COUNTRY REPORT

SWITZERLAND

MIPEX HEALTH STRAND

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MIGRANT INTEGRATION POLICY INDEX

HEALTH STRAND

Country Report Switzerland

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READER'S GUIDE TO THE REPORT

This report was produced within the framework of the IOM's EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at http://bit.ly/2g0GlRd. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5–8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

0 no policies to achieve equity
50 policies at a specified intermediate level of equity
100 equitable or near-equitable policies.

'Equity' between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country's ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1-4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

Section	Key indicators	Text
1. Country data	Eurostat	CIA World Factbooks, BBC News (http://news.bbc.co.uk), national sources
2. Migration background	Eurostat, Eurobarometer (http://bit.ly/2grTjIF)	Eurostat, national sources
3. Health system	WHO Global Health Expenditure Database[1] (http://bit.ly/1zZWnuN)	Health in Transition (HiT) country reports (http://bit.ly/2ePh3VJ), WHO Global Health Expenditure database
4. Use of detention		National sources, Global Detention Project (http://bit.ly/29lXgf0), Asylum Information Database (http://bit.ly/1EpevVN)

These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three 'neighbour' countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

[1] For the definition of these indicators please see p. 21 of the WHO document *General statistical procedures* at http://bit.ly/2lXd8JS

1. COUNTRY DATA

KEY INDICATORS		RANKING
Population (2014)	8.139.631	●●●○○
GDP per capita (2014) [EU mean = 100]	161	●●●●●
Accession to the European Union	n/a	

Geography: Switzerland is a landlocked country located in Western and Central Europe. It borders Austria and Liechtenstein to the East, France to the West, Italy to the South and Germany to the North. The terrain is diverse with mountains, hills, plains and lakes, with the highest elevations in the Alps. There are four official languages: German, French, Italian, and Romansh. The country is divided in 26 cantons, with significant differences in population densities between the cantons depending on their geography and terrain, but with an overall population density of 450/km^2. Switzerland is heavily urbanised as 74% of the inhabitants live in urban areas, with Zürich (population 396.000) as the largest city and Bern as the capital.

Historical background: The Swiss Confederation was founded in 1291 and became a Federal State of autonomous cantons with the Constitution of 1848. Switzerland has long been a neutral country and was not involved in the two world wars. Switzerland is active in many UN and international organizations and remains strongly committed to neutrality.

Political background: Switzerland is a multi-party federal republic (formally a confederation) composed of 26 cantons; Aargau, Appenzell Ausserrhoden, Appenzell Innerrhoden, Basel-Landschaft, Basel-Stadt, Berne/Bern, Fribourg/Freiburg, Geneve, Glarus, Graubuenden/Grigioni/Grischun, Jura, Luzern, Neuchatel, Nidwalden, Obwalden, Sankt Gallen, Schafferhausen, Schwyz, Solothurn, Thurgau, Ticino, Uri, Valais/Wallis, Vaud, Zug, Zürich. The country is part of the Schengen area.

Economic background: Switzerland has a stable economy and a highly skilled labour force with a low unemployment rate (3,2% in 2015) and one of the highest per capita GDPs in the world. Switzerland has a competitive economy benefiting from a highly-developed service sector, led by financial services and a manufacturing industry specialized in high-technology and knowledge-based productions. In January 2015, the Swiss National Bank abandoned the Swiss Franc's peg to the euro, which made Swiss exports less competitive and weakened the country's growth outlook.

2. MIGRATION BACKGROUND

KEY INDICATORS (2014)		RANKING
Foreign-born population as percentage of total population	26,8	●●●●●
Percentage non-EU/EFTA migrants among foreign-born population	39	●○○○○
Foreigners as percentage of total population	23,8	●●●●●
Non-EU/EFTA citizens as percentage of non-national population	34	●○○○○
Inhabitants per asylum applicant (more = lower ranking)	342	●●●●●
Percentage of positive asylum decisions at first instance	70	●●●●●
Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer)	n/a	
Average MIPEX Score for other strands (MIPEX, 2015)	46	●●●○○

Switzerland has one of the highest immigration rates in Europe. The transformation into an immigration country took place at the same time as the industrial take-off during the second part of the nineteenth century. Since the end of World War II, Swiss migration policy has been dictated by the need for unskilled labour. The percentage of migrants in the population, whether measured by country of birth or nationality, is the second highest in the EU/EFTA (after Luxembourg).

