Meeting the perspectives: vulnerability and intersectionality for better health policies

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"Just as in individual medicine, we cannot abandon a person that suffers when there is no cure, a society cannot abandon a part of its population when it's becoming too vulnerable"

Jonathan Mann

INTRODUCTION

In caring for vulnerable populations – such as migrants, and especially newcomers (less than 5 years since landed-immigrant status), health organizations are confronted with their own practices, beliefs, values, cultures and administrations (Nacu 2011). In that case, the change that healthcare organizations are faced with is characterized by the diversification and population mix due to the growing arrival of populations coming from foreign countries with shorter or longer periods of vulnerability, particularly in terms of health. Indeed, the most innocuous clinical or administrative gestures are called into question when applied to a person who may not have the same perception of the world (in this case the health/sickness/culture world is interacting with migration taken as a process) (Sterlin 2006). When dealing with migrants or newcomers, the adaptation of healthcare organizations implies to question the way actors from the various hierarchical levels interact together, and develop the collective clinical and administrative abilities required to address the challenges of difference, i.e. relating to other people, lifestyles and worldviews. Originating from a concern on the linkage between health, social and migration policies within the healthcare organizations of Quebec (Canada), our goal is to understand these phenomena with the perspective of intersectionality and to bring them in a wider framework of multilevel governance. Actually, the perspective of intersectionality will serve to analyze the multiples dimensions of vulnerability, present at all levels of the healthcare organizations. We understand the governance as the coordination of collective action (Hatchuel 2000), and to better understand the dynamic of this coordination, we need to know the different visions of vulnerability.

Aim and research questions

The aim of this article is to share the results of a case study analysis that examined the multiplicity of vulnerability visions through two healthcare organizations and their Environment. Our purpose here is identify these multiple visions with the intersectionality perspective and to understand what are the impacts on the clinical and administrative practices.

Our paper is structured as follows: **firstly**, we briefly present the current evidence on the complexity of the concept of vulnerability, specifically for the migrant groups. **Secondly**, we shortly describe the analytical framework we used in our study: based on the four

worlds of Glouberman and Mintzberg (2001). **Thirdly**, we present the methods through which we empirically applied this framework, before detailing the ensued results to two healthcare organizations and their environment. **Finally**, we conclude this paper by discussing how the multiple visions of vulnerability could be a mirror of the lack of adaptation between the different levels of healthcare organizations and the Environment regarding the coordination of collective action: it is a confrontation between different visions of the world. Bringing closer vulnerability and intersectionality in a systemic view helps to better understand the governance dynamics in a multilevel and integrated perspective.

CURRENT EVIDENCE ON VULNERABILITY : A SUMMARY

The relevance of this research is mainly based on this observation: if the concept of vulnerability is largely employed, it rarely comes with a rich definition that takes into account all of the characteristics that can reveal the complexity of vulnerability, be it structural, organizational and individual.

Specificity and complexity of the concept of vulnerability in healthcare

The level of health of an entire population unconditionally goes through the distribution level of a health capital within vulnerable populations. Vulnerability is on the one hand affected by the perception of the individual and its own vulnerability, and on the other hand it is situational (Rogers 1997). A person that wouldn't be particularly vulnerable to illness (physical and/or mental) in a given environment could become vulnerable in another less favourable environment. The link can be made between migration experiences and health experiences. When an individual finds himself in a foreign country, with customs and a language he doesn't know and without (or little) social support, he becomes more vulnerable, particularly in terms of accessibility and appropriate use of the healthcare system of the "host" country. Vulnerability is much more than the simple sum of various risks factors, combined or not; it is a social reality that the health workers, as well as the decision-makers of health organizations cannot ignore (Stevens 2007). As described by Shi and Stevens, *"Vulnerable populations are defined as those at greater risk for poor health status and health care access. (…) vulnerable populations generally include racial and ethnic minorities, low socioeconomic status populations, and those without adequate potential access to care"* (Shi and Stevens 2005). But this part of the population is also at the mercy of policies imposed by the State, which had a considerable impact on their sanitary and living conditions. By taking the cases of recent immigrants and refugees, Steel and al. (2002) show how changes in the healthcare policies of Ontario (budgets cutbacks for hospitals, community and social health services, strict limitations of criterion to access social support and implementation of fees payable by the patient for his prescriptions) had an

impact on the wellbeing of that type of population, especially for women (mental health, domestic violence, quality of life). This qualitative study stresses the need for decision-makers to keep in mind the goals of universality of access and equity, necessary for the achievement of health within vulnerable populations (Steele, Lemieux-Charles et al. 2002).

