

Second Health Monitoring on the migrant population in Switzerland (GMM II)

Management Summary

Initial situation and goals

The Swiss Federal Government pursues a goal of enabling all the country's citizens to have equal opportunities to remain healthy and to fully exploit their health potential. Various studies indicate that this equality is restricted among sections of the migrant community. The National Migration and Public Health Programme (2008-13) includes measures and schemes for prevention, healthcare, education and research. The programme aims to contribute to a reduction in health discrimination against people with a migrant background in Switzerland and to improve conditions so that they may enjoy the same opportunities to reach their health potential as indigenous Swiss.

As part of its research, the Federal Office of Public Health (FOPH) commissioned a monitoring report on the health of the immigrant population (GMM) in Switzerland, which in 2004, for the very first time, collected representative data about health of selected groups. The FOPH later decided to commission a second health survey for people from migrant backgrounds (GMM II) in order to obtain a more detailed data-set. This research assignment aimed to resolve the following three main questions:

- What are the principal *health differences between the indigenous population and people with a migrant background* in Switzerland as regards their health status, their health behaviour, their health skills and their access to the health system?
- Which groups *within the migrant community* in Switzerland are most vulnerable in health terms?
- What are the main *determinants* of the detected health differences, and what impact do they have (sex, age, job/income, education, social integration, migration background)?

Methodology

Target groups and sample

Just as in GMM I (2004), four focus countries were selected in GMM II for male and female migrants from the permanent foreign population and two for refugees (asylum seekers and provisionally admitted foreigners). These are *Portugal, Turkey, Kosovo and Serbia* for migrants among permanent residents, and *Sri Lanka (Tamils)* and *Somalia* for refugees. In addition to the country- and language-specific selection, two additional samples were made. Additional sample 1 is drawn from among male and female migrants from Turkey and Kosovo who have been Swiss residents for less than 2 years. Additional sample 2 is drawn from among (recently) naturalised people. The reference population of Swiss nationals is taken from the 2007 Swiss Health Survey.

Tools

The questionnaire includes four thematic areas: (1) health status, (2) health behaviour, (3) healthcare utilisation, and (4) resources and demand. Variables and concepts from the first three areas can be roughly regarded as target variables and those from the fourth area as an explanatory variable.

Carrying out the survey

The telephone survey was carried out exclusively by CATI (Computer-Assisted Telephone Interview). The start of the various samples was staggered. The core sample and that of recent immigrants (both for all nationalities) began on 24th September 2010. Additional sample 2 - naturalised people – began later (in the week of 11th October 2010). The inclusion of refugees in the field survey was also staggered in time.

Methodological limitations

The following aspects are worth mentioning from a methodological point of view:

- *Migrant population – selected groups vs. comprehensive survey:* It should be remembered that GMM II (like GMM I) does not give a representative picture of the male and female migrant population. The selected groups can however serve as an example of migrants' health status and circumstances.
- *Limitations through small samples:* The small number of cases in the migrant sub-group sample populations under study makes it harder to nuance the findings. This limits the significance of the results in some areas.
- *Design of the study – monitoring approach vs. analysis of cause and effect:* GMM II focused on a monitoring approach, but the questionnaire was designed to permit a certain amount of explanatory analysis.

Monitoring – Permanent Residents*Health status*

The results indicate that currently it is mainly people in comparatively good psychological and physical condition from the study countries that set out to migrate. This is particularly true of people from Serbia and Kosovo, whereas it is less accurate for people from Turkey or Portugal. However, the health status of older male and female migrants residing in Switzerland, who have generally been in Switzerland for quite a long time, is generally worse than that of Swiss men and women of the same age. Women migrants also generally score worse in terms of their health status than men. The older the migrant population, the greater the difference between men and women. Such differences are hardly or less apparent in the indigenous population.

