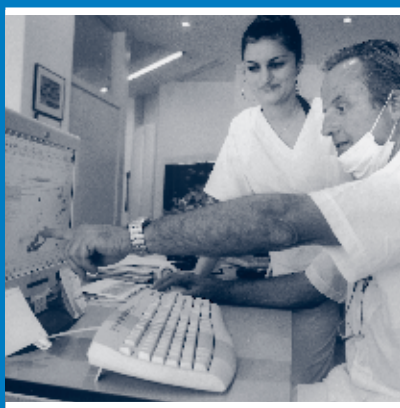
Migration and Public Health

Summary to the Federal Strategy Phase II (2008 – 2013)



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About this publication

Improving the integration of the migrant population in Switzerland is a key area of federal policy. As envisaged in the new Aliens Act, the Federal ministries and offices are, for the first time, addressing this goal on a collaborative basis, perceiving integration as a cross-sectoral task that has to be taken into account in all societal and governmental decisions. Geared to this thinking, numerous integration measures have been approved in Switzerland and a wide range of players have set themselves the goal of improving the integration of the migrant population in our society and thus of promoting solidarity within it.

Equality of opportunity is a basic prerequisite of successful integration. In the healthcare sector this means that migrants must have the same opportunities to realise their health potential as the native Swiss population. Within the framework of the national strategy on migration and public health, the Federal Office of Public Health has been working since 2002 to achieve this goal. The fact is that the health-related behaviour and the health status of migrant communities and their access to healthcare services can be improved in many respects. Migrants are among the most vulnerable members of society. They are often at greater risk of ill health and are more likely to be affected by poverty or unemployment, and their state of health is in many ways poorer than that of the native population.

The quality of a health system can be measured by the quality of the care provided for underprivileged groups. Any attempt to lastingly improve the health of a society must primarily target the underprivileged. Investments in equality of opportunity for the migrant population are not only a noble gesture; they are also worthwhile in terms of their cost-effectiveness. The experts are convinced that, in particular, a greater emphasis on health promotion and prevention in the migrant population and improvement of the intercultural skills of healthcare professionals can reduce costs in the longer term.

All this indicates that, in the field of migration and health, the Confederation should continue the efforts to which the present publication is dedicated. It sheds light on the federal „Migration and Public Health Strategy" Phase II (2008 – 2013) approved by the Swiss Government, and it provides an insight – based on current scientific findings – into the circumstances leading to the current inequality of opportunity in the healthcare sector.
I wish you a stimulating read.

Prof. Thomas Zeltner
Director, Federal Office of Public Health

Switzerland as an immigration country

In past centuries, barren land and famine but also religious intolerance drove many Swiss men and women to emigrate in order to find a better life abroad. When Switzerland changed from an agricultural to an industrial nation at the end of the 19th century, the demand for workers grew and the emigration country was transformed into an immigration country. During the course of the 20th century, the proportion of people with a migration background who are permanently resident in Switzerland rose to more than 25 per cent as a result of a suitable migration policy and the growing complexity of the migrant population: as well as factory and construction workers, an increasing number of professional people in the service sectors and more recently asylum seekers have been immigrating into our country.

"People with a migration background" denotes all those people who hold a foreign nationality at birth, irrespective of whether they were born in Switzerland. The term explicitly includes all first and second generation foreigners resident in Switzerland as well as those who have acquired Swiss nationality. According to the population census in 2000, foreigners accounted for 20.5% of the resident population in Switzerland and another 7.4% were naturalised citizens.

Mainly from Europe

A breakdown of foreigners resident in Switzerland according to their country of origin provides the following picture for the end of 2004 (see table): 85% are of European origin, the majority (57%) coming from the European Union (EU-25) and the EFTA countries. Among the European countries of origin, Italy dominates with 19%, followed by Serbia and Montenegro, including Kosovo (13%), Portugal (11%) and Germany (10%). 5% each come from Spain, France and Turkey. The remaining 15% of the foreign resident population is dominated by Asia with 7%, while Africa and America each account for 4%. Not least, these figures reflect Switzerland's current immigration policy which favours qualified workers from the EU and particularly from neighbouring countries and southern Europe. For instance, there has recently been a high level of immigration from Germany.

Resident population according to nationality, end of 2004

Nationality	Population on 31 December 2004	Share (in % rounded)	Youth ratio (in %)[1]	Age ratio (in %)[2]	Gender ratio[3]
Total	7'529'564	100%	35,5	25,1	96,6
Swiss	5'890'439	78%	35,9	30,3	92,1
Foreign	1'639'125	22%	34,2	9,0	114,6
Total foreign nationals	1'639'125	100%	34,2	9,0	114,6
European	1'397'770	85%	33,7	10,1	117,5
EU-25 / EFTA nationals	931'045	57%	24,1	13,3	124,2
Italian	307'717	19%	23,6	21,4	138,3
Serbian and Montenegrin	211'340	13%	65,4	2,5	109,8
Portuguese	173'278	11%	38,4	0,7	119,0
German	163'923	10%	15,2	13,8	123,9
Turkish	80'462	5%	47,4	3,5	118,0
Spanish	76'080	5%	23,2	9,4	121,3
French	73'999	5%	21,6	13,0	115,3
Macedonian	61'534	4%	62,3	1,1	111,7
Bosnian and Herzegovinian	48'931	3%	51,3	3,1	102,4
Croatian	42'050	3%	45,3	2,9	99,5
Asian	108'524	7%	39,8	2,7	101,7
African	65'092	4%	40,3	1,5	124,7
American	61'752	4%	29,1	3,9	69,0

[1] Ratio of 0-19 year-olds to 20-64 year-olds.
[2] Ratio of 65 year-olds and more to 20-64 year-olds.
[3] Number of men per 100 women.

Source: FSO 2005, modified and completed representation

As a result of this admissions policy, until recently it was predominantly men who immigrated into the country because they find a greater choice of jobs in the employment market than women. Since the mid-1990s, however, roughly equal numbers of men and women have been immigrating here annually, so that now the figures for the migrant population not born in Switzerland are slowly balancing out: in 2004 men accounted for 53.4% and women 46.6% of foreigners resident in the country. There have been and still are national differences in terms of the gender ratio. Among those immigrating from Germany, Austria and France, for instance, women have occasionally outnumbered men. A female majority can also be seen today in the immigration figures from most American and East European states.

