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Health of the Migrant Population – Results of the Swiss Health Survey 2017

Summary of the final report

Research mandate commissioned by the Federal Office of Public Health, Health Policy Directorate Health Equity Section

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Bern, September 2020

Summary

The federal government is committed to health equity for all population groups. Health equity means that everyone has the same opportunities to develop, preserve and, if necessary, restore their health, regardless of their language, origin, social status or level of education. Studies have shown that the health of immigrants resident in Switzerland is at greater risk than that of the indigenous population. But health-related discrepancies also exist generally between people with differing availability of social and economic resources. In light of this situation, this study, prepared on behalf of the Federal Office of Public Health, aims to present in detail and illuminate the **current extent of health inequality in people with a migration background**. It also investigates the extent to which the discrepancies observed in relation to the population without a migration background can be attributed to the unequal **provision of health-related resources**.

Data, concepts and methods

The main data source of the study is the **Swiss Health Survey (SHS) 2017** produced by the Federal Statistical Office (FSO). In this survey, a sample of 22,134 residents in total were interviewed, of which 1,000 interviews with foreign citizens were funded by the Federal Office of Public Health in order to increase the precision of the statements on the immigrant population. The Swiss Health Survey 2017, with the increased number of foreign citizens in the sample, enabled the health situation of individuals with a migration background to be analysed with a previously unmatched breadth of detail. But, like any large-scale standardised population survey, it also has certain limitations. In particular, it cannot make any statements about **asylum seekers or refugees/ undocumented immigrants since these groups of individuals are not included, or are only partially included, in the sample register**. Moreover, because the SHS is conducted exclusively in the three national languages of German, French and Italian, it does not include immigrants who are resident in Switzerland but who do not adequately understand or speak any of these three national languages. The fact that language skills correlate with health status was demonstrated in the Second Health Monitoring survey conducted in eight different languages in 2010 (Guggisberg et al. 2011).

For the present study, the survey data from the SHS were supplemented by information from the Population and Household Statistics (STATPOP) and data on the individual accounts of the Central Compensation Office (CCO) in order to provide a more accurate picture of the employment and income situation of the interviewees.

Migration is a drastic life event that shapes not only the biography of the immigrant but also, indirectly, the biographies of their offspring. And a migration background is not necessarily associated with a foreign nationality. Moreover, the **group of people with a migration background is inherently very mixed**, and the individuals differ in a variety of ways. In order to do justice to this complex reality, the study uses the **population typology based on migration status**, developed by the FSO, which differentiates between people who immigrated (**first generation**) and those who were born and raised in Switzerland with a migration background (**second generation**), to distinguish them from people without a migration background. The study also differentiates first-generation immigrants by **region of origin**. This allows differences to be identified, within the first-generation immigrant population, between individuals originating from different regions. Because the group of individuals belonging to the second generation is much smaller and less heterogeneous than the first generation, a further differentiation by region of origin was omitted for this group.

To take account of the differing sociodemographic composition of the individual groups (particularly the fact that the immigrant population is much younger on average), the health-related differences for people with a migration background described in the study were **adjusted for age and gender** by multivariate statistical methods.

The Swiss Health Survey records the health of the population in all its facets by means of numerous indicators. **Around thirty key indicators** providing comprehensive coverage of the three dimensions of health status, use of healthcare services and health-related behaviours and attitudes were selected for this study.

Health inequality among individuals with a migration background

People with a migration background differ generally from the population without a migration background in respect of both their health status and their health-related attitudes and behaviours. Regarding the use of healthcare services, only certain differences were found between the populations with and without a migration background.

Health status

People with a migration background **are more likely to rate their self-perceived health status as not good.** Moreover, the **proportion of individuals with physical and mental health problems is systematically higher for the corresponding indicators**. This includes, for example, severe physical symptoms, the existence of at least one risk factor for cardiovascular disease (diabetes, cholesterol, high blood pressure) and sleep disorders. In a minority of two of the six investigated immigrant groups, the proportions of individuals with arthrosis/arthritis or with severe restrictions in daily life were increased. The other groups with a migration background did not differ significantly in respect of these indicators from the population without a migration background.