Switzerland used to be a destination country for French, Germans, and Italians seeking employment. In the latter half of the 20th century it has, however, hosted large numbers of Eastern European dissidents, Yugoslavian refugees, and asylum seekers from the Middle East, Asia, and Africa.

Switzerland belongs to those long-standing European immigration countries with a high level of control in terms of admission of foreigners. The country has been characterized for long by a divide between the humanitarian tradition and divisive populistic attitudes towards migrants and refugees. The European integration processes have also permeated its immigration policy, although Switzerland is not an EU member (Ruspini, 2008). The Swiss-EU bilateral agreements on the Free Movement of Persons (2002) led to the adoption of the Schengen Treaty and the Dublin Convention in 2008.

Immigrant integration was first introduced in 2000 and further developed in the new foreigners' law which came into force in 2008. In February 2014, the approval of a popular right-wing referendum initiative on "mass immigration" restarted discussion about the Swiss-EU bilateral agreements. In December 2016 the Swiss parliament adopted a bill that gives priority to Swiss-based job seekers, namely Swiss nationals and foreigners registered in Swiss job agencies, but which avoids quotas on EU citizens as originally requested by the initiators of the referendum. The concomitant signing of an agreement extending the free movement of workers' principle to Croatia, which joined the EU in 2013, has ended a two-year standoff with the European Union.

The distribution of the foreign population in terms of **nationality** (see Table 1) shows a steady increase in the number of migrants from the EU or EFTA countries, beginning with the signing of the bilateral agreements on the Free Movement of in 2002. Between 2009 and 2013, the number of migrants from Portugal, Germany, France, Spain, and Italy increased significantly. Currently, 85% of Switzerland's foreign permanent resident population are of European origin, three-quarters of whom are nationals of an EU or EFTA country. The largest groups of foreigners are the Italians (16%), followed by nationals of Germany (15,5%), Portugal (13,5%) and France (5,8%), thereby reflecting the old guest-worker regime and the long migratory tradition from Germany. The proportion of non-European nationals has doubled since 1980 to reach 14,9% today. Sri Lanka, India, and China are the main Asian countries of origin, with most Sri Lankans seeking asylum and most Indians and Chinese coming as students.

As for the two cantons, namely Bern and Vaud, that will be considered in this report in the framework of the Health Strand of the Migrant Integration Policy Index (MIPEX) 2015, the canton of Vaud is one of the three cantons with the highest proportion of foreign population, with 32% after the Canton of Geneva and the Canton of Basel, each with 35%. The proportion of foreigners in the Canton of Bern is instead 14%, which is well below the national average.