In Québec, the population approach prescribed at the level of primary healthcare requires to reflect on inclusion strategies for vulnerable populations (Frohlich and Potvin 2008). According to these authors, the concept of vulnerable population designates *groups of population sharing the same social characteristics within a given time.* In that perspective, migrant and vulnerable populations share several characteristics. Indeed, risks factors such as socio-economic insecurity, experiences of violence, family isolation and separation, mental health issues, language barriers, as well as pathologies specific to certain parts of the world are factors of vulnerability lived by migrant persons, particularly in the first post-migratory years (Munoz and Chirgwin 2007, Miszkurka, Goulet et al. 2010). In addition, there might be factors related to a negative perception of some professionals regarding newcomers (labeling of "problematic patients") (Wachtler, Brorsson et al. 2006, Bhatia and Wallace 2007, Miedema, Hamilton et al. 2008, Tremblay 2011). For that purpose, the health and wellbeing status of migrant populations, particularly newcomers and refugees, is very fragile (Rousseau, Ter Kuile et al. 2008, Wolff, Epiney et al. 2008, Lassetter and Callister 2009).

In that context, trying to harmonize the issues related to vulnerability with the type and nature of care offer represents a great challenge of immigration. Acting with an integrated and adapted process (collective learning (test-fail), recursion and feedback, model of another organization, of other practices –*gold standard*, etc.) could open the way to forms of *multilevel governance* (bottom-up/top-down dynamic) allowing to provide safe and equitable quality healthcare to vulnerable persons whom migrants can be a part of. Contributing to a greater social equity and to an improvement of the health level of all the population would allow to adequately contribute to the mandate of population responsibility, assigned to the clinical and administrative spheres of health organizations, as well as builders of public policies (Fassin 1996, MSSS 2004, Bellerose, Richard et al. 2005).

ANALYTIC FRAMEWORK

Similarly to McGibbon and McPherson, the theories of complexity and intersectionality should be brought together here within an integrative framework (McGibbon and McPherson 2011). Our research is essentially focused on the interface between the

various hierarchical levels of a health organization, as well as interactions within each of these levels. Interactions with the actors of the Environment are also analyzed here. However, contrary to McGibbon and McPherson, our study doesn't only focus on women's health. We approach the subject with more of an organizational angle (management/health administration), in order to report the various perceptions and definitions of vulnerability, particularly when it comes to migration. The actors interviewed are persons working within or around health organizations. The analysis of these multiple perspectives can help to create an inclusive and integrative governance framework, based on intersectionality perspective and the theories of complexity.

Why Intersectionality perspective?

Considering the extent of studies on intersectionality since the 1980's (Crenshaw 1989, Crenshaw 1991, Guruge and Khanlou 2004, McCall 2005, Ludvig 2006, Yuval-Davis 2006, Yuval-Davis 2007, Nash 2008, Hankivsky 2011), we will retain in this paper three reasons why this approach seems to be necessary to the development (and improvement) of the conceptual framework presented thereafter.

1. Vulnerability and the study of migratory phenomenon are not homogenous entities. There is no one sort of vulnerability as there is no one group of identical persons, who lived the same things, at the same time and at the same place.

2. The intersectional analysis allows to understand, in a systemic way, several perspectives: more than the sum of the parts, the intersectional analysis is an analysis of complexity, be it individual, organizational or societal (analysis from micro to macro).

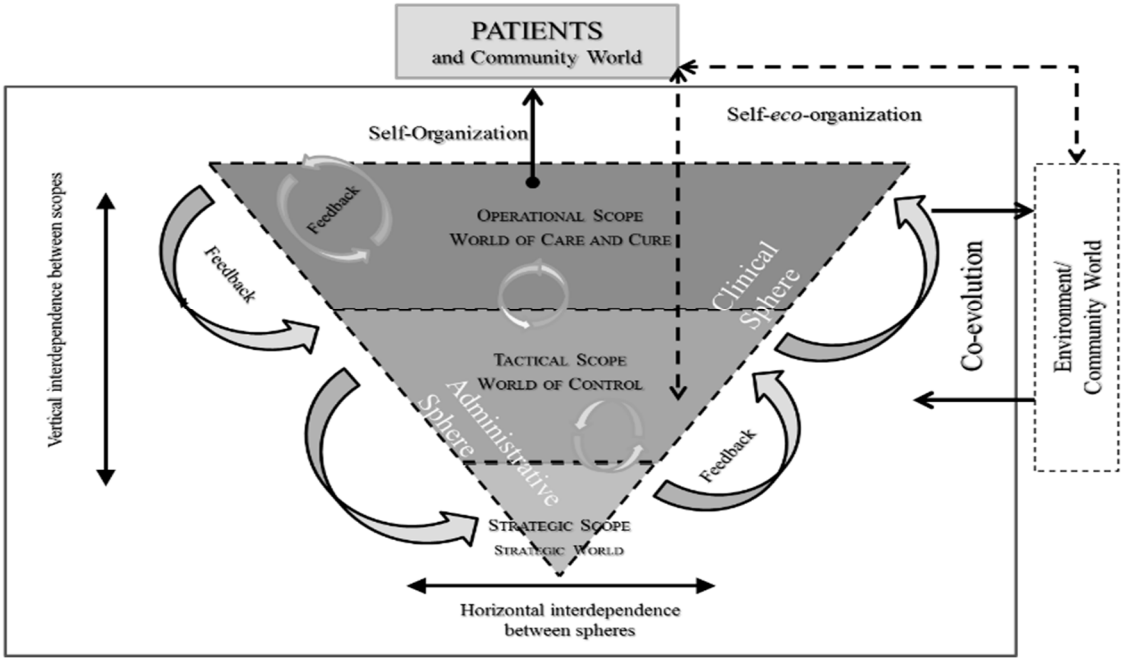
3. The intersectional analysis allows to grasp the politic and social responses to vulnerability issues, in particular towards migrants. Through this analysis, it is possible to examine interaction between migrants and/or vulnerable persons and professionals, interveners and managers of social and health services. Are these interactions a source of support and empowerment or rather an occasion for victimization and multiple burdens for these vulnerable persons and/or migrants (analysis from macro to micro).