There is a marked difference between the native population and the migrant population in terms of age structure. This is because young people aged between 20 and 39 still make up the majority of migrants. The birth rate among foreigners is also higher than among Swiss women. The migrant groups from Turkey and former Yugoslavia contain a particularly high proportion of young people. By contrast, countries of origin which dominated immigration in past decades now account for a comparatively high proportion of elderly people in the migrant population, which is reflected in the figures for Italy, Germany, France and Spain, for instance (see table).

Residence status and period of residence

Furthermore there are striking differences in residence status. Two-thirds of the migrant population hold a settlement permit. Most of the remaining third have a residence permit. Short-term residence permits account for only a small proportion. Finally, a good three per cent of the foreign resident population in 2005 came from the asylum sector. Whereas the predominant residence status for migrant groups from Italy, Spain, Portugal, Austria, Croatia and Turkey is a settlement permit, asylum seekers mainly come from Africa, Asia, Turkey and former Yugoslavia. One striking feature among asylum seekers is the very high proportion of men (76.5% in 2004). Men also make up the vast majority of short-term residents at 63.1%.

As well as the officially recorded migrant population, an estimated 70,000 to 180,000 people are staying in Switzerland without any valid residence permit. These illegal immigrants without papers ("sans papiers") have either entered Switzerland unofficially or failed to leave the country once their residence permits have expired.

The following figures are interesting with regard to the period of residence: around 20% of foreigners have been living in Switzerland for more than twenty years. 60% have been in our country between five and twenty years. Another 20% migrated here during the past five years. 24% of the foreign resident population were born in Switzerland.

How do the people who have immigrated into Switzerland live? They make up 25.2% of the Swiss population in gainful employment. The percentage of employed women within the migrant population is 38.5%. This is a smaller percentage than among native Swiss women, but foreign women are more likely to be employed full-time than Swiss women.

Major differences in working life

Compared with the Swiss population, foreigners working here are found more commonly in industry and less in agriculture and service industries. People from southern Europe are employed in particularly high numbers in industry. Male and female foreign workers are very strongly represented in the construction sector and the hotel and restaurant industry as well as the healthcare sector. For example, men from abroad account for a large proportion of welders and tunnel construction workers, while women from abroad make up the majority employed as chambermaids, in laundries and other cleaning occupations. Foreign women are found in the sex industry and working as domestics – where it is not uncommon for them to live in precarious conditions as illegal immigrants or short-term permit holders.

The make-up of the migrant population is extremely heterogeneous. One expression of this is the fact that migrants are over-represented among the unqualified workforce but also among highly qualified workers. There are also striking differences with respect to people's position in their profession: within the migrant population employees without any supervisory role mainly come from Portugal, Turkey and former Yugoslavia, whereas it is very common to find migrants originating from Germany, France, North America and Australia in managerial positions.
Such differences are naturally reflected in income. On average, the worst paid in Switzerland are workers originating from the western Balkans. The income of immigrants from southern Europe tends to be higher. Foreigners from northern and western Europe are at the top of the wage ladder – and they are even a rung higher than the average for the Swiss population.

The difference in earnings primarily stems from the individual level of education. Half of those in gainful employment from southern Europe and from the western Balkans did not do any further training after completing statutory school education. By contrast, more than half of those from northern and western Europe attended a vocational high school, higher education college or university.

Higher levels of unemployment and poverty

A low level of education and over-representation in highly cyclical sectors of the economy largely explain why the unemployment rate of 6.6% in the migrant population is much higher than the 2.8% rate for the Swiss labour force (figures for 2004). With a rate of 7.2%, female migrants are even more affected than their male counterparts (6.2%). Exactly as in the Swiss population, the 15 to 24 age group among immigrants is also the worst affected by unemployment.

As a result of their poorer overall socio-economic status compared with the native Swiss population, the migrant population has twice the rate of poverty (21.4%) and is also over-represented in the group of the working poor. A low level of education, unfavourable working conditions or unemployment expose female foreigners to a particularly high risk of poverty. However, there are enormous differences in the poverty statistics depending on the country of origin. For instance, 30% of immigrants from the western Balkans, from Turkey, Romania and Bulgaria are affected by poverty, whereas just under 20% from southern Europe and only 7% from northern and western Europe are in poverty. It is hardly surprising that foreigners resident in Switzerland claim state benefits far more often than native Swiss men and women.

What immigrants suffer from

There are relatively few data available with which to assess the health status of the migrant population in Switzerland. As part of the "Migration and Public Health Strategy, 2002 – 2007", a detailed survey on the state of health and health-related behaviour was carried out with selected groups in 2004. This "Monitoring on the migrant population's state of health in Switzerland" (GMM) considered immigrants whose countries of origin were Germany, Austria, France, Italy, Portugal, Turkey, former Yugoslavia and Sri Lanka. Notably absent are data for people from Asia, Africa and Latin America.

Migrants judge their state of health as markedly worse than the native Swiss population does. Female immigrants, in particular, feel far more ill than Swiss women. The poorer well-being of immigrants is more noticeable in the older age groups. As with the socio-economic factors, well-being also reveals enormous differences between the different countries of origin. Thus the fewest symptoms were reported by the groups from Germany, Austria and France; their subjective state of health is very similar to that of the native Swiss population. This is not the case for foreign residents from Turkey and asylum seekers from Kosovo, who feel unwell more often and suffered from physical or mental ailments more frequently in the year prior to the survey. An analysis of current research results shows that the health of the migrant population is often actually worse than that of the native population, thereby confirming the subjectively worse well-being reported by male and female migrants.

