Chapter 4
Home/Sick: The Health–Migration Order

AH: You were saying before [about being recruited for the French mines] that there was a medical at Aïn Borja [near Casablanca], and that there were nine doctors?
Jawad: Oh yes, nine doctors, yes, we took all sorts of tests – weight, eyesight, teeth.
AH: Oh really, even teeth?
Jawad: Oh yes, blood tests, x-rays – for the lungs – oh yes a full physical examination, no mistake (…) They made you take five kilos – two and a half kilos in each hand – they put you on the scales, and they position you like this [Jawad stands up and stretches out his arms to the sides]. You see, the people are looking at the calibre of the applicant, to see whether he can take the strain (…) They don't take just anybody. They look at everything, everything (…) If you are in good health, they take you. And if there's something missing, they say "no, it's not worth it" and they don't take you. Oh yes, it's not like "On you go, worker, come to France!" We entered under the Service of Immigration, we did all the tests. In good health, no illnesses, nothing (…) a worker, a good one, you know.
AH: So they took the strongest ones?
Jawad: Oh yes, they didn't take idlers. Someone who's ill, he's going to come? – no no no.

Interview with Jawad (69, Taroudant, Morocco)

Health has ordered hostel residents' migration trajectories in three key ways. As can be seen from the epigraph above, for Jawad and others, *good* health was a prerequisite for coming to France in the first place. Later in life, at retirement age, health again orders migration, but this time it is the fact of *poor* health which conditions their movements to France, in order to receive healthcare. Hostel residents do not differ markedly from the rest of the elderly population in France as regards health conditions (a higher incidence of type-2 diabetes excepted: see Hadjiat and Fevotte 2008). What does distinguish hostel residents however is their earlier onset of health problems. As a consequence many hostel residents have, over the years, developed strong relationships of trust in French medical services. Just as was seen in Chap. 3 regarding paperwork and access to social protection,

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maintaining inclusion in the French healthcare system is an important priority for older hostel residents, and one which timetables their trips to France. The rationale for these back-and-forth trips constitutes the heart of this book's analysis. However, back-and-forth mobility itself can have a negative impact on health: this is the third way in which health and migration interact, underlining the complex inter-relationship between migration and health (Findley 1988).

I term this inter-relationship the 'health–migration order.' With this term I wish to build on Sally Findley's bi-directional concept of 'health-migration relations', namely whether declines in health status influence the propensity to migrate and, vice versa, whether the act of migration impacts negatively on health (Findley 1988). Findley shows that health-migration relations are particularly salient for older people, while young people's patterns of poor health and migration do not seem to be correlated (ibid). However, Findley draws her findings from cross-sectional survey data mainly recording within-country moves rather than international moves, overlooking a key dynamic insofar as international migrants are widely thought to be selected by *better* health vis-à-vis their peers, giving rise to the 'healthy migrant' effect (Abraido-Lanza et al. 1999; Marmot et al. 1984; Moullan and Jusot 2014; Razum et al. 2000).[1] While utilising cross-sectional survey data provides robust tests of different health-migration models in the studies cited here, the added value of a qualitative lifecourse approach – which this research adopts – is to highlight the influence of both *bad* and *good* health on decisions to emigrate, return and/or circulate across borders, in different historical periods and under different border control regimes (Montes de Oca at el. 2011). As Baykara-Krumme (2013) concludes, health status is a factor in the decision to return but its influence is not clear-cut. For some, poor health leads to a bi-residence strategy in order to benefit from better quality and/or subsidised healthcare in host countries, whereas for others poor health may force individuals to settle definitively either in the home country or the host country (Baykara-Krumme 2013). The findings of this book, in this chapter and Chap. 7, support this insight about the ambivalent effect of poor health.

Just as was found in Chap. 3, the men's 'non-standard' biographies have a bearing on their interactions with welfare institutions, in this case healthcare professionals. As will be covered below, non-standard biographical features include premature ageing due to difficult working conditions and work accidents; language barriers in the patient-carer relationship; and lack of family entourage to provide informal care, meaning that an extra duty of care falls upon formal providers. Finally, the epigraph to the previous chapter showed how an identity based on papers can compensate for the loss of the identity of 'worker' which occurs at retirement. In the concluding pages to this chapter, I speculate as to whether an alternative identity based on illness can play a similar 'compensatory' role, functioning as a rationale for non-return, especially when justifying this decision to family members remaining back home.

[1] Other scholars speak of a migrant mortality paradox: in many contexts, migrants have lower mortality rates than non-migrants, once socio-economic status is controlled for (Darmon and Khlat 2001; Deboosere and Gadenye 2005; Norredam et al. 2015; Wallace and Kulu 2015).

4.1 Health and Mobility in Later Life

Access to healthcare is a major factor in return decision-making for the older hostel residents. Very frequently hostel residents would justify their decision not to return definitively on health grounds. One Algerian hostel resident, when I told him that I was doing a study on retired people living in migrant worker hostels, hurriedly declared: "We are only here for healthcare." Hamid (70, Taroudant, Morocco) was very firm about why the older North Africans are still here: "the only thing is healthcare". If they could get healthcare free of charge back in Morocco, through social security, then they would be back there more often. Saleem (60, Tiznit, Morocco) had this to say:

> There are people who are old, they need care, it is for this reason that each time the people do back-and-forth trips. They want to stay [back home], if there was the advantage of social security like there is in other countries there would be nobody who comes here to France – at any rate there are people who have serious illnesses, but they come here [to France] every three months or so.

That this coming-and-going at retirement is motivated at least in part by healthcare provision in France is a narrative upon which everyone I interviewed was in agreement – healthcare professionals, hostel managers, union delegates, immigration lawyers, civil servants, migrants' associations, embassy officials, and of course residents themselves. I did not hear one dissenting voice during 2 years of fieldwork. The overarching narrative is that the men are in France when they are sick and in need of treatment, and then when they are well enough they return home to be with their families and to benefit from the emotional support that the family offers. This narrative can be summed up in the chapter's title – 'Home/Sick' – a formulation which tries to encapsulate this back-and-forth health strategy.