Why theories of complexity?

Through the complexity theory, we hold on to three major concepts. A **self-organization** is the stakeholders' capacity to adapt autonomously. The mechanism of self-organization highlights the stakeholders' ability to be creative and innovative. They are "*diverse agents that learn*" (McDaniel, Lanham et al. 2009). **Self-*eco*-organization** is the ability of each stakeholder to adapt while interacting with the Environment (Morin 2005

(1990)). Based on our reading of the healthcare system as a complex adaptive system, self-*eco*-organization is the cornerstone of integration from which "manipulations of interdependences" emerge among the various stakeholders in a system (Levinthal and Warglien 1999). The result is an improved coherence between the organization and the Environment. Finally, **co-evolution** is the aggregate of the self-*eco*-organization of the healthcare organization and the Environment: it is the interaction point between the internal and the external. Co-evolution refers to the interdependent relationship between the organization and its Environment. The process of co-evolution between the organization and the Environment can allow, for example, certain forms of shared leadership to develop (Denis, Lamothe et al. 2001). This may lead to tensions, often due to unbalanced relationships of power between the multiple stakeholders (Boisot and Mckelvey 2010).

Figure 1: Representation of multilevel governance in a complex health care organization



From Maillet et al (forthcoming)

Based on the complexity theory, this framework allows to consider hierarchical and horizontal perspectives, putting forward a systemic view of the concept of vulnerability inside multilevel governance of the healthcare organizations (Maillet, Lamarche et al. Forthcoming). According to Duit and Galaz (2008), the term "multilevel governance" emerged in the 1990s and was applied in an extendable manner to the political domain.
Multilevel governance can occur at different scales (organizational, territorial, and societal) and involves stakeholders coming from different structures who interact with each other. Multilevel governance then becomes, through the processes of self-*eco*-

organization and co-evolution, the focal point that can link four worlds: "*cure, care, control and community",* as highlighted by Glouberman and Mintzberg (2001).
In our study, *cure* represents the medical community and the biomedical activities associated with it. *Care* is more inherently linked to the activities of nurses, other non-medical professionals, and community workers. *Control* is the sphere of "bureaucratic" or traditional administration. Finally, *community* represents the persons linked directly or indirectly to the healthcare organization such as patients, community groups, interest or influence groups, and members of the government or local politics.

Multilevel governance consists in sharing responsibilities, decision making and power of influence, both horizontally and vertically, between all stakeholders of the healthcare system (healthcare organizations and Environment: network) for the development and implementation of public policies. Adding the intersectionality approach to our framework could facilitate the links between hierarchical and horizontal perspectives in a systemic view.

METHODOLOGY

This case study is based on qualitative data that examined the relationship between the position of the stakeholders in the Quebec's healthcare system and their vision of the vulnerability. The stakeholders come from operational, tactical and strategic fields of the healthcare system (n=49).

Research strategy
The selected strategy is a synthetic research of multiple case studies (two Health and Social Service Centres - (HC)) – with integrated analysis levels (strategic, tactical and operational scopes), in accordance with a qualitative approach (Yin 2009).

The analysis units (i.e. the cases) are the two HCs known for being the population's access points to health and social services – including migrants (Leduc and Proulx 2004, Battaglini, Désy et al. 2007). The study of two territories, one urban, one semi-urban, aims to best reflect this reality, consistent with the policies currently implemented in Quebec with regards to immigrant settlement regionalization (Boulais 2010).

The study is particularly focused on three clinical programs (A: physical health, B: family-children-youth (FCY), and C: public health & community action) because of the importance of the contacts with migrants and the related challenges. Several administrative services were also retained, in addition to two community organizations (CO1, CO2) that are very important to each of the HC territories subjected to the study.

Finally, an actor from the regional branch of the Immigration Ministry was interviewed. In total, 43 semi-directive interviews were conducted between November 2010 and February 2011 inclusively. Six final interviews (Immigration Ministry and CO1, 2) were realized in April 2012. We deliberately chose to wait for the progression of the analysis of the first 43 interviews, which allowed us to dive deeper on the selected topics with Environment actors. All interviews were conducted by the same researcher.

