious turn:

The insurance is obligatory because sometimes I do dangerous work. So it has to be done. (...) The problem, when I have no work, how do I pay? I have to take any kind of work I can get. (AG)

Remembering OT's statement about friends helping her to pay her insurance and the remarks of the head of the Contact Point about the dependencies undocumented migrants have to enter into, in order to be able to pay premiums, AG's statements reinforce this pattern. Again, we see how healthcare has to provide help with issues, which are to a great extent due to the financial difficulties the process of gaining inclusion to healthcare in it itself has brought. To 'know why you have to pay' therefore also means knowing you have to pay because paying involves getting injured, while doing hard and risky physical work, in order to be able to pay.

To acquire and maintain health insurance also means a lot of administrative work for AG. As soon as the doctor tells him that he needs insurance, he turns to a social worker he happens to know. The social worker does some research and finally tells him that he needs a 'legal' person who he trusts and who trusts him, so that financial transactions and correspondence can be set up. Having found this person, whom AG describes as a good friend, the three of them meet up and organize an appointment at an insurance company:

Because she [his friend] made the bank account and all, and then every time I call or I send an SMS like this, I say listen, are there any bills? (...) She says yes. Ok I'll come at once. And then, sometimes, I don't find her at home, so I put the money in an envelope for her. And then she organizes everything. (AG)

To 'organize everything' means for example to try to get a premium reduction and also to try to handle the canton's contribution in case of hospital stays. As the insurance employee

explains, hospitals who can't assign patients to a certain canton, because they are not registered, tend to send the whole bill to the insurance, while usually the canton has to pay 55% of a hospital stay. The insurance employee adds: "Usually, it is the institution [e.g. a Contact Point] that checks whom one can turn to" (SO).

Still, as we have seen in the introduction to this thesis, AG remains without an insurance card:

I don't have an insurance card, but with the [insurance] number they find it. Now, this works at [this hospital], but the other hospitals I don't know. (AG)

The interesting part of this statement is that AG mentions a specific hospital, the one where he had his eye surgery. Other ones, like the one I accompanied him to, do not have him registered as patient and therefore, being unable to verify his insurance without a card, are reluctant to register him as patient.

Finally, the biggest remaining problem for AG is his lack of papers. Getting back to this fundamental problem, towards the end of the empirical part of this work, it is a particular difficulty for AG. With his country of origin, he has very little chance of legalizing his status in Switzerland. At the same time, he cannot return. Because there is no repatriation agreement between Switzerland and the country in question, the government there would simply refuse to take back any undocumented migrants. As the head of the Contact Point puts it:

It's like they belong nowhere. Switzerland doesn't want them and [AG's country of origin] doesn't want them anymore either. (WM)

For undocumented migrants in this situation, encounters with police end up being pointless, but still have serious repercussions, as the head of the Contact Point explains:

And sometimes they end up in administrative detention because they were stopped by police. And because they can't be deported, they can just keep them there for a few months and then they put them back on the street. (WM)

Being in prison for months can easily result in loss of work, housing and contacts. Living under these threats for 15 years now, AG says, like KF, that he does not tell people about his problems. He states that he is otherwise in good health, he does a lots of exercise to stay healthy and to avoid thinking too much about his problems. He can always rely on the Contact Point when needing to talk. But he adds:

I don't sleep when I think, I don't sleep how I should, really. Even when I spend the whole day outside, I do sport, but there's always a nightmare because of [the lacking papers]. Believe me, sometimes I cry. (AG)

Getting back to the issues surrounding emergency care, this time from the professional's

point of view, we are here confronted with a work accident. Again, apart from the costs, the fear of being exposed due to a lack of personal connections could well also hold back other undocumented migrants from attending emergency care. In the case of work accidents in a black labour setting, for instance, this fear is not completely unfounded. As the hospital's administrative employee confirms:

Well it does happen that they are 'visiting' someone on the construction site. And then they have an accident. And then we see what we can do with the police. (BH)

The head of the Contact Point relates this as a situation of conflicting loyalties:

In some way, they [the hospital's employees] have a conflicting task. On the one hand, to protect the client, and on the other hand, to collaborate with the authorities. (WM)

From the hospital employee's perspective, these different loyalties can however interact with each other in a paradoxical way. Sometimes, it might be better for the patient to lose his authorization to stay in the country, in order to get health care, by forcing the employer to live up to their responsibilities with the help of police:

There's the question as to what's more important. In this particular situation it's probably a matter of weighing things up. And depending on the severity of [the accident] it's certainly better for the patient to accept the consequences. (BH)

AG's case shows well how undocumented migrants try to deal with incidents of ill health when being broadly excluded from health care. To try to simply ignore a problem or to get care while being dependent upon an employer providing transport and payment, are options, but there is also the risk of arousing the suspicion of healthcare professionals, due to one's legal status and/or financial precarity. Also, we see again that fear of being exposed and/or being burdened with very high costs of care, when having no personal connections in an organization, excludes migrants like AG from emergency departments.