Healthcare utilisation

The proportion of people consulting a doctor (general practitioners and specialists) at least once per year is not higher for any of the migrant groups under observation than for Swiss citizens. Indeed the opposite is true: women from Portugal and Kosovo, and men from Serbia and Kosovo, visit a doctor less often than the indigenous population does. However, visits to a general practitioner are more common among migrants than in the indigenous population. As for use of the emergency services and hospital outpatient facilities and/or outpatient clinics, the results show that some of the migrant groups under study call on them more often than Swiss citizens. These differences are relatively small, though. Female and male migrants have a lower rate of medical check-ups than indigenous Swiss. As a rule, a lower rate of use of outpatient health services for preventive measures (vaccinations medical

check-ups, advice), or of outpatient check-ups and care for chronic illnesses, may lead to a need for expensive inpatient treatment later on.

Health behaviour

Female and male migrants consume significantly less alcohol than Swiss citizens, but they also eat less fruit and vegetables and do substantially less physical exercise. Furthermore, female and male migrants are far more frequently severely overweight. There appears to be considerable room for improvement in the promotion of positive health behaviour. Tobacco consumption is far higher among men with a migrant background than it is among Swiss men; for women, the differences between migrants and Swiss citizens are less consistent.

Health skills

From a health promotion perspective, health skills can help people to adopt a healthy lifestyle and to identify and practise their ideas about health. Hence health skills are a resource that furthers equal opportunities for good health, as well as enabling or at least improving people's involvement in the system. No comparison could be made between the health skills of migrants and those of the indigenous population due to a lack of data about the indigenous population. Our analysis therefore focused on comparisons between migrant groups of different origins. This produces no stable pattern regarding the differences between groups of different origins. Although choosing a doctor and communicating with him or her poses comparatively few problems to respondents with a migrant background, medical recommendations and advice are not often challenged. However, between 15% and 45% of respondents, depending on the migrant group, often cannot explain their concerns to the doctor or do not understand the doctor's advice well enough.

Monitoring – refugees

Health status

The two groups of refugees have very different subjective perceptions of their health. Whereas a similar proportion of male and female Somalis to Swiss citizens claim that their health is good, people from Sri Lanka have a far worse perception of their own health status than the indigenous population. Far fewer Somalis are receiving medical treatment for physical and/or psychological problems than people from Sri Lanka.

Healthcare utilisation

There are differences between refugees and indigenous Swiss in respect to seeing a general practitioner in particular - refugees do this more often. As far as the duration of hospital stays is concerned, Swiss men and women tend to spend longer in hospital than refugees, although the only significant difference is with people from Sri Lanka. There are significant differences in how use the indigenous population and the refugees make of accident and emergency departments, outpatients departments outpatient clinics. There is little difference between the two populations in terms of the proportion of people who had visited such an institution at all in the past year. Overall, however, refugees made a significantly higher number of visits to one of these institutions than the Swiss population.

Health behaviour

In terms of nutrition and physical exercise, it is apparent that the proportion of individuals that hardly ever eats fruit and vegetables and is physically inactive is higher among the refugees than among Swiss citizens. Moreover, people from Sri Lanka generally eat less fruit and vegetables than Somalis. There are clear differences to Swiss men and women in terms of alcohol and tobacco consumption.

Alcohol is consumed far less frequently by refugees than by Swiss citizens. The proportion of teetotallers is especially high: almost 99% of Somalis and two-thirds of the Sri Lankan refugees. People from Sri Lanka consume tobacco less often than Swiss or Somali men and women.

Health skills

The health skills of the refugees are on the whole somewhat lower than for the other migrant groups, particularly in terms of assessing symptoms and communicating in the health system. Compared to other migrant groups, the refugees are relatively bad at evaluating whether symptoms require a visit to a doctor. While this is mainly a consequence of a lack of knowledge for physical complaints, the refugees systematically underestimate psychological symptoms. People seldom consider it necessary to see a doctor for psychological complaints, even when it would be medically advisable. There are huge problems of understanding between refugees and the doctors treating them. Only a little more than a third of Somalis and a quarter of people from Sri Lanka can make themselves adequately understood to a doctor; the rest of the refugees cannot do this at all or only occasionally. These people have similar trouble understanding the doctor's instructions or questions adequately.