Pain, infections, accidents

A very variable picture again emerges when respondents are asked about individual symptoms. Over 20% of people from Turkey and from Kosovo mentioned severe back pains and headaches as well as pronounced sleep disorders. Various epidemiological studies have shown that the prevalence of parasitic and infectious diseases, such as malaria and tuberculosis, is higher among the migrant population. Asylum seekers and illegal immigrants from countries with a lot of TB cases have a particularly high risk of tuberculosis. Sections of the migrant population are also more likely to be affected by jaundice and sexually transmitted diseases. For instance, immigrants from countries with a high incidence of HIV, especially sub-Saharan African countries, have an increased risk of HIV and AIDS. Analysis of the group of people affected by an HIV infection reveals that those who have immigrated from Africa are younger than HIV-infected migrants from western and northern Europe and they are more likely to have become infected by heterosexual contact. Women working in the sex industry are a particular HIV risk group.

Children of asylum seekers frequently suffer from skin diseases and caries. Severe caries is found primarily in children who were at least of nursery school age when they came to Switzerland. A lot of young people from former Yugoslavia, who have not been living in Switzerland very long, have particularly bad teeth.

The migrant population has a higher prevalence of age-related conditions (such as rheumatism) than the native Swiss population. After retirement, migrants who did strenuous physical work for a long time have an above-average incidence of chronic pains (especially backache), which are often accompanied by depression and emotional crises. The accident statistics show a high, above-average proportion of foreigners among the male casualties.

Violence that causes illness

Foreigners who have had to experience violence make up a special group. They are more likely to suffer from certain physical and emotional symptoms than people who have not had such experiences. Typical complaints are (often chronic) pains of the musculoskeletal system, migraine, chest and stomach pains as well as insomnia. Gynaecological problems and sexual dysfunction are also possible consequences of having experienced violence.

Furthermore male and female migrants feel mentally more unbalanced and have a higher incidence of mental disorders than the native Swiss population. Particularly asylum seekers and other people whose residence status is uncertain often feel lonely. Within the migrant population, women are treated for mental problems more frequently than men. Foreigners who have had to experience violence or were forced to emigrate often suffer from mental illness as well. Many suffer from general stress, difficulties coping with everyday life and low self-esteem.

The specific health status of the migrant population is also reflected in the invalidity pension statistics. The number of people receiving an invalidity pension who held a foreign passport markedly increased in the early 1990s, but it has remained stable since about 1995. The country of origin for the largest group is still Italy. While this group is no longer growing (mainly because the former invalidity pension holders are increasingly receiving old age pensions), the proportion of people from former Yugoslavia is on the increase. This may be due to the relatively less qualified work done by this group and the associated higher risk of invalidity. It is noticeable that mental illnesses and musculoskeletal conditions are particularly common among foreign claimants receiving newly awarded invalidity pensions.

Striking differences in mortality

In terms of mortality, the migrant population has worse but also better rates than the native Swiss population. The most common causes of death in Switzerland are diseases of the cardiovascular system and the cerebral vessels, but foreigners from the 35 to 60 age group are clearly less represented than the native population and the lower mortality among the men is particularly striking. One possible explanation is that it is mainly people whose health is robust who seek work abroad (healthy migrant effect). Different dietary habits as well as physical exertion at work may also play a role.

In comparison with the native population, however, foreigners are more likely to die from pneumonia and other infectious diseases. Mortality associated with pregnancy and childbirth is also higher in the migrant population. This applies particularly to socio-economically disadvantaged groups. The noticeably higher rate of complications of pregnancy and childbirth is, not least, explained by a lower take-up of prenatal check-ups. This is true particularly of women who only recently came to Switzerland.

The cancer mortality rates are partly higher and partly lower among immigrants than the Swiss population. Breast cancer mortality is lower for foreigners than for Swiss women. While the mortality rate for lung cancer in the migrant population hardly differs from that of the Swiss population, it is about 50% higher for stomach cancer. There are differences specific to countries of origin for some types of cancer. For instance, men from Africa and Asia have a particularly high liver cancer mortality rate. Immigrants from China and South East Asia have a higher rate of nasopharyngeal cancer than the Swiss population. Meanwhile people originating from sub-Saharan Africa die more commonly from AIDS than migrants from other countries.

Many reasons for illness

The results of the "Monitoring on the migrant population's state of health in Switzerland" (GMM) clearly show that socio-economic status has a major influence on health. Foreigners are more likely than the native Swiss population to work in highly cyclical sectors of the economy and they are therefore exposed to a higher risk of unemployment and the vulnerability associated with unemployment. They also do night-work and shift-work more often, are employed in sectors with irregular working hours and their work often involves physically strenuous activity. In the service sector, foreigners very frequently do the worst paid work. It is not uncommon for such working conditions to have an adverse effect on people's state of health.

The harmful consequences are very often apparent in old age. As the proportion of elderly people within the migrant population continues to rise – according to forecasts by the Federal Statistical Office, it is expected to be over 10% by 2010 – the health problems experienced by elderly foreigners in Switzerland are gaining in importance. The health risks are made even worse by the fact that twice as many foreign as Swiss pensioners are living below the poverty level.

Migration does not necessarily make people ill

Migration in itself does not make people ill. Instead there are specific circumstances which make migration a health risk. For instance, women who emigrate with their children are often exposed to greater stresses. When migration is involuntary, the reasons are often war, violence, torture and persecution. This can make victims feel insecure and uprooted from their homeland and leave them with agonising memories which can lead to physical and mental disorders. An uncertain residence status with the associated feeling of existential uncertainty and a lack of future prospects can also have an adverse effect on health. Thus asylum seekers, in particular, experience specific health problems.

However, there are also beneficial factors affecting health in the migrant population. For instance, the very fact that a person has a job or religious convictions may have a favourable impact on that person's health. Good relationships with family and friends are also relevant to physical and mental well-being. For instance, many foreigners continue to maintain regular contact with friends and relatives in their old homeland. The majority of all the groups studied also have family contacts in Switzerland, while relationships outside the core family, such as siblings, are certainly important. Most of the migrants surveyed have a stable civil partnership or marriage in Switzerland and, in the majority of cases, the partner comes from the same national group. Such personal social networks are key sources of information on health issues. Relatives and friends but also neighbours and clubs can form a kind of lay medical support system.