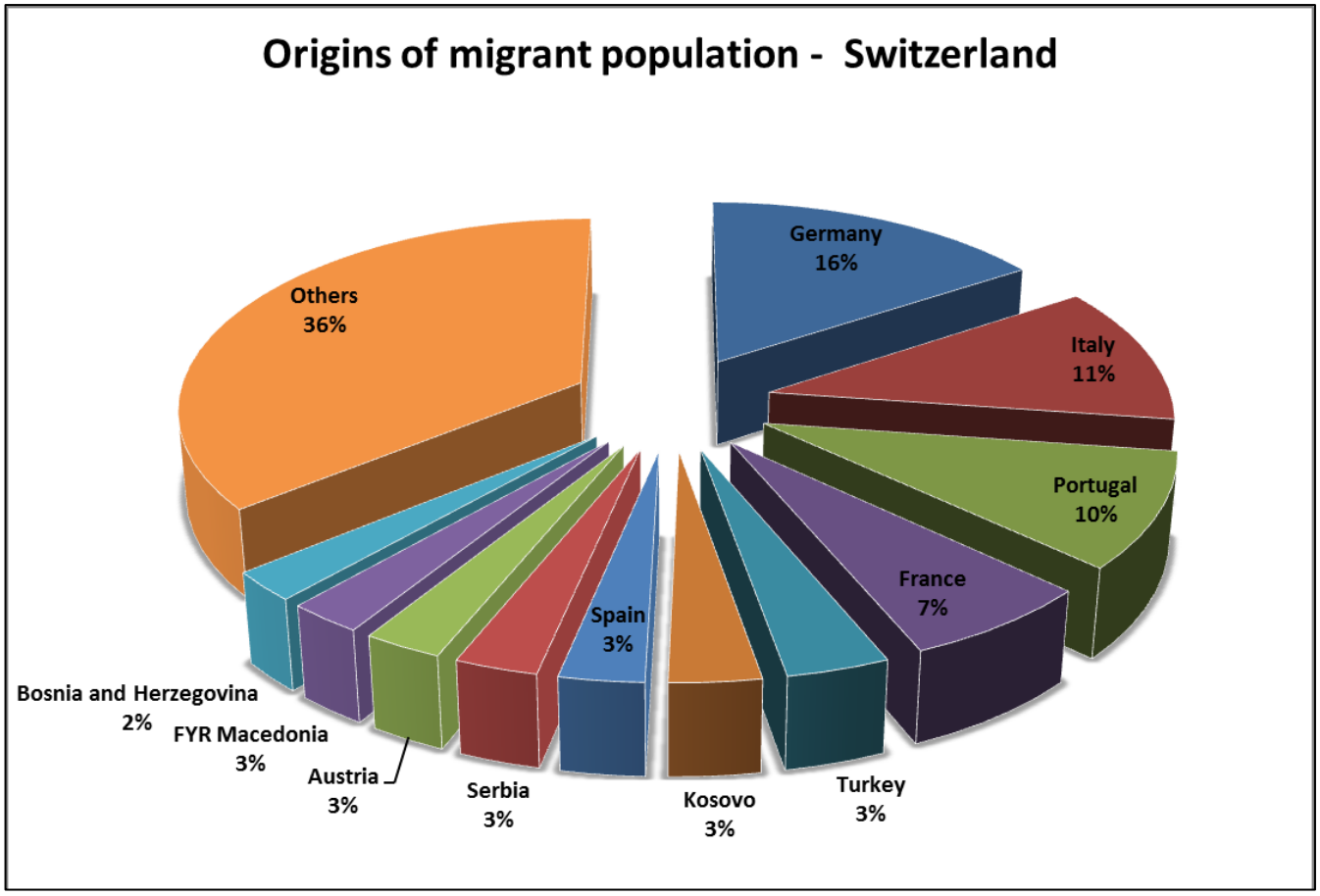
Table 1: Foreign permanent resident population by nationality (At end of year, in thousands)

	2009	2010	2011	2012	2013
Total	1714,0	1766,3	1816,0	1870,0	1937,4
EU-28/EFTA countries	1112,7	1135,0	1177,5	1223,4	1276,9
Germany	251,9	263,3	275,3	284,2	292,3
France	92,5	95,6	99,9	104,0	110,1
Italy	290,6	287,1	288,0	291,8	298,9
Austria	36,7	37,0	37,9	38,8	39,5
Portugal	206,0	212,6	223,7	237,9	253,2
Spain	65,0	64,1	65,8	69,4	75,3
Other European countries	367,1	369,1	368,3	368,4	369,9
Serbia and Montenegro	181,3	…	...	...	....
Serbia	...	121,9	109,3	98,7	90,7
Turkey	71,6	71,8	71,4	70,8	70,4
Africa	57,7	71,5	74,8	78,2	83,9
America	72,7	74,5	76,6	77,7	78,4
Asia	99,3	110,5	113,6	117,2	122,9
Oceania	4,0	4,0	4,1	4,1	4,1
Stateless, unknown nationality (or not stated)	0,6	0,8	1,1	1,1	1,2