Once more, we see the positive value for undocumented migrants of having insurance, in contrast to previous difficult attempts to achieve inclusion into health care without it. This value must be understood as especially high, as again, it not only represents a substantial financial burden, but as there is also a great price in term of health to be paid, in order to be included into insurance.

We also get to see the lengths which undocumented migrants go to, in order to maintain inclusion into an insurance scheme, and how despite putting in all the active effort they can, they remain dependent upon someone else, who functions as addressee and bank account holder. Getting to the point where one is standing in front of medical personnel, is even then not assured, exclusion at a hospital being a potential issue, if it is not possible to rely on an

organization like the Contact Point.

7. Discussion

Having seen undocumented migrants' stories about inclusion into and exclusion from health care and having contextualized them with professionals' perspectives, we can now formulate an answer to the research question of this work: How are undocumented migrants included into and excluded from communication related to healthcare?

Moments of inclusion and exclusion

We have seen already, with the structure given to the empirical chapters, that there are three main moments of inclusion into health care for undocumented migrants with their preconditions and consequences. In this discussion, we will first review those moments, preconditions and consequences and then contrast them with situations where patients remain excluded from communications concerning healthcare.

First, to settle in, is an important moment of inclusion into communication concerning healthcare. But there are preconditions to this kind of inclusion. Thus, knowing somebody in the country of arrival and having migrated for reasons of seeking a different life or work, rather than out of sheer personal distress caused by sickness, war or torture, are helpful preconditions for settling in.

To have contacts within a diaspora community, to find some housing and work, are ways towards what, interviewees say, can consequently be a relatively satisfying and healthy life, even if a certain issues always weigh upon them. Opportunities to get active about one's own situation help to actively address some minor health issues and sooth some of the difficulties of an undocumented life. As we have seen, these difficulties are foremost due to the undocumented status itself, bringing insecurity into work and family life, and bringing fear of being discovered (see also Wismüller & Efonayi-Mäder 2011:44; Biswas et al. 2011; Achermann et al. 2006).

The importance of good health in order to maintain such a situation and the fragility of this kind of inclusion are in turn demonstrated by the cases where serious health issues arose and difficult social situations were in place.

The second important moment of inclusion is getting in touch with the Contact Point and its network. Some social contacts towards a diaspora community, social workers or NGOs is however needed, in order to get to know that this organization exists.

Offering specific inclusion is a core competency of the Contact Point, turning it into an important actor for inclusion. Administrative aspects are made to fit undocumented migrants'

specific situations. Further, the Contact Point takes on difficulties with inclusion concerning ideological, administrative and financial dependency on medical and insurance professionals. If needed, the Contact Point not only provides a space in which patients can receive healthcare, but also provides opportunity to address health issues of their families left behind, and discuss the difficulties of an undocumented life. The consequence of being included into healthcare communications at the Contact Point and its network, is to get at least some care for reduced cost, or to get care for conditions that remained undiagnosed in the mainstream system. But another consequence is also that of becoming dependent on a charitable organization. Inclusion is organized in a framework of separation, in a parallel health care system that necessarily lags behind the one accessible to legal residents.

When undocumented migrants remain excluded from the Contact Point, while having some health issues, they sometimes try to ignore a problem for as long as possible (see also Biswas et al. 2011 and Wolff et al. 2008). Then, in order to still be able to do something about their health, they seek marginalizing and risky ways of inclusion into healthcare, such as lying in pharmacies. They turn to futile and risky asylum procedures and engage in practices that, in turn, harm their health (for other examples of strategies see also Achermann et al. 2006:147ff; Huschke 2014). Inclusion at emergency services is only sought after a trusted person reassures patients that they can attend it safely. In contrast to the professionals' view (confirmed by Dauvin et al. 2012) that even without insurance, inclusion at emergency units is possible, fear of costs, but most of all of being exposed, excludes undocumented migrants. In other countries (Poduval et al. 2015; and to a certain extent Biswas et al. 2011), patients seem to know better that they can obtain health care at these services. This finding strengthens the idea that inclusion is as much the patient's as the professional's concern. Inclusion is indeed a social relation and not an individual feature or a property of organizations.