Before continuing, two disclaimers are in order. Firstly, as noted, many hostel residents were very ready to talk about general healthcare needs as a rationale in their return and residence decisions. However, there was an overall reticence to discuss specific health problems in detail. This reticence means that the balance of testimony here is slightly weighted towards the voices of healthcare professionals. This applied to all health issues, but particularly mental health. Saleem, the leader of the Residents' Committee in his hostel, put it in these words:

> As for me, I'm going to try in the future to propose to the management that from time to time – and it's not easy – to have someone who comes here, as a psychiatrist, to discuss things with people. But it's not easy (…) everyone has a secret, for any person his problems are his secrets, he doesn't want everyone to know that he … he has problems (Saleem, 60, Tiznit, Morocco).

Given that mental health is less prominent in residents' testimonies, I will not discuss this issue in detail in the main body of the chapter. Instead, the theme of mental health will be treated more speculatively in the concluding section (Sect. 4.5).

Secondly, it is important to acknowledge that this *va-et-vient* for healthcare can continue only so long as the men are in a fit state to travel. Once a certain loss of

autonomy is experienced, necessitating assistance with everyday tasks, regular comings-and-goings must cease and the men are forced to make a choice about where they will see out the rest of their days. This decision clearly is related to their long-term care needs, but I will not discuss this in the current chapter, which focuses on more acute medical care (to treat illness), postponing discussion of long-term elderly care until Chap. 7. This distinction between acute medical care and long-term elder care may appear counterintuitive in the light of conventional models of health, such as the World Health Organistion (WHO) definition: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[2] Indeed, this definition has been incorporated by the hostel management companies, as this interview with a senior manager confirmed: "When one ages, one is not necessarily ill, but one can have difficulties with mobility, difficulties completing daily tasks." However older hostel residents tended not to see it this way, often showing a clear disinclination to be helped in everyday tasks. Asked about this distinction between more acute medical care needs and long-term elderly care, Sonia (elder care coordinator, Val d'Oise) agreed. In terms of medical care, the residents "will get themselves cared for, they know the way to the doctor or the hospital, they know the steps to follow." By contrast, "they hardly ever make use of [elder care services]."

For the older hostel residents, health means the sensation of physical pain and the presence of somatic symptoms. One older Moroccan remarked that while French pensioners are very well cared for, North Africans "don't have the same culture" of going to the doctor at the first sign of a problem. Indeed, from my conversations with healthcare professionals, it became apparent that most older hostel residents tend to have recourse to medical care only in cases of acute ill health and pain. "They let the healthcare side of things slide, it's rather marginal with them", notes Abdou (outreach officer, migrant rights association). They wait until the last minute, when they are "really troubled" before getting checked out (Unafo 2002: 49). Béatrice (health advisor, migrant welfare association) concurred: "Why do they seek medical care at the very last moment? (…) They came for work, so as long as they were in a state to work, they worked. To be sick meant to be in one's bed with a fever and not be able to move."

Residents' State of Health The first point to note regarding the health situation of the older men living in the migrant worker hostels is the lack of reliable national-level statistics (Hadjiat and Fevotte 2008: 331). This is compounded by the legal prohibition on ethnicity-based statistical data in France, including in healthcare statistics, making it impossible to infer epidemiological trends in the hostels from wider population data, although the correlations between ethnicity and certain health conditions are by now well-established (Bhopal 2014). A geriatric doctor at Sonacotra-Adoma admitted that there was very little data she could draw on with

[2] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York 19–22 June 1946. http://www.who.int/about/definition/en/print.html [accessed 25/3/2010].

confidence: "In France we are very behind when it comes to studies concerning more specific populations like this (…) There are many rumours which circulate (…) which are not based on any scientific study." This was confirmed in a telling way by her counterpart at the second-largest hostel company Aftam-Coallia, revealing the primacy of financial and administrative aspects in the hostel manager's vocation:

> It's more that we feel the tendencies (…) there is nothing on the medical aspects in the end because they are people who are at home [*chez eux*]. So we're not supposed to enter into their private life, to meddle with the health aspects. The only thing that we can have, possibly, is if ever a report is sent back by the hospital, but it is very rare. So we have few elements to go on, concerning the residents themselves. *In fact, we're more likely to have their tax file, to be honest!* (laughs) [emphasis added]

Despite the lack of data, observers on the ground tend to observe the same types of illness affecting older hostel residents. These include: problems relating to eyesight, hearing, dental health, rheumatology, arthritis, back pain, cardio-vascular disease, gastro-enterology, urinary infections, and respiratory disease (Adoma 2007; Aftam 2006; Migrations Santé 2003; Sonacotra 2005). The range of illnesses experienced by residents, therefore, is no different to the rest of the elderly population (Unafo 2002). Dr. Ismail (geriatric doctor) confirmed that "it's more or less the same schema as everywhere else in the world", listing (i) cardiovascular conditions (high blood pressure, heart attacks) and (ii) "disability" linked to work accidents (back and knee pain). However there are a few specificities in hostel residents' health which are noteworthy. Firstly, health professionals observe a general degradation in health which afflicts hostel residents over the age of 55.[3] As Anne-Marie, a crisis social worker at a hospital in the northern Paris suburbs, put it, "[those in the hostels] have let a whole load of things slide (…) there is a whole list of factors which bring them to hospital, generally they don't arrive for just one thing only." Residents themselves are conscious of a certain decline in terms of health. The words of Saleem (60, Tiznit, Morocco) are characteristic in this regard:

> It's fine, I'm in good health, but each time I feel a negative side (…) I went to see the doctor, he gave me the treatment [for a prostate problem], but I don't know – what it might become or if it is going to become another illness, you just don't know. Because we – we're beginning to deteriorate inside, even if you feel OK like this, you don't know what life holds for you tomorrow.