Source: Swiss Federal Statistical Office
From 2010: New definition of the permanent resident population, which also includes asylum seekers with a total length of stay of at least 12 months

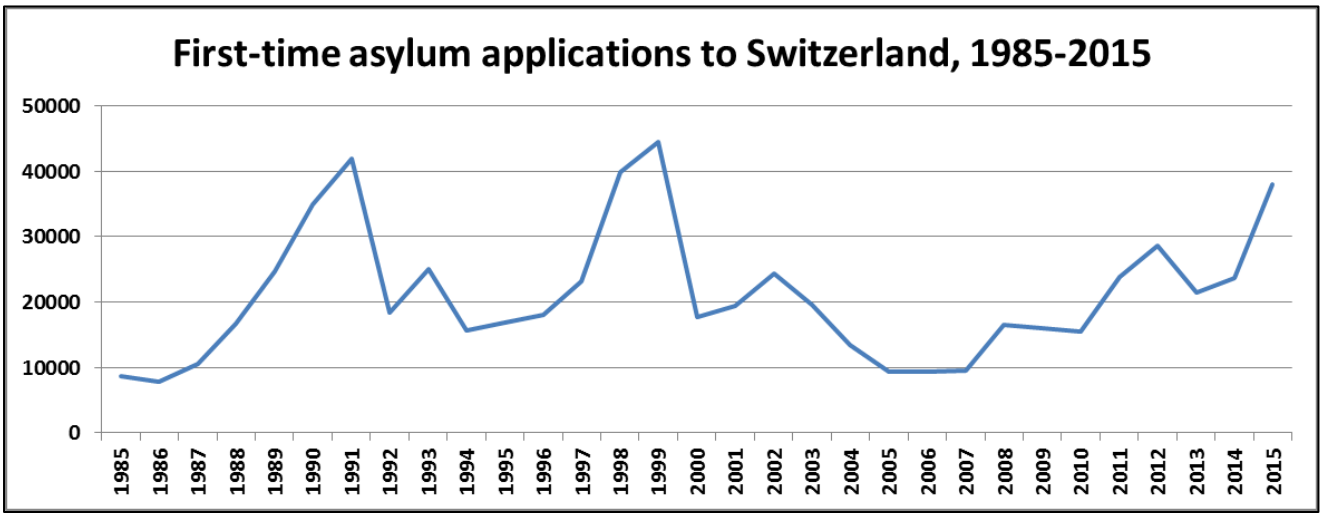
The following diagram shows the origins of migrants in Switzerland in 2014 in terms of country of birth.

Figure 1. Foreign-born population in 2014 by country of birth (Eurostat)



Concerning asylum applications, Fig. 2 shows that these fluctuate considerably in response to changing circumstances. In this graph the peaks in 1991 and 1999 reflect the breakup of Yugoslavia and the Kosovo crisis.

Figure 2. Asylum applications



In 2014, 23.770 first-time applications were filed, so that there were 342 inhabitants per new asylum seeker. Relative to the population, this was the third highest number of new asylum seekers in the EU/EFTA after Sweden and Malta. The main countries of origin were Eritrea, Syria, Sri Lanka, Nigeria, Somalia, Afghanistan, Tunisia, Morocco, Georgia and Kosovo. Numbers were even higher in 2015 (30.060 applications, 211 inhabitants to each asylum seeker), but the total in Europe in that year was over one million and Switzerland was in fifth place relative to its population size.