Closer analysis of health status

The monitoring reveals that younger male and female migrants who have only just immigrated to Switzerland are somewhat healthier than the indigenous population, and that older female and male migrants, and those that have been in Switzerland for longer, are somewhat less healthy. Within the migrant population, women score somewhat worse than men in terms of their health status. Since this study is a cross-sectional study, however, it is not possible to make any assertions about how people's health status has actually evolved since they arrived in Switzerland. No assessment is possible as to whether the results described above are due to an immigration or cohort effect, or whether health developments during people's stay in Switzerland differ between the sexes. It thus remains an open question whether the health of the older and somewhat more ill migrants (in comparison to the indigenous population) was already worse when they arrived in Switzerland or whether they immigrated to Switzerland with above-average physical and psychological health.

Closer analysis seeks to elucidate the differences in various health indicators between people with a migrant background and the indigenous population. This enables us partially to explain these differences by the migrants' lower level of education, inadequate language skills, experiences of discrimination in Switzerland, and experiences of political persecution and violence in their country of origin. In the case of migrants who have been in Switzerland for longer, other factors apply that might have played a role in the past, both in Switzerland and in the country of origin. It is roughly known from other studies (e.g. Spycher, Detzel, Guggisberg, 2006) that female and male migrants lose their jobs quicker than Swiss citizens during times of economic uncertainty or processes of structural change and, after losing their jobs, have less chance of finding a new one than the indigenous population. Additionally, migrants have to cope with multiple responsibilities (family, work, integration) more often than Swiss citizens. What is more, they receive less support from older generations than the indigenous population and are more likely to face conflicts with the younger generation. However, it is also possible that younger, healthier age groups return to their homeland after a certain length of time, whereas those with health problems stay in Switzerland due to the better healthcare.

Conclusions and recommendations for further research

In principle, it was not the task of the authors of this report to derive recommendations from the findings. This step will have to be carried out by the Federal Office of Public Health and the Federal

Office for Migration in conjunction with other actors. Hence the conclusions we formulate below refer exclusively to further research projects.

The second GMM survey required a disproportionate amount of effort for data collection (especially to recruit the respondents, for translation, etc.) compared with the data analysis. One should therefore check whether it might not actually be less expensive *to embed future health surveys of members of the migrant community into the Swiss Health Survey*; this would also fit in terms of both content and timing. This embedding could for example take the form of additional modules and samples. Further analysis of the considerable data-set will first have to show to what extent the major efforts invested in data collection mentioned above are proportionate to the “yield”. The current analysis for this report does however reveal a few sets of questions that need further research and that could also potentially be investigated in more detail during future GMM surveys. These are:

- The *development/observation of the health status* of people with a migrant background over time should be a central preoccupation of future GMM surveys. It would therefore be especially advisable to observe at least one of the migrant groups already interviewed on a continual basis (i.e. in future surveys as well). This would make it at least partially possible to simulate longitudinal analysis and thereby to investigate potential age-related differences in trajectories.
- The GMM survey should focus on a *monitoring approach*, but consideration should also be given to a theoretically based survey of health determinants (resources, risk factors).
- *Utilisation and quality of care*: These research findings point to fairly small and unsystematic differences in how the Swiss population and people with a migrant background utilise healthcare services. Individual migrant groups display a tendency to visit their general practitioners more and they also utilise accident and emergency services slightly more. Closer analysis of the existing GMM data in this area is necessary, taking account - among other things - of the individuals' subjective health status. However, questions about potential undersupply require specific surveys of selected migrant groups. In addition, it would be necessary to verify patients' assessments of the quality of care in future surveys.
- *Health behaviour*: The findings point to a need for action to help people with a migrant background with nutrition and physical exercise. The comparatively high proportion of migrants who are seriously overweight should also be noted. Further analysis and, if necessary, surveys in this area should be seen as a priority.
- *Gender*: Women's health seems to be worse than men's in the migrant population. Efforts should be made to find explanations for these differences.