A second factor to register is the prevalence of diabetes in the hostels. While there are no nationwide statistics for diabetes, in a study of residents over 60 years of age in Sonacotra-Adoma hostels in the Rhône region, the incidence of diabetes was at 15.5%, against 8% in the rest of the population over 60 (Hadjiat and Fevotte 2008). The role of ethnicity in the prevalence of type-2 diabetes is important and has been widely reported in the epidemiological literature (Agyemang et al. 2011; Carulli et al. 2005). Dr. Ismail confirmed that diabetes is a feature, especially for the

[3] This situation is termed *altération d'état général* (AEG) in French elder care services.

older North Africans whom he sees. Its prevalence among the hostel population is linked to diet in particular, as well as lack of exercise following retirement.

The third key element to note is premature ageing. Vivianne (geriatric doctor) recounted that when she first joined Sonacotra-Adoma she was "surprised to see that [in the company] we started speaking of old people from the age of 55." Many other professionals mentioned 55 years of age as a milestone, and numerous studies use 55 years and above as the basis for their sampling frame (e.g., Migrations Santé 2003). While not all are in agreement on the significance of the age of 55,[4] what is clear is that immigrants in general experience loss of autonomy at a significantly earlier age than native-born French elders. The average age of dependency among retired people originally from North Africa is 75.3 years, versus 82 years for people born in France. For the age bracket 60–69 years, the proportion of dependent people born in France is 1.3%, against 4.5% for those born in North Africa (Hadjiat and Fevotte 2008). These differences are attributed to migrant workers' exposure to difficult working conditions and work accidents.

This said, the phenomenon of premature ageing is not necessarily a problem confronting all older migrants in the hostels, a point stressed by Jean, a union official:

> Not all older migrant workers are confronted with a loss of autonomy at the age of 50 – I know people who are 90 and who are as fit as a fiddle, never been to the doctors. And there are people at 55, afflicted with a respiratory infection, who are in such a state that they look 70 instead of under 60.

What is critical for Jean is the particular sector of employment, not the fact of being an 'old' immigrant *per se*. "Some illnesses are quite common, notably everything which is linked to mobility, following work accidents, things like that. Also you find everything connected to respiratory illness for people who were exposed on the building sites." Thus, as was seen in Chap. 3., specific biographical features – in this case sector of employment – have a bearing on the hostel residents' situation. Indeed, it is important to acknowledge the prevalence of work accidents among the population of hostel elders. While foreigners make up 6.8% of the workforce in France, they account for 13.1% of work accidents (Alidra et al. 2003). More specifically in the construction industry, where around one in five workers is a foreigner, their work accident rate is 30.2% (ibid). At the regional level, a survey by Migrations Santé underlines the serious risk of work accidents among this population. This survey indicates that 39% have already had a work accident, of which 30% continue to feel the after-effects. 17% receive an invalidity pension, and 10.6% are recognised as disabled workers (Migrations Santé 2003).

[4] Gerontologists have long recognised that measuring age on a chronological basis alone is problematic, insofar as this neglects biological, cognitive and social dimensions of ageing (Bradley 1996; Markides and Mindel 1987).

4.2 Inclusion in the French Healthcare System

Given the earlier-than-average incidence of health problems in their medical histories, it is not surprising that many hostel residents have built up strong relationships with their doctors over the years. Maintaining these relationships is one important rationale for hostel residents' back-and-forth trips at retirement. According to a study by the NGO Migrations Santé, an "immense majority" of residents are registered with a *médecin généraliste* (general practitioner[5]: hereafter GP) whom they see several times per year (El Moubaraki and Bitatsi Trachet 2006: 88). This was affirmed by a geriatric consultant at Sonacotra-Adoma: "the residents in general have a great confidence in the French healthcare system, be it their doctors, be it the hospital. They have a great confidence and a great respect." This is echoed in an article by Fanny Schaeffer on older Moroccans in France:

> It is understood then that migrants, who have arrived at the age of retirement, have established a privileged relationship with their doctors, and more generally with the entire French health system. Indeed, to any elderly person who is used to certain care, certain medication, there is a risk that treatment will be rejected, if administered suddenly and under different forms and conditions. Moreover, the fear of not being correctly cared for in Morocco, linked to the generalised distrust towards the Moroccan health system and to a well-established medical relationship in France, is an equally important brake on definitive return (Schaeffer 2001: 170; author's translation).

Trust in GPs is evidenced also in residents' care preferences in case of illness. 64% consult their GP as soon as they feel ill, with only 11% opting for Accident and Emergency (A&E) care at hospital, and 10% making the local pharmacy their first port of call (El Moubaraki and Bitatsi Trachet 2006: 88). By contrast, Sandrine and Elvira from the crisis social work team strongly disputed these figures and were adamant that most patients they see from the hostels do not have a GP. The perspective of Sonia, an elder care coordinator in Val d'Oise, was more nuanced in this regard. She identified two broad groups: a majority who receive regular care and monitoring following detection of a chronic illness, and then a marginal minority who "let themselves go completely". It appears to be the latter group who are seen by the crisis social work team.

For those who do benefit from regular monitoring, appointments with doctors and consultants have a strong influence on the timing and duration of their back-and-forth movements. This is the first way in which healthcare has the potential to 'timetable' hostel residents' return trips. Lassana, a Dembancané man who works in Paris and is yet to retire, takes care of banking affairs (i.e. holds a proxy) for three retired former migrants who have returned to the village. They have not completely settled back in the village just yet and still do the *va-et-vient*, primarily for health reasons. They remain domiciled principally in France, they have their pensions paid in France, but they are

[5] *General practitioner* is the term used in Britain, Ireland and some Commonwealth countries to describe a medical doctor who works in primary care as the first point of contact in the treatment of acute and chronic illnesses. In other countries this type of doctor may be referred to as a *family doctor*, *home doctor* or *family physician*.

often back in the village. In Lassana's words, "they prefer to not break with their doctors and their medical appointments."

Nasser, a retired hostel resident from Nador (Morocco), followed a similar strategy, spending on average 9 months of the year back in Morocco. When I spoke to him, he told me that he was due to go back to Morocco very soon, but would be returning to France for a doctor's appointment on the 9th of October. Similarly, Tariq (66, Tlemcen, Algeria) explained that he was scheduling his next trip to Algeria around his next doctor's appointment, when he hoped to get the all-clear for a prostate condition for which he had recently undergone surgery. The excerpt from my interview with Issa (70, Tambacounda, Senegal: see Box 4.1) touches upon many of the themes noted immediately above – preference for French medical provision; relationships of trust with staff; and the timetabling effect of medical appointments.