When it comes to the number of undocumented migrants in Switzerland, there are only estimates as there are no official statistical data. The first estimate is provided by a study conducted on behalf of the Federal Office for Migration (FOM)[2] in 2005, which refers to 80.000–100.000 undocumented migrants (gfs.bern 2005). A report on 'illegal migration,' published by the former Office for Migration (IMES), put the number of undocumented migrants in Switzerland at between 50.000 and 300.000 (IMES, 2004), some of whom have been living in Switzerland for over a decade.

The largest part of this unlawfully resident population consists of former seasonal workers from third-countries who could not renew their residence permits after the introduction of the 'three-circle' policy in the 1990s, but who nonetheless remained in Switzerland. Unsuccessful asylum seekers make up another group in this context. It was supposed that these persons may have either left Switzerland without documents or may have remained in the country undetected after their asylum claims were rejected (ibid.).

[2] As of 01.01.2015 the FOM has been renamed as State Secretariat for Migration (SEM).

3. HEALTH SYSTEM

KEY INDICATORS (2013)		RANKING
Total health expenditure per person (adjusted for purchasing power, in euros)	4.392	●●●●●
Health expenditure as percentage of GDP	11,7	●●●●●
Percentage of health financing from government National health system (NHS) / social health insurance (SHI)	19	SHI
Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)	26	●●○○○
Score on Euro Health Consumer Index (ECHI, 2014)	855	●●●●●
Overall score on MIPEX Health strand (2015)	69	●●●●●

Switzerland is characterized by a highly federalized government structure with its federal government, cantons, and communes or municipalities. This decentralised political structure applies also to the Swiss healthcare system. The basic principle of subsidiarity guiding Switzerland's federalist system means that the central government should have a subsidiary function, i.e. it ought to perform only those tasks which cannot be done at a more local level.

The main responsibility for the provision, governance, and funding of healthcare lies with the 26 cantons. The federal state's competencies in healthcare are limited. Consequently, the cantons maintain and, together with the mandatory health insurance scheme, co-finance hospitals and nursing homes, which they also supervise. Furthermore, most hospitals are owned or controlled by cantons and municipalities. The cantons secure healthcare by means of hospital planning, emergency and rescue services. Together with the federal government and local municipalities, they are also responsible for preventive healthcare and healthcare promotion. Swiss cantons monitor licensing for medical and paramedical professions, and finance the training of doctors through cantonal universities. They also assess and adjust the premium reduction for people on low incomes.

On the federal level, the public health agenda falls under the competence of the Federal Department of Home Affairs (EDI), under which the Swiss Federal Office of Public Health (FOPH) is responsible for developing national health policies and strategies as well as for monitoring their implementation on the cantonal level. The responsibilities of the FOPH also cover, for instance, the supervision of mandatory health insurance and decisions on reimbursement for healthcare treatments and medication costs. The control and monitoring of epidemics and infectious diseases, as well as the monitoring of research also fall within its remit. A further FOPH function is in the area of addiction prevention.

Lastly, cantonal health ministers jointly form the Swiss Conference of the Cantonal Ministers of Public Health (GDK), which promotes cooperation and common policies between cantons.

Mandatory Basic Health Insurance

In Switzerland, the mandatory health coverage, i.e. the basic social insurance, is regulated by the Health Insurance Act (LAMal), which came into force in 1996. The basic principle of LAMal is in guaranteeing that all persons residing in Switzerland for longer than three months, including undocumented migrants and asylum seekers, have access to medical care. Since 1996, everyone who lives in Switzerland has thus been required to obtain basic health insurance, while being free to choose from privately organized and registered insurance companies under FOPH monitoring.

Health insurance companies are required to accept residents for the basic package of benefits regardless of health and age. Individual premiums depend on the place of residence of the insured, and differ depending on insurer, but within these differences the level of protection is the same for each age group and for both sexes. It is also important to stress that the premiums are not dependent on income, and there are no employer contributions. Low income earners can request a premium reduction, which is then subsidised by the federal state and by their canton of residence.