Eligibility and sampling

For the selection of the respondents, a stratified sampling was applied to both HCs, and "snowball sampling" was applied to the Environment (Poupart, Deslauriers et al. 1997). Stratified sampling was completed with the help of a key informer in each HC, by selecting respondents from each scope. Additionally, the key informer allowed us to target, within the three programs, the persons working more frequently with migrant patients. However, in order to limit any selection bias, we also targeted stakeholders with less exposure to this type of patients. The objective was to improve our understanding of the circumstances in which a "non-expert" practice – applied to cultural diversity – is experienced by operational actors.

For the *operational* scope, we interviewed health professionals who, as clinical practitioners, are directly in contact with patients. For the *tactical* scope, our respondents comprised executive counsellors, human resource managers and communication managers. Finally, for the *strategic* scope, we interviewed the directors and chief-administrators, i.e. the general directors and deputy general directors, members of the nursing care and professional services directions, clinical directors as well as members of the board and of the advisory councils.

Environment actors belonged to one of the following types of organizations: (1) two community organizations that were unanimously mentioned by the HC interviewees, (2) the regional health authority and (3) the Ministry of Immigration (regional branch).

Out of the 57 interviews initially planned, only 8 were not conducted. It should be noted that it is mostly the respondents from the operational scope of HC1 who refused to participate (6 out of 8). The fact that a smaller number of operational actors were represented in our sample may have introduced a bias in the diversity of the perceptions. For this reason, a triangulation of the data was critical in order to not overlook key inputs more likely to be provided by operational actors. The sample was predominantly female: 12 men and 37 women. The participation rate for the study was 86%, which is satisfactory. Frequently, during the interview scheduling phase, respondents would spontaneously get in touch, offering to contribute. Actors showed a strong interest for the subject matter addressed by this study.

Data analysis was completed based on interview transcripts. We conducted a coding analysis by classifying the codes according to the topics and sub-topics obtained through our theoretical framework and through the data itself when the subject was recurrent (Miles and Huberman 2003). A topic was retained if at least three respondents (regardless of their level) mentioned it.

Table 1 Sample for the study: Interview distribution by site, scope and sphere

Site	Strategic Scope (n)		Tactical Scope (n)		Operational Scope (n)	Withdrawal (n)	Total
	Administrative Sphere	Clinical Sphere	Administrative Sphere	Clinical Sphere	Clinical Sphere		
HC1	4	5	3	3	3	6	18
HC2	4	5	2	2	7	1	20
Agency	4		1			1	5
CO 1 & 2					5		5
Ministry of Immigration			1				1
Total	**22**		**12**		**15**	**8**	**49**

Document sources were used to situate the challenge of migration and health service adaptation at the level of government archives, ministerial archives and regional agencies, but also at a local level – i.e. at the level of HCs and partner Community Organizations operating and interacting with migrants. This comprehensive documentation search allowed us to enrich the resources provided by the interviewees.

Semi-directive interviews (N=49) were conducted with professionals, managers and administrators (Table 1). Throughout this fieldwork, we kept a *logbook* inventorying precise details of the research process (anecdotes, personal thoughts of the researcher, etc.) (Copans. 1999).

Also, a *"summary sheet"* was completed for each interview (Miles and Huberman 2003). Each summary sheet was transmitted to the respondents from HC1 so that they could validate and confirm its contents. Because all summary sheets were compliant for all respondents, we postulated that the same approach was not needed with HC2. HC1 was selected for practical reasons: interviews were conducted first with HC1. Moreover, interviews with the Regional Agency and Community Organization 1 were conducted from September to December of 2011. Several respondents from both HCs attended.

Preliminary results were presented. Discussions ensued, and the respondents expressed satisfaction with regards to the approach. Throughout the study, restitution checkpoints facilitated information feedback and transparency with the respondents, thus reinforcing the study's *internal validity* and *credibility* (Poupart, Deslauriers et al. 1997).
The research protocol successfully met all the criteria set by two Ethical committees.

Instruments
An interview grid was developed with the objective to cover all of the concepts and dimensions of the proposed conceptual framework. The flexibility of the grid allowed us to tailor it to each actor group. The grid was made of three key areas mapped to the research objectives: 1) identification of the actors involved in service adaptation within each of the HCs studied, as well as the interactions that they entertain within this process; 2) identification of the levers available to actors from different scopes to facilitate service adaptation; and 3) identification of the factors affecting governance and service adaptation. Moreover, we asked various actors to share ideas or strategies that – in their opinion – could benefit the service adaptation process. Interviews were recorded with the participants' consent.

Analysis strategy
Analysis and data gathering activities were performed simultaneously; they included some iterative aspects with regards to coding and categorization, which allowed us to adjust the interview grids. The QDA Miner software – version 3.2 (2010) – was used to capture the data and facilitate the analysis. Output data was reduced (matrixes, relationship mapping, memos, case summaries), which permitted the development of assumptions (Patton 2002).