The second way in which healthcare has the potential to 'timetable' hostel residents' return trips concerns eligibility for the state-subsidised health insurance scheme, CMU (*Couverture de maladie universelle*). Geriatrics specialist Dr. Ismail

Box 4.1: Issa's Views on Healthcare

AH: Ok, you mentioned earlier the necessity to come to France, for healthcare. So you have had a few health worries recently?

Issa: Yes, because, health problems – we talked about this yesterday – when I'm ill there's good healthcare in France, they care for you well, there's no problem, the hospital is good, the drugs are good, there's everything you need.

AH: Ok, and the quality of care is better here than in Senegal?

Issa: It's better, it's not the same, because [the doctors] have the means here, they know the job well, it's not like in Africa.

AH: Oh really?

Issa: No, because they have the means here, the machines are good, the right drugs, all that, they have the capacity. I find that for care, here is better.

AH: So the clinics and hospitals in Senegal, it's not very – it's not a good quality?

Issa: Good quality establishments do exist, but they lack the resources. The only thing is that they lack the resources, the drugs aren't the same, the equipment, the material isn't the same.

AH: Ok, yes, it's clear that in France, it's a very good system.

Issa: Yes, it's strong.

AH: (…) And so at this moment in time, you feel in good health?

Issa: Yes, but there's something not quite right all the same. But tomorrow, even tomorrow, I have an appointment -

AH: Tomorrow? Ah I see.

Issa: – at the Hospital [in town.]

again was informative on this subject. On the medical level, if a person is away from France for more than 6 months, she forfeits the rights she has gained under the CMU to subsidised healthcare.[6] However, provided the individual returns to France within 3 years,[7] the person remains eligible for the CMU, but will need to request a "re-opening" of her rights to the CMU. If a health problem arises during the sometimes lengthy administrative processing of this request, "the person may find themselves without medical cover for two or three months, and as a result they are obliged to pay for everything", according to Dr. Ismail. The calamitous situation which ensues for those foreigners who unwittingly no longer have rights to the CMU and end up in hospital[8] has prompted the staffing of crisis social workers in many hospitals in order to anticipate any potential financial problems from the outset of treatment, so that patients do not find themselves in massive debt unavoidably.

The availability of medicines prescribed for chronic conditions in places of origin also has a bearing on the frequency and regularity of residents' back-and-forth trips. This is the third element of medical timetabling. The lack of medicines and drugs available back home was a particular feature of respondents' accounts. Germain (outreach officer, social and legal rights charity) noted, "Some say that they have all they need back there, but a larger proportion say they are obliged to return, especially for more serious conditions." When asked whether he would be returning home to his family, Mehdi, a building site foreman from Algeria who was due to retire at the end of the year, replied: "It's better to head back home at retirement." I asked him if that's what he intended to do: "That depends. You never know. With health, you never know. There's a worry about health. It's better here, there's a lack of medication over there. For the immigrants, it's better to get care here." Denis, a hostel manager, echoed the sentiments of the residents concerning lack of medication: "The major thing is medicines. Back home there isn't very much to choose from. Here there's everything they could need, and furthermore it's taken care of by social security."

Among my respondents, this issue was most crucial for those who are diabetic. Kader (70s, Mostaghanem, Algeria) is diabetic, and self-administers a treatment of insulin by injection every day. But he cannot find the type of insulin he needs in his home region in Algeria, which is why he comes back to France. In Dembancané (Senegal), I spoke to a retired former migrant, who showed me his diabetes kit and notebook for recording the four daily readings that he has to take to make sure he is within safe limits. He explained that his doctor in France had advised him to visit

[6] The condition of "stable residence", one of the eligibility criteria for the CMU, is fulfilled if the individual resides at least 6 months and 1 day in France per calendar year (see Decree n° 2007-354 of 14 March 2007; see also Grandguillot 2009.

[7] An absence from France exceeding 3 years automatically invalidates one's residence permit. This document is essential for proving the "regularity" of one's status in France, a second criteria for eligibility under the CMU. See Grandguillot 2009.

[8] The minimum price for a bed in an Ile-de-France hospital is €700 per day, and can rise to €2000 in specialist cardiology centres.

twice a year for a check-up, but he can only afford to go once a year as the plane tickets are expensive.

What appears crucial is the quantity of medication that an individual can take back home with him, dictating the length of time the individual can be absent (Barou 2007). This leads to the thorny issue of prescription renewals. I asked Hamid (70, Taroudant, Morocco) how often he returns to Morocco now that he is retired. He replied by saying that he continues to return once a year, just as when he was working, but that the duration of his absence from France has increased from his month-long paid holidays to 4 months. He does not go back more than 4 months in a year. The real problem is with his diabetes medication. He cannot get more than 3 months' medication at a time; the doctor cannot sign off the prescription for 6 months like in the past. The current maximum is 3 months. But it's a cruel irony – they have contributed to social security all their lives yet "at retirement, this is the time when you need the medication, but we can only get three months' worth!"

Dr. Ismail explained these changes to the system of renewing prescriptions. When the GP or specialist hands out a prescription, it is valid for 1 month, with the option to renew it for a period of up to 3 months. Before, with chronic illnesses, in order to limit the number of times the patient had to go to the pharmacy, a pharmacist could sign off on a treatment of up to 6 months. This permitted hostel residents to spend longer periods back home, but now the maximum duration is 3 months.

Intriguingly, Dr. Ismail outlined several ruses to bypass these administrative rules. In other words, just as with paperwork, there are various 'tactics' which are deployed by hostel residents to circumvent bureaucracy. Firstly, the patient can leave their *Carte vitale*[9] with a complicit pharmacist before going away, collect all the medication he needs prior to his trip, and then every month the pharmacist swipes the card and renews the prescription. This is of course very much in contravention of regulations. A similar ruse can be effected if the holidaying patient leaves his card with a family member or a close friend. They can then collect and send the medication to the patient's address in the place of origin. I should add that none of my respondents admitted to engaging in such practices, and one may assume that they are not particularly widespread. The men I spoke to felt constrained to observe the 3 month prescription renewal limit.