As regards mental health, people with a migration background more often suffer from high psychological strains and from moderate to severe depressive symptoms. This suggests that some of these individuals experience migration and the associated living conditions during and after migration as psychologically stressful.

Only the indicator relating to long-term health problems is at odds with the general pattern observed for the indicators relating to health status. **Chronic health problems are among certain groups with a migration background not as widespread** compared to the population without a migration background. The fact that chronic health problems can also be the result of birth defects and that those affected tend not to emigrate could also be relevant here. This would accord with the theory of the "healthy immigrant" effect proposed in the literature, which states that healthy individuals are more likely to risk migration.

As a rule, the health-related differences between populations with and without a migration background are more pronounced in the **higher age groups**. The health of first-generation immigrants also deteriorates **as the length of their stay increases**. However, the extent to which these are life course related or cohort effects cannot be ascertained from the cross-sectional data. Life course related effects occur as a consequence of accumulated or intensified health-related stresses and risks, for example as a result of practising certain occupations or unhealthy related lifestyles. Cohort effects can arise, for example, if healthier and more resilient individuals have immigrated in the recent past.

Regardless of the migration status, considerable differences in health exist in some cases between men and women. Immigrants are also affected by these gender-specific inequalities in health. On the other hand, there was no evidence to indicate that the migration-related health differences observed in the study manifest themselves differently in male and female immigrants.

Attitudes and behaviours

The health-related attitudes and behaviours reveal a more mixed picture compared to that for the health status: The proportion of individuals who stated that they lived their lives uninfluenced by health considerations was higher in the population with a migration background. **People with a migration background are also more likely to be overweight and physically inactive**. One noteworthy finding was that second-generation immigrants were also considerably more likely to be overweight, whereas this group of individuals differed from the population without a migration background to a lesser extent in respect of numerous other indicators. Action programmes for specific target groups focusing on diet and physical activity in children and adolescents would probably be particularly suitable for reducing the health inequalities in this area. With the exception of first-generation immigrants from northern Europe, **cannabis use** is less widespread among all immigrant groups than in the population without a migration background. **The results for alcohol and tobacco are mixed**: depending on the immigrant group, these substances are more or less frequently consumed compared with the population without a migration background. Tobacco use is more common among first-generation immigrants from east, south-east and south-west Europe, as well as second-generation immigrants, and less common among first-generation immigrants from non-European countries. Daily alcohol consumption is much more widespread among first-generation immigrants from south-west Europe, but much less common among first-generation immigrants from east and south-east Europe. The other immigrant groups did not differ significantly in respect of these indicators from the population without a migration background.

There are also non-substance related risks associated with dependence. Apart from first-generation immigrants from south-west Europe, the percentage of individuals with **problematic internet use** is increased in all immigrant groups, particularly in first-generation immigrants from non-European countries, although it should also be noted that immigrants frequently use the internet to maintain social contacts with family members and friends in their country of origin.

Use of services

The **access to family doctors and general practitioners**, the central gatekeepers in the Swiss healthcare system, for people with a migration background covered in the SHS is largely guaranteed **to an equal extent to that for the non-immigrant population**: the proportion of people with a migration background who have had a corresponding consultation in the last 12 months is even slightly higher than for the population without a migration background (taking into account the health status).

By contrast, there are isolated differences in the use of the other investigated health services, which suggest a **differing usage behaviour**: first-generation immigrants from south-west, east and south-east Europe, as well as those from non-European countries, are less likely to make use of the services of specialist doctors, although the same immigrant groups visit hospital emergency departments more frequently. Treatments in hospital emergency departments are repeatedly the subject of political debate. The basic objective is to avoid treating "minor" cases in emergency departments where possible.

Among the measures for **prevention and early detection,** the interviewed immigrants were much less likely to seek cervical cancer screening. It is not clear, however, whether this is simply a reflection of the lack of awareness of such services among the interviewed women, since no differences were observed in the use of gynaecology consultations, i.e. where such screening usually takes place.

A possible under usage of services is indicated by the results for dental services, which are not usually covered by the statutory health insurance system. These are much less likely to be used by immigrants than by the population without a migration background.