A third key moment of inclusion into healthcare is to take out insurance. It opens up access to costly and prolonged treatments. But more than that, insurance can give a feeling of being able to make inclusion an active undertaking and to be able to interact, in certain cases quite autonomously, with the different actors related to healthcare. As Laranché (2012) explains in her study, to know one has a right to healthcare and to be entitled to this right by a contract can be a "means of becoming recognized as existing" (Laranché 2012:862).

But again, a Contact Point or a person having special knowledge, like a social worker, is essential in order to take out insurance. To hold it, one again needs trusted people and it is important to be settled and above all to have some money at hand through work.

And insurance as moment and lasting relation of inclusion can result in patients being bound into dependency on family, friends, acquaintances, clients or employers. It can in itself

substantially threaten good health through its financial demands. As Fleischmann puts it, financial pressures "perpetuate the cycle of harsh work conditions and deteriorating health" (2012:93). To have work in an official market, or to have access to a welfare state via citizenship, proves indeed to be a - frequently unspoken - prerequisite of obtaining healthcare via health insurance. And still, having taken out insurance, patients risk being excluded from healthcare facilities, if they cannot rely on people accompanying them, or on organizations taking up advocacy for them. Underuse is therefore not only, as Hügli & Rütli (2011:39) state, due to patients who do not dare to use services, but also due to excluding services. This makes it, as Dauvin et al. (2012) have also asserted for the UK, difficult for professionals to refer patients to other health care facilities on their own. Biswas et al. (2011) confirm the importance of knowing citizens in order to obtain health care in Denmark. Still, lacking insurance can also be a heavy health bondage, tying patients to the limited possibilities of paying for care themselves or forcing them to use up the financial resources of a charitable organization.

Taking all moments of inclusion into health care together, we can see that all of them make the life and health of patients better. In contrast to this stand those situations where patients are left with only partial inclusion, or even exclusion from healthcare. Such situations exacerbate bad health or bring patients to the point of seeking out for marginalizing and risky ways of obtaining healthcare.

Then, we can see that for all moments of inclusion, certain preconditions have to be fulfilled. To know some people in the country of arrival and to be able and have the possibility to work are necessities in order to situate oneself. Having contacts is necessary in order to get to the Contact Point. And such contacts are in turn needed in order to take out insurance. Concerning the latter, having enough paid work is an indispensable prerequisite. Inclusion into healthcare thus requires inclusion into social systems of diaspora communities and inclusion into an economic system.

Finally, we can see that whatever patients and professionals undertake in order to include undocumented migrants into healthcare, important limitations remain. For uninsured patients, examinations and treatments are limited to the strictly necessary, unless some professionals are willing, out of the goodness of their heart, to make time for more. Important health problems sometimes simply cannot be addressed. When having insurance, inclusion is not available at the same level as for Swiss citizens, advocacy being needed. Even more, in order to achieve inclusion, patients are frequently forced to take on occupational health risks in disproportionate measure when compared to Swiss citizens. Exclusion from the nation state and system of citizenship is thus causing exclusion or precarity of inclusion into health care. Exclusions foster further exclusions. Thus, our research confirms the idea, that being

undocumented is a social determinant of health on its own (Martinez et al. 2015; Castaneda 2009, Affronti et al. 2013; Kuehne et al. 2015, Fleischmann 2012). In a systems theoretical approach, such 'spill over' is seen as a contradiction, with self-description of systems which see themselves as autonomous and independent from each other. Also for Switzerland, access to healthcare is (as we have seen in section 2) de-coupled from citizenship in the formal self-description of the system. In practice, in the operative enactment of communication, this is however not the case. Stichweh refers to such effects as "corrupt local structural couplings"⁸ between systems (2005:175f). In consequence, patients are often pushed into a parallel healthcare system, such as that offered by the Contact Point with its network. Integrative inclusion seems to be much less commonly the case than separating inclusion, to again lean on Stichweh's (2007) terminology.