4.3 Non-standard Biographies Impede Healthcare

From the above, it is clear that maintaining access to healthcare has a timetabling effect on hostel residents, just as inclusion in administrative systems timetabled residents' presence in France in Chap. 3. The other principal point made in that

[9] The *carte vitale* is the card which proves an individual's affiliation to one of the health insurance regimes in France. It is a chip-and-pin card, bearing the holder's name, and everyone over the age of 16 is required to present it when undertaking the administrative procedures required to get health costs refunded (see Grandguillot 2009: 40).

chapter was the divergence of hostel residents' biographies from the 'standard' life-course institutionalised by the welfare state, complicating their access to social protection. The same trend applies in the relationship between hostel residents and healthcare providers. Here I will underline three problematic biographical features common to many older hostel residents: premature ageing, absence of family in France to provide informal care, and difficulties of communication with French medical professionals.

Premature Ageing and Lack of Family Entourage In Sect. 4.1, premature ageing was identified as a key problem affecting hostel residents. In the hostels, residents are defined as 'older' from 55 years of age, whereas elder care services in France tend to be aimed at a quite different demographic segment, namely the 'oldest old' (85 years and over). Due to women's longer life expectancy, this segment of the population also tends to be disproportionately female. Put simply, elder care providers in France are not accustomed to treating men in their 60s and early 70s, and as a result may overlook the hostels as locales where their intervention is required (see Chap. 7 for further details).

A second way in which hostel residents differ from the customary clientele of elder care services pertains to informal care provided by family members. In France and other European countries there is an institutional assumption that much elder care is provided informally by relatives (Walker and Maltby 1997). Yet for hostel residents the family entourage is most often absent, given that their wives and children reside in countries of origin. By stressing the role of informal care provided by relatives I do not mean to reproduce the culturally-essentialist assumption that ethnic minority families are more involved in caring for elderly relatives (see Shaw 2004 for discussion). Rather I wish to stress that family entourage is a key foundation of care for *all* elderly citizens in France, as it is in other countries typified by demographic ageing and welfare state retrenchment. The absence of relatives able to provide informal care when the hostel residents are in France means that a heavier care burden falls upon the (often overstretched) formal care and health services, with negative consequences on overall care for the men. As Jean, a union official, observed, "the institutional mechanisms in place to deal with ageing are very weak in France, so it's often in this role of proximity and urgent attention where the close family is going to see the person, they are likely to alert the doctor." In a similar vein, when I asked Anne-Marie what distinguished hostel residents from other older patients who are seen by her crisis social work team at a hospital in Paris' northern suburbs, she remarked that–

> It's isolation which counts because other old people be they immigrant or not, when they have family our work becomes less difficult because families are a big support for us, they can take steps to help, and especially in this case they are vigilant vis-à-vis the person, and they can warn of danger before it's too late. Whereas for the people who live in the Sonacotra hostels, generally they arrive (at hospital) when really they are not well at all (…) they have no wives or children who are going to tell them "look now, you're not ok, you better go and see the doctor." (Anne-Marie, crisis social work team)

Due to the lack of such *aidants naturels* – an expression signifying the family as the 'natural' caregivers – the burden of caring for hostel residents is delegated to state agencies and hostel managers. Yet the hostel management and outside partners do not have the resources to accommodate the residents in their needs to the same extent. The absence of family can create a problem for healthcare professionals who do not have knowledge of the patient's prior medical- and life- history; more time is required on the part of these services to explain to the patient what their care entails (Sonacotra 2005). More will be said in Chap. 7 about the policies and mechanisms which hostel companies have put in place to compensate for this lack of family vigilance when residents suffer loss of autonomy.

An additional consequence of family separation is that hostel residents are often under an obligation to provide financially for dependents back home (see Chap. 5 for more details), and this obligation to continue sending remittances after retirement age can take precedence over paying one's own medical bills. "Prevention measures (notably subscribing to health insurance) are considered to be an additional financial charge, acting as a brake on the amount of money sent back home" (Sonacotra 2005: 3; author's translation). This point was raised by staff at an elder care coordination centre in the *département* of Val d'Oise to the north of Paris. Paying health expenses means sacrificing revenues which otherwise would have been sent to their family, according to Sonia (elder care coordinator, Val d'Oise). As a result, the men go without the care which is appropriate. Research by the Migrations Santé NGO shows the clear impact that reduced income has on the ability of older hostel residents to pay for care, with up to three-quarters of residents aged over 55 in certain hostels experiencing difficulties in paying for medical treatment (Migrations Santé 2003).

Ill Communication The final factor I would like to stress in this section is the potential for communication difficulties between hostel residents and health professionals. This is a significant issue for many hostel residents, with 54% of residents in a Migrations Santé survey unable to read and write French, and 73% judging their language abilities as poor (El Moubaraki and Bitatsi Trachet 2006: 83). Poor mastery of the host country language impacts health in two distinct ways: lack of claims-making due to ignorance of social rights; and mutual incomprehension between hostel residents and medical staff.

Firstly, linguistic difficulties complicate administrative procedures and produce a situation where there is a high degree of ignorance surrounding the services and rights to which the older men are entitled, as was intimated in the previous subsection. Saïd, who represents a migrant association in Paris, argued that the hostel residents do not know about the facilities and support available for elderly people, and so they do not know their rights. To this end, his association are in the process of making a guide for elderly North African immigrants in both French and Arabic. Sonia (elder care coordinator, Val d'Oise) was categorical when I asked about the take-up and use of services provided by the elder care coordination service she works for:

AH: The hostel residents, do they come here [and make use of your services]?

Sonia: No, because already there is a lack of awareness. They don't know. Because they are in their bubble, in their hostel, they don't know all the services which we can offer them. (…) So when they experience a loss of autonomy where an association could come and help them, they can't call them because they quite simply just don't know.