4.USE OF DETENTION

Detention policies

The **Federal Act on Foreign Nationals** (FNA, 2005) includes "an assortment of detention-related enforcement provisions covering a broad range of grounds and varying lengths of detention." [3] In early 2011 the EU Returns Directive was officially adopted, limiting the maximum length of detention to 18 months.

For children between 15 and 18, the maximum period of detention is 6 months and may be extended by up to 6 months, thereby totalling 12 months.

In addition, the 1998 **Swiss Asylum Law** (amended several times) provides a set of detention measures for asylum seekers, including at the border.

Cantonal immigration authorities are responsible for the enforcement of detention and deportation measures in their regions. Because cantons have discretion in the implementation of federal immigration law, enforcement practices can differ from one canton to the next.

Detention conditions

Switzerland makes use of a wide range of facilities for medium to long-term immigration related detention ranging from custodial facilities at airports, prisons for persons sentenced to deportation, immigration detention centres, and reception centres for asylum seekers. The conditions in these centres can vary greatly from canton to canton, and the federal government typically contracts private companies for their day-to-day running and administration.

Access to health care

As of 1 February 2014, an amendment to the Asylum Law states that when a removal decision is effective, social assistance is automatically withdrawn and the asylum seeker may have healthcare access only on request (Derron & Bregnard, 2015).

The responsiveness of the Swiss detention facilities to different health situations involving migrant detention vary from canton to canton and from custody site to custody site. The situation in Switzerland has been described in the final evaluation of the project "Detention" of the Swiss Red Cross Humanitarian Foundation (HS-SRK), and critical situations pertaining to the health of detainees have been collected in the reports of the National Commission for the Prevention of Torture (NCPT) that regularly visits the detention centres.[4]

The surveyed detainees often define healthcare services as insufficient. Because of limited clinical examinations, medical conditions are often not attributed to physical causes but to psychosomatic conditions, and most of the time a wide range of medical complaints are only treated with medications.

[3] https://www.globaldetentionproject.org/countries/europe/switzerland

[4] Information on the project "Detention" can be found at: http://www.croix-rouge-fr.ch/de/dienst-und-hilfe/nothilfe/projekt-detention ; see also Kapko et al.(2011).

Furthermore, the NCPT reports staff shortages, language difficulties in accessing health care, threats of or attempted suicides, and general health risk concerns about the mental health of the detainees since they live in constant fear of being deported or transferred to isolation cells, and health problems due to hunger strikes.[5]

[5] The reports of the National Commission for the Prevention of Torture (NCPT) are available in the national languages at: http://www.nkvf.admin.ch/nkvf/de/home/publiservice.html

5. ENTITLEMENT TO HEALTH SERVICES

Score 75 **Ranking** ●●●●●

A. Legal migrants

Inclusion in health system and services covered

Legal migrants in Switzerland are covered for healthcare costs by the same risk-sharing system as Swiss nationals, with no additional requirements and no forms of care excluded. The compulsory basic health insurance covers primary and secondary care when a person falls ill or has an accident, maternity care, psychotherapy, preventive check-ups and tests, as well as rehabilitation measures. Healthcare costs for comparable treatments are the same for everybody. Every insured person pays a monthly premium to the insurance company. The amount of the premium varies from insurer to insurer and from canton to canton. Children up to 18 pay lower premiums; low income earners may be also entitled to a reduction.

Insured persons must contribute to the cost of the services they receive. This contribution comprises an annual fixed amount (i.e. deductible, often referred to in Switzerland as *franchise*) and 10% of any further costs above this fixed amount (i.e. retention fee). The standard deductible (*franchise*) amounts to 300 Swiss Francs (CHF) per calendar year and the maximum annual retention fee to CHF 700 for an adult. In other words, for an insured person with an annual deductible of CHF 300, the maximum cost is CHF 1000 per calendar year. For adults, the available deductibles are 500, 1.000, 1.500, 2.000, and 2.500 Swiss Francs and for children 100, 200, 300, 400, 500, and 600 Swiss Francs. This explains why on an individual basis, the costs of health care can change according to the deductible amount he/she has opted for. The latter costs are the same for legal migrants as for nationals in comparable circumstances.