Quality of the results
The analysis was completed in two steps: the first step was an *internal case analysis*, i.e. focused on each HC. The aim was to regroup and synthesize the models in order to draw a clear picture of the dynamics and processes within the HC regarding service adaptation to migrants. A deep analysis of each case allowed us to achieve strong internal validity (Yin 2009). Interpretations were verified with actors from different scopes in order to meet the criterion for credibility (summary sheets for HC1 respondents, and two restitutions of the preliminary results involving several respondents). Moreover, the validation of both analysis and the interpretations were the subject of several conversations between the research directors and the doctoral candidate.
The second step consisted of a *transverse case analysis*, which allowed us to compare the two HCs in an effort to expand observations on the various governance levels. In doing so, we favoured the investigation of explanatory links in order to uncover the mechanisms behind the adaptation process. (Poupart, Deslauriers et al. 1997).

RESULTS

Our results confirm our intuitions: five different visions coexist inside the healthcare system: clinical, social, community, political and stratified. Nonetheless, the management and application of health programs are decided by the actors who have clinical and political visions. However, emergent perspectives come from the advocates of vulnerable patients: actors who have the social and community visions. They are less (or not) heard, neither are they considered for the management and application of healthcare programs.

Based on our assumptions and Bastia's work (2014), we focus on the "vulnerability code" in the data base: we extract all verbatim that was labelled "vulnerability". All data was extracted by scope: strategic, tactic and operational. After reading the verbatim, five visions of vulnerability emerge.

1. Clinical vision

This view takes into consideration purely medical characteristics: it is a reference to the biomedical model that is predominant in the current health system of Québec. Several actors from the strategic scope, in the clinical and administrative spheres, share this vision. Besides, it is on that vision of vulnerability and of vulnerable patients that the programmes of the health insurance board (RAMQ) are built, as well as most of the programmes implemented by the ministry of health: is considered a vulnerable patient "a patient who suffers from one or multiple health issues or who is 70 years-old or more" (RAMQ, website).

This definition is mainly based on a population-at-risk approach. This approach was mostly driven by the Lalonde Report (1974).

The notion of population at risk refers to the fraction of the population that has the greatest impact on the average risk. It gathers three types of information: the causes of mortality and types of morbidity, the determinants of both and the susceptible part of the population that has the most important risks factors.

Regarding migrant persons, they are not part of vulnerable patients: according to several actors interviewed for our research, it is not a criterion that has to be considered when it is possible to communicate:

> *"I think that it's easy to remain relatively simple in our ways, at least to have access to interprets, because in the end, if we understand the request, and we're able to look at the situation as an intervener, medical or other, after that, the rest of the intervention, it's going to run its course. I mean, whether it's an*

African, a Mexican, or a Quebecois that we send to take a CT scan, we're going to give him a CT scan, period."
(Strategic actor, GP, Health Center 2).

Clearly, many actors from the cure and control worlds share this vision and, for them, the biomedical and administrative spheres should be leading the decisions, whatever the status or background of the patients.

1. Social vision

This vision of vulnerability allows to take, in addition to biological factors, socio-economical characteristics to assess the level of vulnerability and the person's needs as a whole. This social vision facilitates a holistic view of the persons, highlighting an approach based on fundamental causes of health and/or diseases. It is a vision that remains centered on the individual.

In our study, this vision is rather supported by the operational actors, particularly of the clinical sphere, working directly with the patients: it is closer of the caring and control worlds. Indeed, the emphasis is always put on the individual's medical and social factors. There is no real apprehension of the person in a more complex and intersectional system (see the example of the verbatim in table 2).

2. Public health and community vision

This vision takes into consideration, in addition to the individual characteristics, the characteristics of the Environment surrounding the person: this can include the immediate family, the social network composed of friends, parents and actors of community organizations for example. This is more of a population approach, placing the individual at the center of a system that is expanding more and more (from micro to macro).
The reforms of the healthcare system in 2003 and 2004 in Québec hoped to apply this type of view to the ensemble of health organizations. One of the strategies was the development of the population responsibility concept, making the health organizations accountable for the whole population covered on their territory. The health organizations (Healthcare Center) had to take into account the particularities of the various communities who compose the population of which they are responsible, including the cultural and linguistic characteristics of persons coming from ethnocultural communities and their family (Agence de la santé et des services sociaux de la capitale nationale 2006)