The second way in which poor language skills impact on residents' health is the mutual incomprehension which can arise during residents' interactions with care professionals. In a report for Unafo, the Union of Professionals in Accompanied Housing, Omar Hallouche notes:

> Certain practitioners have made us aware of their difficulties of communication with this public. They recognise that they do not always have adapted responses in terms of reception, prevention and care. The first obstacle evoked is that of language. In fact, the North African population is in the majority illiterate and does not have good mastery of spoken French (Hallouche 2002: 16; author's translation).

Obviously, hostel residents are not unique in their poor mastery of the host country language and in the outcomes that this has for their healthcare. A large body of literature in public health and gerontology has noted the impact of communication breakdowns between older ethnic minority patients and healthcare professionals (Cook 2010; Ellins and Glasby 2016; Emami and Torres 2005). Two contexts will be examined here: the doctor's surgery, and the hospital.

In a Dutch study of GP interactions with ethnic minority patients, one of the principal findings was the lower incidence of 'solution-seeking' communication between GPs and their ethnic minority patients, with such patients often not seeking to be involved. The authors went on to note that "previous research suggests that patients from non-Western backgrounds seem to have less need for information and decision-making than more Western-oriented patients" (Schouten et al. 2008: 473). Dr. Ismail, who holds drop-in medical advice sessions in several Parisian hostels, would certainly dispute the finding that ethnic minority patients have less need for medical information. During our interview, he commented that if hostel residents do not understand a treatment or feel that it is not working, they come to him to get information in Arabic or Kabyle (the language of Kabylia region in Algeria from which many hostel residents originate: see Sect. 2.1). Most typically, they want to know which kind of specialist to see. In his opinion, poor mutual comprehension between patient and GP is a significant health risk.

Other respondents underlined mutual incomprehension in the hospital environment. Studies have shown that hospital can be a disconcerting environment for any older person since complex pathologies, medical histories and sensory impairments may fall outside a "one-size-fits-all" service delivery culture in hospitals (Parke and Chappell 2010: 115–6). Elderly people's lack of fit is likely only to be magnified when it comes to treating migrant pensioners. This was most evident in the hospital setting where older hostel residents may become disoriented (*dépaysé*) by their

Box 4.2: Language Barriers to Care in the Hospital

Elvira: When they arrive at hospital, there is all sorts of medical jargon which is, let's say, a little bit complicated even for a French person who is quite well off. So when one doesn't speak the language well and when the people speak to you about illnesses or examinations, similarly it is a moment where they don't understand the meaning.

Anne-Marie: They don't understand the meaning of the care, and furthermore the linguistic barrier means that already – well, when you see your GP, he has known you for a long time, he can take the time to chat with you (…) except that they're not going to get a GP, they're not going to get someone they know. They arrive at A&E, the doctors have fifteen patients all at the same time, they see a medical problem, they're not necessarily going to take the time to chat, and furthermore this immigrant, if he already has a few problems when it comes to speaking French, he is going to have a hard time explaining what is not right with him, and the doctor is not necessarily going to take the time to try and understand everything (…) So yes, I think that when they are – especially at A&E – there are "boxes" for the people who are most serious, and then there is a room where all the stretchers are. So you are in the room, everyone is lying on their side like this, and there are carers who are going in all directions. Staff are moving in all directions, so it's definitely a bit scary as well, and then you have the impression as well that you are being abandoned because you are there to be cared for and (…) they keep you waiting until the results are ready, and then return three hours later to see how you are.

experiences in such a highly medicalised context, "parachuted into a care system which operates at high speed", as Elvira and Anne-Marie, crisis social workers at a hospital frequented by some of my respondents, discussed in some detail (Box 4.2).

Nonetheless, one must be careful not to interpret such findings in a culturally-essentialist perspective, as the 'cultural competence' model of elder care too often reproduces (Emami and Torres 2005). The cultural competence model especially prioritises difficulties in 'host' country language acquisition as the principal source of exclusion in healthcare, identifying the patient as "'deviant' for not being able to adapt to Western culture and language" (Brotman 2003:225). As a growing body of research shows, mis-communications and conflicts between ethnic minority patients' explanations of illness and the bio-medical view of the dominant Western healthcare model can be better understood by focusing on other underlying factors or commonalities which elderly ethnic minority patients experience (Emami and Torres 2005; Torres 2015). One important factor to consider is migration history, with late-in-life migrants being at risk of a number of disruptive stresses (Emami and Torres 2005). For more established migrant populations who moved to host countries in early adulthood, the great diversity of ageing migrants points in favour of an intersectional approach combining multiple axes of social differentiation

(Torres 2015), such as socio-economic status, gender, the presence or otherwise of family support, as well as country-of-origin factors such as rural or urban milieu. It is to these country-of-origin factors which I now turn.

4.4 Healthcare Provision in Countries of Origin

The literature on ageing migrants has primarily analysed how such individuals engage with health systems in countries of immigration: by contrast, very little is known about their recourse to healthcare provision in countries of origin, with the work of Sun (2014) being one notable exception. Nonetheless, for the hostel residents, places of origin in North and West Africa do offer certain advantages when it comes to healthcare. Dental care, eyesight and hearing are three health needs where the country of origin is the preferred place of treatment. Data made available to me by the Migrations Santé NGO show that in general residents prefer to return home for dental care, where it is cheaper. A study by Paul and Berrat found that hostel residents perceived dental, visual and hearing problems as of minimal importance and would only take recourse to specialist care if the trouble became really handicapping, preferably in the country of origin (Paul and Berrat 2005). This excerpt from an interview with Ibrahima (59, Gorgol, Mauritania), is indicative of the financial logic behind this choice:

> In Africa it is less expensive, and they say that here [in France] there are guarantees etc, but over there also it's still very good, you know. (…) Because I heard that in Dakar, for the dentist, my friend he went to see the dentist, it cost €150. €150, but here [in France] another guy I know went to the dentist, and he paid almost €1000 (…) Yes, €1000, but it's over there where [the care is] more solid, where it is better.