Medical prevention neglected

What are the health behaviours of migrant men and women? Despite generally poorer well-being, they make use of the services of the healthcare system roughly as often as the Swiss population. However, they are more likely to consult a general practitioner than specialists and they do so mainly because of illness or accidents and less for preventive check-ups. Screening services are used less by migrants overall than by the native population. The respondents to the GMM survey from Sri Lanka and former Yugoslavia stated that it was relatively rarely for them to have check-ups for the purposes of cancer screening, such as prostate or breast examination or cervical smear. The proportion of women who have obtained practical guidance during a gynaecological consultation or been informed in any other way about self-examination of the breast is markedly lower among foreigners than among Swiss women. Tamil respondents and people from former Yugoslavia and Turkey are far less likely to have an HIV test done than the Swiss population. The vaccination status of the migrant population is also poor among some groups. Interestingly, however, the degree of mass inoculation is higher for foreign infants than for Swiss infants.

Too much smoking, too little exercise

Various groups of the migrant population, particularly the young, display distinctly risky behaviour in the areas of tobacco and alcohol consumption, exercise and diet. There is a high level of tobacco smoking among people from Turkey, whereas immigrants from Sri Lanka tend to smoke very little. In all the groups, men smoke more than women, the difference between the sexes being greater than between nationalities. All the migrant groups have a higher alcohol abstinence rate than the Swiss population. In common with smoking, foreign women generally drink far less alcohol than their male counterparts. Binge drinking also tends to be rare in the migrant population.

The very high consumption of medication among Turkish women and asylum seekers from Kosovo is striking. This largely relates to sedatives and sleeping tablets, which are mainly prescribed by a doctor, and pain-killers.

The question of whether the migrant population is more at risk of addiction than the Swiss population cannot be conclusively answered on the basis of data relating to addiction counselling and therapy. Surveys done with the individual groups of people are basically unreliable because addictive behaviour does include criminal practices. Thus the drug consumption declared by the foreigners questioned as part of the GMM survey is consistently lower than the known incidence for the Swiss population.

With the exception of groups from Austria, France and Germany, migrants take part in less sport than the native Swiss population. Particularly among the Italian and Tamil respondents, a noticeably high percentage stated that they did not participate in any kind of sport. It should be borne in mind, however, that foreigners often work in physically strenuous jobs.

People immigrating into Switzerland frequently stick to the eating habits of their old homeland and a traditionally healthy diet leads to low mortality from cardiovascular diseases. However, a section of the migrant population alters its dietary habits in a way which results in serious health damage. Compared with the Swiss population, migrants are far more commonly overweight or obese. Within the migrant population, the problem is particularly prevalent among schoolchildren and the 51-60 age group.

Risky sexual behaviour

Noticeable features in relation to sexual behaviour are the numerous unwanted pregnancies due to inadequate contraceptive and the resulting high number of abortions. Abortions are three times more common among foreigners living in Switzerland than native Swiss women. Inadequate contraception is often attributed to financial constraints, reservations about the contraceptive pill, a difficult relationship with a partner or precarious residence status. Foreign women working in the sex industry, especially women from sub-Saharan Africa, are exposed to a higher risk of HIV infection or an AIDS-related disease.

The problem of female genital mutilation is very specific to certain countries of origin. Circumcised women or girls who are under threat of this ritual practice predominantly come from Somalia, Ethiopia and Eritrea. In 2001 this risk group was estimated as numbering 6700 women in Switzerland.

Necessary language and social skills

An individual's health-related behaviour is strongly dependent on that person's capability to make decisions in everyday life which will have a positive impact on his or her health. This health competence requires the individual to have good enough reading and writing skills as well as language knowledge, making it possible for him or her to access information that is relevant to health. Social skills, which enable people to deal responsibly with their own health issues and which involve the social environment in a health-promoting way, are equally important. Another desirable asset would be a critical ability, enabling people to judge information for themselves but also to enter into a constructive dialogue with the political and economic aspects of the healthcare system.

People with a migration background, however, are not infrequently disadvantaged in gaining access to information and services provided by the healthcare system because of specific obstacles, such as speaking a foreign language or lack of familiarity with the local conditions. It is known, for instance, that sections of the migrant population are inadequately informed about how the Swiss healthcare system works, which is why they do not make best use of the services available for health promotion, prevention, but also medical treatment. Poor health competence is likely to be an important reason for people missing out, especially in terms of cancer prevention, in sexual and reproductive health, but also in relation to the risks caused by incorrect diet and lack of exercise.

Several studies indicate a demand from the migrant population for information in their native language. What they miss most are explanations about health insurance, actual medical treatments, screening possibilities and advice on where to find male and female doctors who can communicate in the required mother tongue. It is Tamil respondents who feel worst informed about the Swiss healthcare system.

The most important sources of health information for the migrant population are newspapers, magazines, television, GPs and friends and family. Information leaflets and the internet are less used; self-help groups have no significance for migrants.

In order to deal with any discrimination against foreigners arising from their use of a foreign language, the integration policy pursued by the federal authorities places special emphasis on language skills. Thus immigrants are expected to acquire one of the national languages of Switzerland as evidence of their willingness to integrate and take responsibility. Bearing in mind that conversations in the healthcare sector often require sophisticated language knowledge (which is even a challenge for many native Swiss) there are distinct limitations to some immigrants acquiring such language skills. Furthermore, not all migrants are in a position to learn a Swiss national language within a reasonable amount of time because of their living circumstances.

Inadequacies in the healthcare system

Overall the Swiss healthcare system is still too poorly equipped to deal with the recent sharp growth in the diversity of the migrant population. The qualified staff quite often lack the transcultural skills, in other words the ability to perceive migrant men and women in their individual life context. Thus appropriate medical treatment is hampered by difficulties in comprehension. In addition, individual migrant groups are often overlooked during the planning and provision of public health promotion and prevention services. Depending on their living circumstances and experiences, people with a migration background sometimes require specific medical services. For instance, there is a need for easily accessible treatment and care that takes account of the specific situation of refugees. Moreover, when treating migrants, healthcare professionals may sometimes be confronted with very specific ailments and diseases rarely found in Switzerland (e.g. health problems resulting from female circumcision) for which there is a lack of medical experience and hence appropriate treatment is not guaranteed.