Table 2: Five visions of vulnerability

Vulnerability visions	Definitions emerging from data	Verbatim from some extracts	Main assumptions from existing literatures	References
Clinical: Cure and control worlds	Medical characteristics (chronicle illnesses and no MD) to consider a person as vulnerable. Moreover, an "accounting" speech is used to define more precisely what is considered as vulnerability conditions or not: official definition from the Régie de l'assurance maladie (medical insurance board) with medical and administrative speech.	*"Well, there are medical criterion of vulnerability, actually they're not social criterion, they're truly medical criterion, where… there are prioritization, 1, 2, 3, 4, 5, so for example 1, it's someone who comes out, as I said earlier, of the hospital, who needs a close follow-up for his medication"* (Strategic actor + GP) *"So, where does the migrant clientele stands? They almost have to be sick, to be taken care of"* (Strategic actor + GP) *"In the network, a vulnerable clientele, it's a clientele that is predisposed… actually, who is suffering from chronicle illness, I think, or who is part of persons that are more at risk to develop diseases or… I think that's it in the network"* (Tactical actor, HC1).	**Population at risk approach**: Vision of a population or a group who is at risk (cardiovascular, diabetes, chronicle illness, HIV, STI, etc.) The notion "population at risk" refers to the fraction of the population that has a greater impact on the average risk. It joins three types of information: the causes of mortality and types of morbidity, the determinants of both and the susceptible part of the population who has the most important risks factors.	(Lalonde 1974, Shi and Stevens 2005, Frohlich and Potvin 2008)
Social (socio-economical): Community world	Socio-economic characteristics taken into account in order to assess the level of vulnerability and the needs of the person or of the family.	*"When we have vulnerable clienteles, immigrant clienteles, we see some of them here in prenatal clinic. For sure we know there are some needs. It's people that are going to be referred in services, people that are going to have the same services as any other client who would have vulnerability needs. Considering the age or the financial needs"* (Operational actor, HC2) *"Someone who is vulnerable is someone that is going through something difficult. It can be punctual. But he's living; he's in an adaptation period. So yes, it can be someone who's coming from abroad"* (Operation actor, HC2)	**Fundamental Causes approach:** The social conditions are the fundamental causes of illnesses.	(Phelan, Link et al. 2004, Phelan and Link 2005)
Community and public health (humanism): caring and community worlds	Characteristics of the environment surrounding the person (social and familial network, knowledge of the language, the country and the customs).	*"But at the end of the line, if we're not able to support them so that they are in good health, in shape, not depressed, … that they eat well, that they, that they… cure themselves, they can't… the rest won't, they won't… it's not favourable adaptation conditions to a new, a new environment"* (Strategic actor, HC1) *"So for me, a vulnerable clientele, it's a clientele that needs care, sometimes, yes, healthcare but, also more human care, so, make sure that they are fed, at least give them a call sometimes"* (Tactical actor, HC1)	**Population approach** (Rose, 1992): The distribution of exposition to risks in a population is due to the environmental conditions (context) and to the fact the most of these cases in this population have an average level of exposition to risk. Rose's insight: *"the majority of cases in a population occur with individuals with an average level, or even low level, of exposition to the risk"* had major implications for intervention and strategies of prevention in public health as well as in public policies.	(Rose 1985, Frohlich, Ross et al. 2006, Frohlich and Potvin 2008)
Policy (challenges of the	Political, judicial and social characteristics such as migratory status and the situation of the case, taken into	*"The reception organization for refugees has difficulty accepting this because they say "Hey you need to give migrants and refugees a greater*	**Naturalization of prejudices** (racial, sexists, homophobic, etc.) by the law:	(Ashton and Seymour 1988, Crenshaw 1991, Draper

Vulnerability visions	Definitions emerging from data	Verbatim from some extracts	Main assumptions from existing literatures	References
migratory statuses and accessibility to healthcare services): Control world	account to talk about vulnerability and accessibility to certain social and health services.	*accessibility to those services"… it's not the same thing for the medical system because they say "No it's not their migration status that will make me judge how I have to administer healthcare, it's their health that will control and prioritize that, not their status" …or anything else, a 75 year-old lady could have a lot of taxes to pay or whatever it's not that that we take into account, we take into account her health state"* (Tactical actor – region)	Binary vision between having a status giving access to healthcare services or not (paid and funded by the society, so the taxpayer). Normative link between institution, professionals and vulnerable persons (needs)	1991, McKinlay 1993, Hankivsky and Cormier 2011, Bastia 2014)
Stratified: Juxtaposition of 4 worlds	Categorization of vulnerability depending on the addition of several conditions (sedimentation). However, vulnerability is seen as dynamic, changing, and punctual (timing).	*"Vulnerable clientele, in our lingo, it's often the clientele who doesn't have a family physician, and who holds multipathologies, and who doesn't do a systematic follow-up. That is our vulnerable clientele, and we can find them in several layers of the population, and also at every level of clientele. We have a lot of them, especially at the level of elderly, 70 years old and more when we talk about elderly. We also find them at the level of the young adult population with addiction issues, distress or social misery. And we have people between both groups"* (Strategic actor, Health center 2) *"So, someone who has economic disadvantages, but also social disadvantages, we speak of isolation, absence of network, support, etc., and who is more and more isolated and moreover, will have financial issues, I consider that they're vulnerable persons, OK. Some will say that in the average population, even in the better-off populations, that there are vulnerable persons"* (Operational actor, HC1)	**Additive approach**: Juxtaposition of different conditions. Their interactions are not taken into account. It's a linear model, which doesn't allow taking into account the complexity, being it within each of the groups, or between the groups. "The groups are the subject of equality and each strand of inequality is seen as distinctive" (Bastia, 2014)	(Rogers 1997, Shi and Stevens 2005, McGibbon and McPherson 2011, Bastia 2014)

This vision is labelled as community and public health because it is rather supported by actors from the clinical sphere: the terms of humanism and caring are mentioned several times in order to make the clinical practices (and administrative?) more adapted to the various contexts surrounding the migrant persons and/or vulnerable. We are clearly in a community and caring world when the interests of the vulnerable persons are put first.