Another aspect which merits attention is the possibility of recourse to more traditional remedies in places of origin when 'Western' medicine is not able to deliver a cure. Dr. Slimane, a Paris-based psychiatrist, remarked upon the "need to go and see the repairers of disorder, the wise men, the healers back home." Although healthcare professionals in France may view such practices with incomprehension, traditional medicine nonetheless exercises an attraction for some hostel residents. Once again, Ibrahima's comments are insightful, when he alludes to 'African' treatments:

> Last year I fell ill too, but it was because of fatigue, bad fatigue. Well it was [my GP] who sent me to hospital, at the hospital they did x-rays, other [tests]. All that, for a year, but there was nothing, they found nothing. But I knew already – I've been around, I know what life's about – it was simply fatigue. So I returned to Africa, and took treatments in Africa, medicine – African treatments, you know, it's very good (…) I'm much better now (Ibrahima, 59, Gorgol, Mauritania).

A further advantage of a return home is the more propitious climate which is found on the other side of the Mediterranean. This tallies with studies on amenity emigration which show that the attraction of climate is the primary factor in the

decision to spend all or part of the year in destinations such as the Mediterranean for Northern European retirees and the 'sunbelt' of the southern United States for North American pensioners (see Hogan 1987; King et al. 2000; Smith and House 2006). As regards return at retirement, research by Martin Klinthäll in Sweden has found a correlation between temperate climate in the place of origin and propensity to return at retirement, with relatively high return rates for retired labour migrants going back to Greece and Italy (Klinthäll 2006: 168). In the context of return migration to Jamaica, Elizabeth Thomas-Hope notes that:

> Return migrants of all types expect to obtain standards of living which are equal to, or higher than, those experienced abroad. This is usually achievable in Jamaica, and one of the more positive aspects of the migrants' experiences relate[s] to the pleasant lifestyles which they enjoy on return. Likewise, conditions are generally conducive to good health, primarily on account of favourable climatic conditions (1999: 195).

I had expected to hear similar stories from my respondents, but the evidence was not so straightforward. In France I asked retirees in the hostels about whether climate was a factor in their return practices. Rather than being a positive reason for return, this generally entered into their planning insofar as certain very warm or wet periods should be avoided. As Amadi (65, Matam, Senegal) commented, it is difficult to adapt to the very hot climate which is experienced in Senegal between March and August – "you're going to suffer". A Moroccan resident I spoke to intended to return to Morocco in September, avoiding August when it is too hot for him: he had recently undergone an operation for an intestinal problem and reasoned that the heat would not be good for his health. West African hostel residents tended to avoid the very hot and humid rainy season, preferring to return when it is cooler, starting in October. To the question 'Did you use to leave in winter or in summer, or did it vary?' Djimé, speaking from Dembancané (Senegal), replied:

> No, always in winter, the climate is really agreeable at that time – well, as you see, when you're used to Europe, and when you come here during the heat it's very difficult and complicated. But in winter we are at ease.

For a small selection of health needs – dental care, eyesight, and hearing – the place of origin is perceived as being a preferential source of care. In general however, for most conditions, French healthcare is preferred and in some cases obligatory, since treatment for some conditions is not – or only rarely – available in the place of origin. Such illnesses include diabetes, Parkinson's and Alzheimer's (Unafo 2006), as well as conditions requiring kidney dialysis. All older hostel residents who return home periodically "live in fear of not being able to get cared for in the country of origin in case of chronic illness" (Hallouche 2002: 19; author's translation). This is especially the case for those whose families live in rural regions back home. As Jacques Barou notes, "there are problems in finding medication, a GP and in particular specialists, in rural areas essentially" (Barou 2007: 1; author's translation). This was further stressed by Anne-Marie (crisis social worker):

> If they have for example diabetes, and what is more with their old age, and the pathologies associated with it – how are they going to get cared for at home? Everything depends on where you live. But if you're not in a big city, if you find yourself in some village in the

countryside, to have access to a doctor, to insulin, anything, it's complicated. This they are well aware of, you know.

Furthermore, as noted in Chap. 3, in many North and West African countries national social security systems are restricted to employees in the formal wage-earning sector. As a result, few rural inhabitants are covered and healthcare expenses incurred back home are usually not reimbursed, a point forcefully made by Djimé (Dembancané, Senegal) when I asked how his health was:

Yes I'm still in good health, yes there are some who return to France to get cared for, for health problems, yes, because (…) if you fall ill here, well, the prescription, you pay the prescription and you pay it all, because there are no reimbursements. [AH: So it's not like in France, with social security?] It's not like in France, so people if they fall ill they prefer to go and get cared for in France, with social security. Even if they pay, they pay less, they pay the balance after insurance (…) Fortunately I haven't reached that stage, for the time being I look after my health. But death will come one day! (laughs)

In summary, then, the cost of care back home and the impossibility of being reimbursed for one's health expenses when away from France are two major motivations for doing the *va-et-vient*. A third motivation stems from residents' concerns over the quality of treatment for chronic, non-emergency care back home, and the availability of medicines.

Nonetheless, this raises a key question: what are the impacts on health of the *va-et-vient* itself? Can it be considered a sound healthcare strategy? I asked this of all the healthcare professionals I interviewed, and opinions were mixed. Conflicting messages also emerge from the literature on the subject. A minority answered in the affirmative: "The regular return trip is the best way to care for oneself." (Barou 2007: 1; author's translation). Similarly, in response to my question whether the *va-et-vient* could be considered as a healthcare strategy, Béatrice (health advisor, migrant welfare association), answered:

Yes [emphatic], for two reasons. Some treatments cost less back home. Teeth and glasses. That costs a lot here, it costs much less back home. So they go home for these treatments. There's also the fact that they need to return home, to see the country, to see their wife, to see the children and grandchildren – that helps their morale. And then also when they go, they can see their traditional doctors. So, yes, it's easier – they return home, they can see their traditional doctor, the *marabout*, etc, so it is part of a healthcare strategy, yes, both medical and psychological.

Sonia (elder care coordinator, Val d'Oise) was less optimistic however. The fact that treatments are supposed to be rigorously adhered to over the long term, and yet patients can only take with them a month's (or maximum 3 months') worth of prescribed medication, means that the mobile hostel residents "return in an even more deteriorated state then before". She continued:

It's not really a healthcare strategy; I would say that for some it might be a healthcare strategy because it is true that the Mediterranean climate is much more favourable than here. Of course, there are some doctors who say "go to the Mediterranean, you'll feel much better", for their rheumatism, and things like that, OK. But when they take just one month of treatment and then afterwards they have no more drugs, and they stay there two or three months. So they're going to go without treatment for two or three months, and they then return in an even more catastrophic state. It's not at all a good strategy, no.