A lack of transcultural skills and inadequate sensitisation to the specific health problems of the migrant population make medical diagnosis and treatment more difficult and also have an influence on treatment compliance. This can result in symptoms of disease being misinterpreted or too little differential diagnosis being applied to certain clinical pictures. It has also been observed that patients receive less attention when language causes communication problems. In psychiatry certain therapies, which are largely conveyed through speech, are hardly ever used when there are problems of comprehension. This may mean that doctors fall back on drug treatment instead of psychotherapy which would have been medically valuable.

Helpful intercultural translation

Surveys in Switzerland show that doctors, nursing staff and other healthcare professionals regard language barriers as a major problem in caring for migrants. A large section of the migrant population expresses a wish for proper communication with the service providers through the involvement of an interpreter. In everyday practice, relatives or staff who happen to be present are often called in as ad hoc interpreters. According to the GMM, people from Sri Lanka and Turkey as well as asylum seekers are most likely to make use of translation assistance. Women use language help far more commonly than men. Apart from their husband, partner or other relatives, it is not uncommon for them to call on their own children for help. Such improvised solutions, however, can cause serious problems because of a lack of competence.

As a rule, the use of professional interpreters improves the quality of treatment and care. In Switzerland, around 500 people are certified as intercultural interpreters and numerous placement agencies exist. However, there is still a lack of professional translation for certain services, such as GP medicine or among staff in regional hospitals. Many migrants, but also many healthcare professionals, would like to see professional intercultural translation institutionalised and an improvement in these services. However, it has been found that the existing translation provision is still under-used. Lack of information, financial considerations and uncertainties about calling in professional services play a role in this under-use. Financing is a problem since it is not yet uniformly regulated.

The Confederation's "Migration and Public Health Strategy, 2002 – 2007"

It is being observed in other countries as well as Switzerland that certain migrant groups have poorer well-being and more health problems than the indigenous population. Such health inequalities to a large extent reflect social inequalities. However, they may also result from barriers to access and communication difficulties as well as a lack of sensitivity in the local healthcare sector to the specific health problems of migrants.

An internationally observed problem

In various recent conventions and declarations, states are being called upon to work towards equality of opportunity in health by adopting suitable measures. For instance, according to article 12 of the UN pact on economic, social and cultural rights, states which are party to the pact, including Switzerland, are obliged to recognize everyone's right to the enjoyment of the highest attainable standard of physical and mental health and to assure adequate medical attention in case of sickness.

The World Health Organization (WHO) has also focused on equality of health opportunity as a central goal and has launched various programmes to realize this goal.

The European Union (EU) attaches great importance to reducing inequalities in health. In 2002, for instance, the EU Commission created the European migrant-friendly hospitals (MFH) pilot project, which invites all European hospitals to develop into transculturally competent organisations. In various countries, such as the UK, Germany and Austria, national programmes to improve the health situation of the migrant population have meanwhile been initiated.

Successful Swiss projects

In Switzerland, the Federal Office of Public Health (FOPH) launched the Migration and Health (PMG) project as early as 1991, which developed intervention strategies for HIV/AIDS prevention for certain migrant groups. In 1995 the project was extended to addiction prevention and comprehensive public health promotion. Groups from other countries of origin were also included. Furthermore a migration unit was set up in the FOPH, which was responsible for all measures to promote health in the migrant population. In 2002 this became the Migration and Public Health service and in 2004 it finally became the Migration and Public Health division as part of the Equal Opportunities and Health section.

In order to improve the health status of the migrant population in Switzerland, the Confederation launched the "Migration and Public Health Strategy, 2002 – 2007", under the auspices of the FOPH. Various federal offices and federal agencies as well as other organisations were involved in implementing the strategy.

As part of the strategy, a relatively large number of projects have been carried out, some of which can be highlighted as particularly successful:

- In collaboration with the umbrella organisation on intercultural translation, 500 interpreters received further training and were certified according to defined standards. Today they are employed via cantonal agencies. In addition, a manual and a film on employing interpreters for healthcare professionals were produced and distributed.
- Based on the Migrant-friendly hospitals EU initiative, a network of 40 hospitals was created in collaboration with "H+ Swiss Hospital Association". These have taken measures and exchanged experiences in the area of migration and health. Subjects have included translation services, information in foreign languages and quality control. On the subject of diversity and equal opportunities, a manual was written which is aimed at hospital management.
- The documentary film "Comprehension can cure. Global migration – Local solutions in health care" was screened at the University Hospital in Berne. The film is used to sensitise healthcare professionals and illustrate how migrants experience everyday hospital life.

– The "Monitoring on the migrant population's state of health in Switzerland" (GMM), which included questionnaires in migrants' mother tongue, marked the first time a broad-ranging survey of the health of many migrants in Switzerland was carried out.
– The website www.migesplus.ch enables healthcare professionals to obtain booklets in various foreign languages, which they can pass on to those seeking advice. The subjects of the booklets include diet and exercise, oral health and infectious diseases, for example. A booklet on how the Swiss healthcare system works has already been produced and has been incorporated into various courses (e.g. German courses for migrants).
– In conjunction with the Swiss Red Cross and the Swiss AIDS Federation, an HIV / AIDS prevention programme for people from sub-Saharan Africa has been designed and implemented.
– With support from the FOPH and Health Promotion Switzerland, migrants have themselves carried out easy-access projects on health promotion and prevention. This meant that resources within the migrant population were mobilised and new target groups were reached.

Critical evaluation of the national strategy

The "Migration and Public Health Strategy, 2002 – 2007" was thoroughly evaluated by an external team. The overall evaluation of the strategy is good. The targets are seen as relevant and the majority of the approaches adopted as appropriate. The Confederation reportedly based its strategy on a sound but very ambitious concept. The goals have only been partly achieved because they were set too high in view of the limited resources and difficult political, economic and institutional conditions.