3. **Politic vision**

This vision of vulnerability is directly linked to the status of the migrant person, be it legal or symbolic. Indeed, from the political vision of vulnerability emerges the ensemble of political, judicial and social characteristics that are taken into account in order to assign a particular status to a migrant person and thus a particular access to the health services of the country of immigration.

Similarly to Crenshaw (1991), we think that the migratory status ensures a naturalization of prejudices through the law, by attributing in a binary way the right of access (or not) to health services: "because as a migrant, you don't have the right to access the services financed by the community, to which you are not a part of".

Hence, the criteria of vulnerability are limited to the attribution or not of a legal status to a person. Besides, this vision is frequently in contradiction with the public health and community vision of vulnerability: preferring the heterogeneous micro and macro criterion surrounding the person to intervene (see the verbatim of table 2). For that, the political vision is closer to the control world.

4. **Stratified vision**

Finally, the stratified vision of vulnerability concurs with a juxtaposition or sedimentation visions of the ensemble of factors and characteristics of the individual and his Environment. Unlike the four previous visions, the stratified vision has a dynamic perspective of vulnerability: it is not a static state, but often a transitory situation. However, the interactions between the various factors of vulnerability are rarely taken into consideration, limiting the apprehension of complexity and vulnerability, be it inter or intra-groups (Nash 2008, Bastia 2014). Nonetheless, all 4 worlds are present in the stratified visions but not like a coordination of the whole: rather like an addition of one + one, etc.

Impact of these visions on the clinical and administrative practices: Two examples that implicate different visions

Case 1: A migrant father comes with his son to the health center. The son is injured at his knee. The father does not know how to take care of his son and his injury. They do not speak French fluently.

The nurse wants to "educate" the father: it is her mandate. But she has a negative judgement about "migrant men": they don't take care of their children. There is no reason that this father is not like "fathers from Quebec".

> *"Men, eh, they are not used to care - immigrant men. They are less, I think, interested in child care. I think it is the responsibility of the woman, that's when they come with their child, they feel they are not able to do that here, so that the people of our province are the most often"*
>
> Operational actor, Health Center 2

> *"They feel that they have to be supported and they can't get involved in their treatments. And more difficult with men. If they have to do something like either their wives or their children, many, many reservations. That is difficult for us because that's our mandate"*
>
> Operational actor, Health Center 2

In the first case, the visions of vulnerability are closer to the clinical and politic visions. The professionals focus on their mandate: provide care and education. This type of interaction is what current policies call for: people, especially the most vulnerable, need to fit in the molds and thus have the expected behaviors in institutions. If this is not the case, the person may be a victim of prejudice without opportunity to explain. This case illustrates a strong and anchored clinical vision from the cure and control worlds. In this vision, two choices remain for the vulnerable person: cooperation according to the established model or a mutual misunderstanding and status quo.

Case 2: After 10 years spent in a refugee camp, a 12 year-old girl (14 is the age of majority for health care in Quebec) arrived from Rwanda, without family (but her aunt lives in Quebec) or papers. She was in contact with cases of active tuberculosis.

In the second case, the first evaluation from the vaccination team doesn't allow to immune this girl against Hepatitis B and tuberculosis. The reason: she has no legal documentation and nothing to prove that her aunt is an actual relative.

"We had to ask directly, it is we who have treated there, public health who treated him, was asked a microbiologist to look after and it did. Besides, very generously and kindly. They were eleven in that family, though. Finally, everything was done anyway, but it took no stone unturned to provide this service to these people because ... when it comes to adapting services, that's what we mean"
Tactical actor, Health Center 2

At first, "by the book" practices were applied by the professionals: no vaccine for children without legal status. And this regardless of whether the child and the rest of the family had access to healthcare and a doctor that supported them. Thereafter, the actors from the other levels (strategic and tactical) and from the Environment were warned: the vulnerability of this family and the risk for the community to contract tuberculosis was stronger than administrative rules and norms.

"Our Quebec rules, the Quebec Immunization Protocol, requires certain things, but in situations like this you have to be able to go beyond, because we made a mistake, we made a clinical error. Legally we should ... but that's adaptation. We will have to establish specific protocols, processes, specific procedures not endanger people's health"
Strategic actor, health center 2

However, a stakeholder had to coordinate the health organization so that a solution was applied. This case shows that adaptive capacity is indeed present but that it rules on a case by case basis: there is no real organization around the management of refugees and vulnerable persons. Here, the stratified vision allows to adjust the response to the needs and to consider the complexity and multidimensionality of vulnerability.