4.5 Conclusion

As was shown at the start of this chapter, for some respondents being in *good* health was a prerequisite for entry into France, given the rigorous recruitment procedures which selected migrants on the basis of physical strength and conditioning. Health *orders* migration, then, but the relationship works in the reverse direction too: the long-term consequences of being a migrant worker also impact (negatively) upon health. What is particular about older hostel residents is not the range of conditions from which they suffer. Rather, they diverge from the wider elderly population insofar as their health problems manifest themselves earlier. The absence of family members able to provide informal care also constitutes a particular element of their biographies which complicates care arrangements. As in the previous chapter, two particular aspects which lead to a timetabled presence in France deserve underlining, namely hostel residents' non-standard biographies, and the temporal and territorial demands of inclusion in social systems – in this case the healthcare system. As was argued in the previous chapter, social systems theory appears best placed to account for these phenomena.

Hostel residents' long-term health needs lead to strong relationships of trust with medical professionals, and explain their confidence in the superiority of the services available in France, both of which are powerful rationales for doing the *va-et-vient*. Various factors have the result of 'timetabling' this back-and-forth mobility, including doctors' appointments; minimum residence periods to be eligible for state-subsidised medical insurance (CMU); and the limited amount of medication which GPs can prescribe. Thus, at retirement, health again *orders* migration to France, but this time it is the fact of *poor* health and the availability of subsidised – and, importantly, better quality – treatment in France which motivates these movements. Finally, in the section immediately above, it was noted that the *va-et-vient* for healthcare reasons may also have a problematic bearing on the men's health.

This chapter has focused primarily on physical health, but to conclude some words need to be said about mental health. As Leavey and Eliacin (2013) note, the topic of mental health has been largely neglected in the literature on return migration (see also Barrett and Mosca 2013). While physical ill health tends to be a gradually emerging consequence of the hard working conditions that the men have known throughout their careers, the issue of mental health is more commonly associated with the abrupt and sudden switch to retirement.[10] As was discussed in Chap. 3, the transition to retirement is a critical juncture when the men need to find a replacement for what previously constituted their principal identity and reason for being in France, namely work. In the epigraph to that chapter, it was suggested that an identity based on 'papers', and the entitlements to social protection which they prove, can compensate for the loss of the identity of 'worker' which occurs at retirement. More

[10] As Ben Jelloun (1977) records, mental health issues were also a feature of the lives of younger migrant workers in France.

problematically, however, an alternative identity based on ill-health is discerned here whereby illness plays this compensatory role, functioning as a justification to 'left behind' relatives for non-return. As Jacques Barou comments, "the medical argument [to stay in France] often hides other forms of reticence to return" (Barou 2007: 1; author's translation).

Thus, over the long run, the health-migration *order* may become a health-migration *disorder*, a mental health issue. For some residents, physical pain – from a work accident, for example – may not (or no longer) be severe, but there is a tendency on the part of the individual to focus on the trauma of the injury, which is experienced as a rupture: "an initial stage in the process of marginalisation and exclusion" in society (Ballain 1992: 23; author's translation). In this way, the long term consequences of physical injury are mental and social. Although respondents, as noted, were wary of discussing mental health issues directly, the constant justifications I heard for remaining in or returning to France on health grounds can be interpreted in this way. For those individuals, their self-image has shifted from the ideal of the young, active worker to the old, worn-out '*malade'* [sick person, invalid], who is 'paralysed' in France.

Some of my respondents used the debated term 'sinistrosis' to describe this shift in identity. This term, which has not translated into anglophone medical terminology, was initially developed by the French academic psychiatrist Edouard Brissaud in the early-twentieth century to describe the symptoms of fatigue, nightmares and diffuse pain (with no neurological basis) among employees who refused to return to work after a work accident (Brissaud 1908). However, in the context of new financial products such as employer liability insurance, sinistrosis soon came to be used by forensic psychiatrists as a pejorative diagnosis to undermine workers' claims of compensation for such accidents, by implying that a worker's psychological distress was in fact simulated (Fassin and Rechtman 2009). By the 1950s and 1960s, this use of the term had come to be applied uniquely to migrant workers (Sayad 1999), a manifestation of racism which was soon condemned within the psychiatric profession, effectively consigning the term to history (Fassin and Rechtman 2009). Nonetheless, Sayad's writings on sinistrosis[11] have ensured its place in critical scholarship on French immigration history, and it was in this context that a number of my respondents mentioned it. From these discussions, it seems that the term is being adapted in nuanced ways – no longer a justification for financial compensation or refusal to return to work, but rather a justification not to return to one's family and one's place of origin, or what I would label 'exile sinistrosis'. In our interview, Jean, a union official, elaborated on his understanding of the term:

> A form of withdrawal into illness, and into the symptoms of illness, in the sense that – and this is a hypothesis which would greatly benefit from discussion – that perhaps illness becomes for some of these people the justification for the presence here, and notably in relation to their family; so, as a result there is a form of withdrawal, of brooding, which – to objective elements of problematic health – are added psychological elements which mean that the person can have a tendency to withdraw into a situation of 'sick person' or to con-

[11] See Sayad (1999) 'La maladie, la souffrance et le corps', in *La Double Absence*. Paris: Seuil.

> sider themselves above all as a sick person and with this label to construct a health of adversity [*une santé de malheur*] (…) I have observed this quite strongly and have always referred it to this problem of identity for these people. Who am I? – I am a sick person. I was a worker, so I was justified to be here; I am a sick person so I'm justified to be here.

That this justification is directed first and foremost at family members remaining behind in places of origin speaks volumes for the complex family relations which have crystallised over the long years of prolonged absence. For some respondents, the family is a source of moral support; for others the family is a source of conflicts from which they take refuge in the hostel. These ideas will be explored in the following chapter.

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