According to the evaluation, the strategy has increased the visibility of problems in the area of migration and health and performed services which have had the desired impact among the migrant population. There is room for improvement in the design and organisation of implementation of the strategy. For instance, the implementation structure proved complex and not clear enough. In addition, the cantons were not sufficiently integrated into the implementation process.

The evaluation makes a series of recommendations for any successor strategy. The key points are:
– Maintaining equality of health opportunity as a vision.
– Starting from a broad overview when analysing problems.
– Defining problems more accurately, based on new knowledge.
– Striving for thematic continuity in the fields of action and ensuring the sustainability of hitherto successful projects and activities.
– Giving more emphasis to communication about implementation of the strategy.
– Improving support for the strategy and FOPH internal networking.
– Strengthening cooperation with the cantons.
– As far as possible, pursuing an integrated approach which takes account of migrants' needs in the regular structures of the healthcare system.
– Strengthening the sensitisation role of the strategy and getting additional groups of people to become active as well.

Successor strategy on Migration and Public Health 2008 – 2013

The Federal Council commissioned the Federal Office of Public Health to develop a second phase of the Migration and Public Health Strategy due to finish at the end of 2007. Based on the experiences gained in the first phase and taking into account the recommendations made in the evaluation, the FOPH, in cooperation with the Federal Office for Migration (FOM) and the Federal Commission for Foreigners (FCF), drew up Migration and Public Health Strategy Phase II (2008 – 2013). For the most part, the programmes and measures from the first phase will be continued in the second phase. Specific areas of implementation are also to be rooted more effectively at the institutional level and among the migrant population. Consolidating the strategy and making it more firmly established will further secure the investments made in phase I.

The Swiss Confederation attaches great importance to the subject of migration and health, not least because the principle of equal opportunities is rooted in the federal constitution and is a central theme of national integration policy. In response to implementation of the FOM integration report, the Federal Council instructed the Interdepartmental Study Group on Migration Issues (IAM) to submit to the council an overview of the action required by all federal offices and put forward proposals for a coordinated package of measures by the end of June 2007. With the Migration and Public Health Strategy Phase II (2008 – 2013), the FOPH is now complying with the Federal Council's request to develop and implement meaningful integration policy measures in the policy field of public health.

Widespread approval

In spring 2007, the Migration and Public Health Strategy Phase II was submitted to the healthcare directorates of all the cantons and 22 national organisations from the healthcare sector for their comments. According to their feedback, this phase II is being met with considerable approval and, in implementing the strategy, the FOPH can count on the support and cooperation of numerous players at the federal and cantonal level and from civil society.

The integrated approach enjoys general approval. The respondents attach the highest priority to public health promotion and prevention. Other important factors seem to be measures involved in training and continuing education, in healthcare provision (such as specific services for particularly vulnerable groups) and putting research findings into practice. At the end of June 2007, Phase II of the strategy was passed by the Federal Council. The annual budget for implementation of the strategy is around 2.4 million francs.

Vision of equality of opportunity

The strategy is based on the following vision: "Everyone living in Switzerland shall be given a fair opportunity to develop their health potential. No-one will be disadvantaged by avoidable discrimination." Thus the efforts involved in implementing the strategy are not only being made on behalf of the migrant population but are also intended ultimately to enable socially disadvantaged people in the native population to benefit from improved awareness of discriminatory elements in the healthcare system.

This vision gives rise to a higher goal for the strategy: "The migration and public health strategy will help to break down avoidable discrimination in health and improve the conditions so that people with a migration background in Switzerland have the same opportunity to develop their health potential as the indigenous population."

The strategy defines a number of goals in order to improve health-related behaviour, the health status and access of migrants to the healthcare system. The most important goals are:

- Public health promotion and prevention programmes incorporate the migrant population.
- People with a migration background are adequately informed and have the skills to adopt healthy behaviour on their own responsibility.
- Healthcare staff gain migration-specific competence.
- Increased and need-based use is made of professional intercultural translation services.
- Additional knowledge about the health of the migrant population is gained and available to interested groups.

Principles of action of the strategy

Implementation of the strategy is guided by several principles of action:

In line with the first goal, migration-specific concerns are to be integrated into the existing provision by means of information, coordination and networking. This **integrated approach** is intended to give the migrant population, in particular, easier access to facilities and services in the healthcare sector while existing barriers are torn down. Under certain circumstances, however, it may make sense to sponsor programmes specifically addressed at individual migrant groups in addition to the existing provision.

Greater use is to be made of the **resources already available** in the **migrant population.** For instance, the health-related knowledge and experience of the social networks within the migrant population are to be incorporated into the individual projects associated with the strategy. The aim is to work increasingly with experts who have a migration background, particularly on public health promotion and prevention measures.

With respect to equal opportunities, it is particularly important always to take the **gender aspect** into consideration. No infrequently, gender-specific factors play a part in defining the private and working lives of men and women and may also influence their health-related behaviour. This is why implementation of the strategy must always take into account the differing viewpoint and way of life of men and women. Sensitisation to gender-specific factors and to any discriminatory elements will lead to better utilisation of the personal resources of men and women.

In order to maintain, promote and restore health, factors from various areas of life, such as work, housing and education, need to be included. In view of the strategy's limited resources and scope for action, a comprehensive cross-sectoral approach is admittedly too ambitious. Integrating migration-related considerations into numerous health-related areas nevertheless involves pursuing a **cross-sectoral approach.** For instance, measures can be taken to link and coordinate healthcare concerns with the content of other policy areas. Hence implementation of the integration report by the Federal Office for Migration offers an opportunity to link up public health promotion and integration promotion – a step towards a multi-sectoral health policy.

Four fields of action and one cross-sectoral task

The measures to achieve the strategy goals are translated into four fields of action, bearing in mind the stated principles of action. In terms of content, the fields of action largely coincide with those of the earlier "Migration and Public Health Strategy, 2002 – 2007". A new addition is the cross-sectoral task of Mainstreaming Migration.