Aspects and qualities/values ascribed to inclusion and exclusion

Now, we can turn in more detail to aspects of and to qualities ascribed to moments of inclusion and exclusion. Inclusion and exclusion of undocumented migrants into health care comprises three aspects:

1. financial aspects
2. organizational/administrative aspects
3. aspects of treatment

Financial aspects are tied to inclusion into the economic system as a functional system. Here, work brings with it the ability to mediate social relations through monetary payment. Organizational and administrative aspects concern inclusion into organizations, be it insurance or healthcare organizations. Finally, aspects of treatment concern inclusion into the system of healthcare, as functional social system.

Talking about these three aspects, three important qualities ascribed to inclusion become evident, while in each case the reverse circumstance means that exclusion is looming. These qualities can be said to be shared values of undocumented migrants and the professionals caring for them, when it comes to inclusion and exclusion. They concern:

- a. the question of whether inclusion can only be achieved for a short time, or whether it can be stabilized for a longer period
- b. the question of how much dependence inclusion brings with it, or of how much independence and self-determination it allows
- c. the question of whether inclusion respects and addresses the specific conditions undocumented migrants live in, or not

Each aspect mentioned above can be tied to these qualities ascribed to inclusion and exclusion. For example, financial inclusion can be said to be achieved over a longer or

⁸ korrupte lokale strukturelle Kopplungen (Stichweh 2005:175f).

shorter period, it can yield more or less dependence and can respect or not respect conditions of undocumented migrants. The same holds true for the other two aspects.

As we will go through these aspects and the qualities that are ascribed to them, we will see once more how tightly they are interlinked with each other and how they are tied to the legal status. It would be interesting to compare these findings with stories of other vulnerable populations and see where similarities and differences appear. What is striking is, that while the interviewed patients had very diverse migration backgrounds and had their emigration countries widely spread over the globe, it is possible to condense common themes and values concerning inclusion and exclusion. Much more than any regional culture, it seems to be the fact of being undocumented that creates a specific culture, that brings forward specific needs and values, also concerning health care.

First, financial aspects of inclusion are affected by undocumented migrants' very low and irregular incomes in black markets. The lack of any protection as workers leaves them with little leverage when it comes to negotiating for salaries, conditions of notice, protection in case of accident, sickness or maternity. While financial precariousness certainly is also an issue among poorer Swiss citizens (De Pietro et al. 2015:229ff), being undocumented "exacerbates", to borrow a term from Fleischmann et al. (2015) these problems.

Concerning continuity of inclusion in relation to financial questions, all care, be it paid out of pocket or covered by insurance, remains constantly threatened by interruption of payment, due to loss of work, sickness or inadequate wages.

Paying for care out of pocket, or paying for an insurance, in turn brings with it dependence. As we have already mentioned numerous times, as a consequence of financial pressures due to the high costs of healthcare, undocumented migrants are pushed even more into bad and health-threatening jobs. They have to carry out all kinds of services for employers or more or less self-interested friends, or have to rely on charity. In social systems theory, money is conceived as a medium of communication in the economic system (Luhmann 1997). As such, money facilitates communication, which in the economic system consists mostly of financial exchanges. It seems that in the absence of such a medium, emotions, pity and personal concern are used as a substitute. Patients, as well as NGOs, end up begging for treatment at reduced prices.

To achieve financial inclusion into health care is thus, for undocumented migrants, always an act of force that does not respect their living conditions.

Secondly, administrative aspects of inclusion are affected by difficulties with proofs of residency, lack of registration, need for compliance with special data protection rules, but also practical issues, like reliance on appointments. Inclusion into healthcare, even in

emergency situations, is directly put at risk, because of administrative exclusion, for example when insurances do not issue cards to undocumented migrants. As Laranché (2012) shows for France, and Fleischmann (2015:92) for Israel, and as we have seen in the present study, such administrative exclusion re-appears in the statements of undocumented migrants, who think they are not entitled to emergency care. These administrative aspects of inclusion are however also affected by financial aspects. We have encountered the problem that insurance companies practice exclusion via risk selection, or find legal loopholes to not cover costs and therefore financially exclude patients at the beginning of a treatment. We have encountered hospitals who, driven to be profitable in a healthcare system that has chosen to operate on managerial logic rather than the logic of national economy, require their staff to react with suspicion and block procedures if in doubt about coverage of costs. An interesting question for further research could be to ask, following again Laranché's (2012) approach, how discourses and politico-legal constructions about undocumented migrants in Switzerland shape such organizational arrangements and practices of inclusion and exclusion.