Finally, in connection with the results on the use of healthcare services, it should be noted that statements about very specific immigrant groups, such as asylum seekers or refugees/undocumented immigrants, but also those who do not speak any national language, are either not possible or are possible only to a very limited extent on the basis of the SHS data. However, major obstacles hindering access to the healthcare system are known to exist for these groups. Nor can anything be stated, based on the survey data, about any quality differences in the health services used, for example as a result of language barriers, lack of health literacy among the patients or the lack of intercultural skills of healthcare staff.

Heterogeneous migrant population and vulnerable groups

People with a migration background form a heterogeneous population group. This fact is also reflected in the health differences in relation to the population without a migration background, which are more or less pronounced within the population with a migration background depending on the group of individuals concerned. The health differences described above tend to be more pronounced in the following **especially vulnerable immigrant groups**: first-generation immigrants **originating from south-west Europe** (most frequent countries of origin: Italy, Portugal and Spain), **from east and south-east Europe** (predominantly from the successor states of Yugoslavia, Turkey and Poland), and **from non-European countries** (predominantly from Brazil, Eritrea and Sri Lanka).

The latter – proportionally small – group of first-generation immigrants from non-European countries is itself extremely heterogeneous, including immigrant workers with widely differing skill levels, individuals that have emigrated to Switzerland to join family, recognised refugees and provisionally admitted foreigners. Since the numbers involved are low, no further differentiation was possible for this group in this study. Earlier studies have shown that **asylum seekers and refugees** are particularly vulnerable (see Guggisberg et al. 2011).

More rarely affected by health inequality, and if so to a much lesser extent, are first-generation immigrants with (in most cases acquired) **Swiss citizenship** (most common countries of origin are Germany, Italy and France) and first-generation immigrants **from north and west Europe** (predominantly Germany, France and Austria). The similarity of the latter group of individuals with the indigenous population is particularly striking, since they hardly differ at all in respect of their health situation and, where they do, this only applies to a few individual indicators.

The differences are also minimal for **second-generation** immigrants who were born and raised in Switzerland (most common countries of origin: Italy, Turkey, Germany, Spain, Portugal).

Resource differences as a key explanatory factor

To explain health-related differences, most of the existing studies refer to the lower level of resources of immigrants, and particularly to the fact that immigrants tend to be worse off than the indigenous population in terms of their socioeconomic situation. In fact, the **proportion of**

individuals without post-compulsory education and individuals with a low income is much higher for those with a migration background. An exception also applies here to the group of first-generation immigrants from north and west Europe, whose socioeconomic status is even higher than that of the indigenous population.

Social support – including practical help, good advice and emotional support from family, friends and neighbours – is another central health-related resource which, without exception, is less available to first-generation immigrant groups. On the other hand, the extent of social support for the second-generation group is largely identical to that for the population without a migration background. Another resource that was considered in this study to be a potentially explanatory factor is **work integration**. The proportion of individuals in receipt of daily allowances from unemployment insurance is increased in all immigrant groups compared to the population without a migration background.

To what extent can the observed health-related differences between the populations with and without a migration background be attributed to these differing levels of resources? As shown by the results of the statistical model estimates, taken as a whole the considered **resources show a high degree of explanatory power**. For the health status indicators, 40 percent of the differences between the groups with and without a migration background, on average, can be attributed to the differences in resources. The corresponding figure for the indicators on health-related attitudes and behaviours is much lower, at 15 percent, but still a substantial proportion. By contrast, the significance of the resources in explaining the differences in the use of healthcare services is fairly low.

This finding suggests that other factors more specifically associated with the migration context but that could not be further illuminated in this study also play a role. Nevertheless, on the whole, the **lower level of resources has a major impact on the health inequality among individuals with a migration background**. Consequently, measures designed to promote the health equity of socially disadvantaged people in general can also greatly benefit people with a migration background who are also affected by health inequality.

An analysis of the impact of the individual resources shows that **not only the socioeconomic situation in terms of the level of education and income** but also – and particularly as regards the health status – **the amount of social support available** are key factors in explaining the inequality in the migrant context. While socioeconomic status figures prominently in numerous studies as a key explanatory factor for health inequality among migrants, this is only rarely the case to date for the resource of social support. A wider focus in this context would be welcome. It can likewise be concluded from this report that high priority should be given to attempts to socially integrate people with a migration background, including in respect of their health.