The fields of action in detail:

Health promotion and prevention. Previous programmes have often neglected sizeable groups of the migrant population. One main objective of the health promotion and prevention field of action is to shape existing provision to cater for migration. Where such an adjustment is not realistic, supplementary programmes will be created. Last but not least, ways of staying healthy or regaining health even under stressful living circumstances will be indicated. Another objective is to improve the health competence of migrants with the aid of specific forms of health information. This information is to be provided as part of integration and language courses and via health promotion and prevention agencies active in the particular subject areas.

At the national level it is planned to incorporate migration-specific concerns into the national programmes, offerings and projects on health promotion and prevention. Based on the epidemiological data, there is a need for action in the following areas: diet and exercise, alcohol and tobacco, medication abuse, workplace, sexual and reproductive health, cancer prevention, mental health, dental health. Contact will be maintained with those in charge of the most important programmes in order to sensitise them to specific problems of the migrant population and to motivate them to make appropriate modifications to their programmes. The migration aspect is already being included in the programmes on prevention of HIV / AIDS and drug abuse. Here the aim will be to ensure that the sensitisation already achieved is maintained.

At the cantonal level the aim should also be to work towards reshaping the existing health promotion and prevention projects in a way that takes account of migration. Where there are gaps in the provision, pilot projects may be developed and implemented (for example on the subject of dental health). The plan is to find out the demand in conjunction with the cantonal authorities. They will also receive technical support. Project development is expected to be carried out by cantonal offices with the involvement of people from the migrant population.

In order to improve the health competence of migrant men and women, information material in the different native languages is being drawn up and delivered. The Health Guide Switzerland is already available in 18 languages. A number of advice booklets can also be obtained via the website www.migesplus.ch. In addition, the teaching aid "How to live a healthy life in Switzerland" is suitable for use in language courses. It is important not only to produce health information but also to make sure that it reaches its target audience and is heeded by them.

Training and continuing education in healthcare. The educational landscape is in upheaval and various regulations on education are currently being revised. This means it is a good time to incorporate the goals of this strategy. Training in healthcare shall be designed to take account of migration, and transcultural competence is to be promoted among professional staff. Where possible, the knowledge required to deal competently with the migrant population is to be integrated into existing training and continuing education for healthcare professionals. Specific teaching materials and continuing education courses on the subject of migration and health are being provided. Another goal is quality assurance in the training for intercultural translation.

One of the planned measures is collaboration with the offices responsible for training and continuing education, such as the Federal Office for Professional Education and Technology OPET, OdA Santé, other sections of the FOPH, the professional medical associations of the FMH or the Swiss Conference of Nursing Schools SKP, in order to check the extent to which the subject of migration and health is already contained in training regulations and syllabuses and to find out how gaps can be closed. High-quality teaching materials are being provided and the teaching staff motivated to use them.

In the area of continuing education, low-threshold courses, for example for hospital staff without standard training, are being promoted. Courses for qualified professionals are also being sponsored, for instance in the form of a "migration and public health" module in the existing Master of Public Health advanced training course. As part of the "Migration and Public Health Strategy, 2002 – 2007", a pool was created for incentive financing of transcultural training events. This pool of resources is to be maintained and will be modified, depending on the experiences gained. For instance, it may be used to reach staff in hospitals and other nursing establishments who have not had standard training in the healthcare sector.

The training for intercultural translation also launched in the first phase of the strategy will be sustainably secured and integrated into the system of professional translation training. In particular, an appropriate professional examination with a Swiss Federal Certificate recognized by the OPET is to be created. In order to develop a planned telephone interpreting service, the necessary training concept is being devised and will be implemented.

Healthcare provision. Healthcare provision encompasses all the people, organisations, institutions, programmes and measures that promote health and prevent and treat diseases. This includes in-patient services in hospitals and homes for the chronically ill, disabled and elderly as well as out-patient services provided by GP practices and Spitex organisations. State-run and private agencies working with the service providers are also part of the whole system of healthcare provision.

Access to these services must not depend on language, religion, gender, age or socio-economic circumstances. This is why a basic aim of the strategy is to ensure that medical care in Switzerland is readily accessible and appropriately designed for the migrant population. Appropriate means that the chances of successful medical treatment are as great for people with a migration background as they are for the native population. The ultimate aim is that immigrants into this country should be satisfied with the services provided by the healthcare system. However, the staff should also have a positive perception of their work with the migrant population.

There is a need for action particularly in private practices and Spitex organisations as well as hospital sectors where migrants are frequently dealt with (women's clinics, emergency admissions, geriatric hospitals, rehabilitation clinics and pain clinics). One of the planned measures is to develop a concept in order to support private practices and Spitex in implementing migrant-friendly care ideas. This is to be done in close collaboration with the relevant associations (FMH, GPs, dentists, gynaecology, psychiatry, Spitex).

Another measure is to motivate the responsible persons in hospitals to implement the "Migrant-friendly hospitals" recommendations worked out in the first phase of the strategy. For this purpose, a "Diversity and equality of opportunities" handbook is already available. The pool created in the first phase will also continue to be available for start-up financing of measures to improve the quality of care for migrants in hospitals.

There is equally a need for action in the area of intercultural translation. This vital service in terms of communication with the migrant population is to be improved and used more widely. In particular, it needs to become better known among healthcare staff as well as the migrant population and be made more easily accessible. Not least the open questions regarding legal rights to such services and their financing have to be resolved. Furthermore it is planned to build up a national telephone interpreting service for the healthcare sector. Such services are already run successfully in Paris and Amsterdam. Whereas translation in delicate communication situations, such as psychiatry, will continue to require the presence of a trained interpreter in person, telephone interpreting services may be a relatively inexpensive and efficient alternative for many purposes.

Another aim is to improve healthcare provision especially for traumatised refugees, illegal immigrants and newly arrived asylum seekers. For instance, many illegal immigrants ("sans papiers") have no health insurance, even though they are subject to a compulsory insurance contribution and may obtain a reduction of their premium. The existing platform, which promotes the networking of services provided for illegal immigrants, will continue to be supported by the FOPH. Furthermore, quality assurance on measures involved in border health checks will be guaranteed. In the case of traumatised refugees, the FOPH provides its technical expertise to support the Federal Office for Migration, which subsidises the therapy offered to torture victims.