Based on these 2 cases, we will join the studies of Bastia and Nash (2014; 2008) on intersectionality and the necessity to outgrow a binary or dichotomous view of dynamics between individuals and structures. Indeed, the analysis of the five visions of vulnerability within both health organizations shows that the multiple intersecting identities of a vulnerable person under healthcare policies, like a migrant, can be understood as a result of policies that, conversely, reinforce these identities through the construction of structural barriers to effectual integration. These structural barriers encourage the reproduction of powers already in place because the decision-making processes are far from the persons concerned: the migrants and/or vulnerable persons.

Each of the five visions in both organizations has particularities that might conflict with those of the others: example of a clinical vision of vulnerability (Case 1) versus a stratified vision, more inclusive and taking into account the lives and migratory experiences of newcomers on the territory (Case 2). None of the five visions consider a nested view of multiple dimensions of vulnerability. At best they are juxtaposed or added, but in a complex system the whole is greater than the sum of its parts.
Regarding case 1, the practice stays at an operational level: self-organization by the professional who acts to respond to his mandate. There is no interaction with other colleagues or with other actors from the Environment: no self-*eco*-organization. Also, there is little interaction with the patient (here: migrant father), so no process of co-evolution even in the smallest interaction: professional / patient.
In case 2, on the contrary, the first decision from the vaccination team is self-organized. Thereafter, the protocol for a tuberculosis case requires interactions with the Public Health authorities: self-*eco*-organization. This process allowed to change the decision and find an appropriate solution: vaccinate the child and have a doctor do a follow-up for the whole family. However, it is a "case by case" management.

It is clear that difficulties of comprehension, hence of action, may follow. However, it was found that being in a regulated and structured health system in a biomedical vision of care, it is frequently the "clinical" (cure world) view that is the norm. The other views of vulnerability become "accessory".

DISCUSSION AND CONCLUSION

Bringing closer complexity and intersectionality in a systemic view to improve public policies and trying to reduce vulnerabilities

By these analyses, we recognize that intersectionality "as a significant research and policy paradigm" helps to appreciate "how social issues and related inequities are addressed".

An intersectional analysis revealed how the types of vulnerability intersect through immigration and healthcare policies, which has established structural barriers to integration. However, the different perspectives of vulnerability, described and operationalized in a piecemeal way don't allow to apprehend this reality as a whole, and with all of its complexity. It is all the more true if their coexistence within one organization is not known. That is why it is important that they are integrated within a systemic framework in order to take into consideration the clinical (and managerial) visions, while nuancing those with social, community and stratified visions.

Actually, none of the five visions of vulnerability allows to take into account all the dimensions of the phenomenon. Even the most comprehensive vision, the stratified vision, is based on the addition of the characteristics of the other visions, but there is no integration of the whole. This lack of coherence should be put forward in order to truly contribute to collective action overall. With a governance able to take into account both populations, organizational and political needs will compose an integrated governance that is able to act between different levels. They will each have a power of influence and of decision making.

The framework used here is a part of an integrative model that we developed to analyze the co-existence of multiples perceptions of vulnerability (multidimensional) and the difficulty of their integration (Frohlich and Potvin 2008, McGibbon and McPherson 2011) in the healthcare system and in the public policies.

Through the analytical framework presented above (Figure 1), another perspective is possible by involving, from the beginning, the community, social and stratified visions in the development of actions and programmes related to vulnerable persons: emergent process. The decision processes go through a vertical integration as well as a horizontal integration, allowing the voice of local and emerging actions to be heard, most frequently from operational initiatives bringing an "active" vision of vulnerability: self-*eco*-organization. These operational initiatives are shaped by the needs of the clienteles and the Environment: co-evolution.

Within the framework of this study, it seems important to mention that the perspectives of migrant and/or vulnerable populations were not directly heard. This limit is due to the initial project (PhD) and to the conditions of realization. However, we were based on the already existing literature as well as our experiences with this type of population, then involved in other research projects. Moreover, the extension of the intersectional segment in our studies is an integral part of future research projects.

Finally, there is a coherence between the results of this study and the intersectionality perspective: to be taken into account in governance, the interdependence of factors has to go through an analysis of the vulnerability conditions coexisting within the health system. Our results allow to show what are the underlying issues of the *multilevel governance* based on collaboration of interdepending's actors (sharing a common vision, incentives, clarification of the responsibility towards vulnerable persons, dedicated resources (interprets, etc.), intersectionality work, interaction between governance level) and the emergence of needs via a bottom-up decision process so that this governance can operate depending on the needs of each stakeholder, including the vulnerable persons (or persons who consider themselves as such). This type of concerted and structured action challenges one to rethink our current systems of decision-making and implementation of public policies.

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