As we have seen, it is possible to set up administrative aspects of inclusion in a way which makes them responsive to undocumented migrants' situations and specific needs. Still, in the present situation, this means that patients have to rely on special knowledge, inaccessible to themselves. NGOs, having such knowledge at their disposal, navigate grey areas where procedures are again replaced by personal contacts, goodwill and special arrangements.

Third, coming to healthcare as the interaction between medical professionals and patients, we have seen that continuity is possible, if trust can be built up and if administrative and financial inclusion is achieved.

Sometimes, and especially when concerning isolated physical conditions, inclusion need not be specific or, said in other words, can be the same care as for all other patients. Exceptionally, taking into account the conditions in emigration countries, additional explanations about treatments might be needed. On the other hand, we have seen that for health issues which are more closely tied to their legal status, undocumented migrants need to be and are included, especially by the Contact Point, in a specific way that often can go beyond what healthcare in a narrower sense might encompass (see Baldassar et al. 2016 for care in transnational families). For professionals without sensitivity to such issues, healthcare for undocumented migrants might, at certain points, become a difficult task. Confirming this finding, Duvin et al. (2012) state that for primary health care, "communication barriers" were reported to be more important, than for emergency services.

It must be said again, that even with all efforts made by patients and healthcare professionals, the fundamental problem, the lacking papers, cannot be addressed in most cases, or even then only after long years of unnecessary suffering and difficulties.

The tight interwovenness of the diverse aspects of inclusion supports the idea that inclusion is a multi-faceted and multidimensional process. Inclusion means much more than getting to interact with medical staff. Regarding this, research should focus not only on medical personnel, but also on administrative and managerial functions. As we have seen, these persons prove to be, in some circumstances at least, as important for inclusion into healthcare as nurses and doctors. Even more, sensitivity to specific conditions might be needed more from administrative, than medical staff.

Comparison with other patient groups might show important differences in the mechanisms of inclusion. That said, it could be interesting to not only advocate a "patient centred" approach to access and use of healthcare (Levesque et al. 2013), but taking the idea even further a "patient informed" approach to inclusion into social systems related to healthcare.

Conclusion

Summing up moments of, preconditions for, and consequences of inclusion into and exclusion from healthcare, as well as an overview of their aspects and qualities ascribed, we can see:

Addressing financial aspects of inclusion, be it by paying out of pocket, by bargaining with an itself restricted and dependent NGO, or by buying insurance, is always difficult in the long term. These strategies are often threatening to the patients' health, and only in rare cases operate as a source of self-esteem. Patients can be included financially – but at a very high cost financially, socially and to health.

Adapting administrative aspects of inclusion to the needs of undocumented migrants is possible. However, such adaptations are only rarely made by health insurers and care facilities. The situation is similarly unsatisfactory for both uninsured undocumented migrants in need of emergency care, as well as insured undocumented migrants in need of regular healthcare. This leaves patients dependent on charitable organizations and trusted persons for administrative inclusion.

Finally, for inclusion into treatment, is not always mandatory, but sometimes desirable to adapt the process to address at least some specific health issues of undocumented migrants. This task is mostly left to specialized charitable organizations and their volunteer networks.

In conclusion, we can say, that inclusion remains partial and precarious. Exclusion is practiced and is an ever-present threat, even while patients and professionals are making every possible effort for inclusion. Undocumented migrants are included into some aspects of healthcare, but only by paying a high price. They are included partially but not completely.

Additionally, they are always excluded from some aspects of healthcare, notwithstanding entitlements like insurance. The health and healthcare of undocumented migrants remains thus deeply marked by their legal status.

8. Acknowledgments

First, I would like to thank my supervisor, Dr. Kristen Jafflin. Thanks to her professional and well put feedbacks, this thesis has found a good balance between giving room to empirical data and reaching out for theory. For their conceptual and literature input but also their warm welcome to Queen Mary University, I would like to thank Sajida Ally and Jessica Potter.

Thanks to Cindy-Jane Armbruster and Clara Benn for having had the patience of reading through my English. And thanks to my friends and family and especially to Lukas for listening to my stories over and over again.

Thanks also to my employer, the EQUAM foundation, for their support, trust and flexibility.

Last but not least, thanks go to the medical and administrative professionals, especially at the Contact Point but also beyond, for having given their time for interviews. My greatest thanks, however, go to the undocumented migrants for agreeing to share their stories and a part of their lives with me.

9. Literature

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