Research and knowledge management. In the research area of migration and health, questions about the health status and health-related behaviour of the migrant population, causes and consequences are studied. Other subjects include the particular features of the healthcare system and the question of how much the service providers make allowance for migration-specific concerns in their work. This research is extremely interdisciplinary and embraces different approaches from social, legal and economic sciences, from social epidemiology, medicine and nursing science. However, there are gaps in current knowledge in this field. For instance, the Swiss health survey has hitherto only recorded people who speak one of the country's official languages, thereby excluding large sections of the migrant population. The aim of this field of action is to obtain and make available additional knowledge about migration and public health.

A planned measure is to integrate migration-specific questions about the state of health and healthcare provision as standard into existing or planned national surveys. As well as the Swiss health survey, this applies to the national population census, which in future will be replaced by a new statistical system based on persons and households (SHAPE). The Federal Statistical Office is responsible for these surveys. The FOPH itself carries out around thirty data collections on specific subjects, half of which are also relevant to the Migration and Public Health Strategy. In consultation with those responsible for the surveys, the plan is now to examine where and how migration-specific concerns can be newly introduced. Useful additional information, for example, would be details of people's migration background, living situation or degree of integration.

Wherever the existing surveys are inadequate, the information about migration and health which is lacking should be gathered through appropriate research projects. The strategy will include ascertaining whether the "Monitoring on the migrant population's state of health in Switzerland" (GMM) first conducted in 2004 should be repeated or, based on experience, should be modified. The use of intercultural translation will also be evaluated with a cost-benefit analysis. If the use of such a service is also worthwhile from a commercial point of view, this would be a strong argument for broadly promoting intercultural translation in the healthcare sector.

In relation to science management, selected research results as well as the know-how gained in projects implementing the strategy are to be processed and conveyed to professionals in a useful form. The programme team keeps up-to-date with the latest knowledge in the area of migration and health at the national and international level and passes on relevant information within the strategy community.

Cross-sectoral task of Mainstreaming Migration. Mainstreaming Migration means all the activities aimed at ensuring that those active in politics, administration and society systematically take migration-specific factors into consideration in the planning, implementation and evaluation of programmes, projects and measures. This cross-sectoral task is perceived as a support function in all four fields of action by both the programme managers and those with communication responsibilities. The changes being sought are to be sustainably established in the various offices of the Swiss healthcare system by means of information, coordination and networking.

The cantons, in particular, will also be addressed because they still differ widely in their levels of commitment to the strategy. Some cantonal offices are already playing a pioneering role today; they should be encouraged in their efforts. Other cantons are not so active. In these cases Mainstreaming Migration aims to stimulate greater involvement and motivate cantons actively to implement measures in line with the federal strategy. Close collaboration between the Confederation and the cantons is important because it is primarily the cantons that are responsible for healthcare provision in Switzerland.

As part of the networking measures, the relevant groups in the healthcare sector will be encouraged to support the content of the Migration and Public Health Strategy and to allow for migration-specific concerns in their work. The aim is to commit them as strongly as possible to implementing the strategy. The networking meeting "Great Migration Forum on Health" is planned for April 2008. In addition, members of the programme team are serving on various external networking committees in order to represent the strategy.

Special attention is being paid to networking within the Federal Office of Public Health. As a result of in-house sensitisation work, the strategy concerns are being integrated into all activities of the FOPH that affect the migrant population. Thus it is hoped that the strategy will enjoy the broadest possible support in the Federal Office.

As a communication measure, the knowledge and experiences gained in respect of the strategy will be communicated selectively to the various service providers and decision-makers in the healthcare sector. The methods used will include articles in the FOPH publications "FOPH Bulletin" and "spectra" as well as items in external specialist journals or newsletters.

As well as the specialist healthcare groups who are directly involved, it is hoped to inform a wider specialist audience and the general public about the goals and measures of the national strategy on Migration and Public Health. For instance, the publications, DVDs, strategy papers as well as research and evaluation results arising from the strategy can be ordered or downloaded as PDF files from the website of the FOPH Equal Opportunities and Health section www.miges.admin.ch.

Strategy support and implementation

The body responsible for the Migration and Public Health Strategy Phase II is the Federal Office of Public Health (FOPH) with the cooperation of the Federal Office for Migration (FOM) and the Federal Commission for Foreigners (FCF). Financing is mainly assured by the FOPH via the prevention fund. The FOM can make contributions to therapies for traumatised asylum seekers under the terms of the asylum law.

As previously, the Equal Opportunities and Health section of the FOPH will continue to manage implementation of the Migration and Public Health Strategy and provide the primary support. An action plan is being drawn up for Phase II, specifying the goals and tasks of the individual fields of action and allocating resources. The plan will also stipulate timings and will be periodically updated.

The implementation and impact of the strategy will be reviewed by means of regular reporting and self-evaluation by those in charge of programmes and projects. Assessment of implementation of the strategy is again planned to take the form of an external evaluation. It is hoped this will provide a reliable basis for necessary modifications with respect to future activities in the area of migration and health.

References, addresses and links

Federal Office of Public Health
Health Policy Directorate
Equal Opportunities and Health Section
CH-3003 Berne; Email: migrationundgesundheit@bag.admin.ch

www.miges.admin.ch
The website provides information about the Migration and Public Health Strategy, its partner organisations, projects and achievements; with numerous addresses, links and publications to be ordered or downloaded.

Federal Office of Public Health (2007):
Strategie Migration und Gesundheit (Phase II: 2008 – 2013)
The 96-page strategy paper, which was passed by the Federal Council in June 2007, contains an extensive list of references in the appendix. It can be obtained in German and French as a PDF file from www.miges.admin.ch.

Federal Office of Public Health (2007):
What about the health of migrant population groups?
The most important results of the "Monitoring on the migrant population's state of health in Switzerland".
The above publication provides current data on the state of health and health-related behaviour of migrants living in Switzerland.

Federal Statistical Office (2005):
Ausländerinnen und Ausländer in der Schweiz
Report 2005. Neuchâtel. (available in German and French)
The table on page 9 of this publication is based on the above report (with some additions and amendments).