Medical and Social Practices of Social Inclusion for Precarious Persons in the French Health System-A Psychosociological Approach

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Abstract:

The insecurity problem requires a two-way analysis of ontological and social factors, of vital vulnerability and social vulnerability interdependence, as well.

Numerous research and healthcare systems analysis showed that health disparities reflect structural inequities that far exceed the scope of the health system (Inserm,1995). "Physical disparities between individuals are not absolutely determined by biological essence of the human being, but that society establishes inequalities" (Leclerc, 2000).

Thus, the origin is in the precarious process of social and individual joint. Recent researches are highlighting the psychosocial mechanisms during which social factors and "life events", and individual variables such as "ability to cope" may affect a person's biological state. "The ability to deal with" is not only personality, but is also related to social experience and the social inclusion of one person, allowing it to mobilize various resources, more or less important. Sociologists are constantly changing the image that society has on the poor and vulnerable; poverty can be explained by regression injustice, poverty progression explains the lack of courage of those persons who are characterized by irresponsibility, laziness or incompetence.

Feeling that solutions should be found to avoid the poor to take advantage of social assistance is becoming more prominent, while those who are in precarious situations lose self confidence and the ability to have activity, because their health has been deteriorated over time and their psychological condition has deteriorated acts as an additional barrier.

Phenomenology insecurity and psychosocial distress

Guillaume Le Blanc (2008) believes that the awareness level of social distress and poor persons can repair the toxic effects of precariousness. He maintains a policy of health clinic, a clinic for certain illnesses caused by insecurity, and, in general, a program of social care leading to poor people for autonomy.

Precariousness and practice

In France, the disadvantaged appeal to health care is not their first concern, so that medical emergencies are usually their first contact with the health care system. Without a family doctor and little track before reaching the ER, they are later called health care system only when pathologies are advanced or when they are already in a serious condition. These people are, more often than others, brought to the hospital unconscious and in critical condition.

Hospital and precariousness

For centuries, In France, the hospital meant nursing, poor settlement, charitable institution for the elderly and terminally ill; then it has become a prototypical institution of the modern society. Integrated to an increasingly complex health system, with a diversification of specialties, the GP often has the feeling of having lost position in this area of practice.

The patient, on the other hand, has the feeling of a fragmented system whose coherence misses. It is even more difficult to be understood by the poor people.

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The complexity of hospital organization can limit the access of the most vulnerable patients who meet, in some cases, resistance to treatment from the hospital staff or various forms of discrimination: delay or denial of care, standards of care reducing health or specific cultural behaviors (Fassin, 2002).

Constant example of access to health, PASS, created in France in the late 1980s.

In the context of an increasing stated specialization, general medicine seems to become slack by the latest medical techniques, marginalized or even practiced outside the hospital. Situations of extreme social suffering patients have been treated by humanitarian associations which created dispensaries in the late 1980s. The Act of 29th of July 1998 which "fights against exclusion" formalized the constant access to health care in hospitals, PASS, that existed in several hospitals in Paris since 1992, and the general medical consultations as' cells of social and medical facilitating the poor access in the hospital system." Thus, the medical consultations resist standardization and segmentation of medical activities (Lecarpentier, 2010).

The division of labor in the field of health care system reveals a process of "social structure by excluding the so-called less prestigious professions" and offers reduced career opportunities. It thus creates the outskirts hospital specialized in treating what has been removed from society: health care for the poor, immigrants, deviance and social work. But PASS professionals are regarded as less competent, having a less noble work in the "moral division of labor". Permanent access to health services takes a marginal position, created in the last step of the "hierarchy stature" (N. Elias, 1965). The work of these professionals represents the position abandoned by those who are experiencing social ladder, an activity that allows operation in the hospital and the social inclusion of patients in precarious social situation.

Key words: health care service, medical and social practices of inclusion, precariousness, hospitals.