Depending on which health insurance company and insurance model a person chooses, e.g. by agreeing to restrict one's choice of doctors or hospitals or by increasing one's own share of the costs (the deductible), the insurance premiums can be reduced accordingly. Moreover, the level and conditions for cantonal premium subsidies vary across cantons. Depending on the place of residence, health insurance costs may differ significantly.

Finally, to take out a 'basic health insurance' as foreseen by the Federal Public Health Insurance Law, a person who lives in Switzerland must indicate an address in the country, which does not necessarily have to be the person's legal administrative address. Insurance companies do not ask for additional proof of legal addresses. According to the Public Health Insurance Law, art. 84-86, insurance companies are not allowed to pass on data on the residence status of their clients.

Special exemptions

According to the Federal Public Health Insurance Law, children and adolescents up to their 18th birthday do not pay a standard deductible (franchise), and their maximum retention fee is CHF 350.

Low income earners are entitled to reduced health insurance premiums. This measure also applies to migrants, even, in some cantons, to undocumented migrants who are gainfully employed and paying taxes.

Barriers to obtaining entitlement

None.

B. Asylum seekers

Inclusion in health system and services covered

Healthcare entitlements for asylum seekers depend on whereabouts they stay in Switzerland. In general, asylum seekers are covered for health care costs by the same risk-sharing system but with the exclusion of certain forms of care. All healthcare costs (*franchise* and retention fee) are borne by the cantons. According to the agreement between the federal state and the cantons, the cantons are responsible for the compulsory basic health insurance coverage of asylum seekers within the framework of the Federal Public Health Insurance Law. Cantons are free to choose any health insurance company, with whom they contract a collective insurance coverage for asylum seekers (dependent on welfare public assistance) and to negotiate special terms related to its utilization. This explains why there may be important differences between cantons regarding healthcare access.

In the Canton of Bern, asylum seekers are insured for illnesses and accidents. The choice of doctor is, however, limited. Change of doctor, i.e. the general practitioner or *Erstversorgerarzt* (herein GP) upon asylum seeker request is not possible except in case of change of residence. When a medical treatment by a specialist is necessary, the GP must first send a request to the canton's Migration Office. On the other hand, asylum seekers may consult specialists such as paediatricians, ophthalmologists, gynaecologists, and use emergency treatment without prior GP referral.

In the Canton of Vaud, asylum seekers are insured for illnesses and accidents as in Bern. The Canton of Vaud applies a system called 'double gate-keeping': the applicant has first to consult a health centre, which is staffed by a registered nurse who holds a medical record for the applicant and is in close contact with the social services in charge of assistance to asylum seekers. When the health centre cannot meet the needs of the applicant, it sends him/her to the GP, who can in turn refer the patient to a specialist.

In both cantons, if an asylum seeker is currently employed, not dependent on public assistance, and able to pay their insurance premiums, they are covered by the same system as nationals with no additional requirements and no forms of care excluded. However, this scenario applies only to a handful of asylum seekers.

Special exemptions

According to the Federal Public Health Insurance Law, children and adolescents up to their 18th birthday do not pay a standard deductible (*franchise*), and their maximum retention fee is CHF 350.

Low income earners (including asylum seekers) are entitled to reduced health insurance premiums.

Barriers to obtaining entitlement

None.

C. Undocumented migrants

Inclusion in health system and services covered

Undocumented migrants are covered for healthcare costs by the same risk-sharing system as nationals, with no additional requirements and no forms of care excluded. According to the Public Health Insurance Law, every person who lives in Switzerland has the right and duty to take out the already mentioned 'basic health insurance,' i.e. *Grundversicherung*. This right and obligation also applies to undocumented migrants.

Health insurers as well as healthcare providers may not report any personal data of undocumented clients to a third party, except for information required by the insurer for purely administrative purposes.[6]

Healthcare entitlements depend, however, on being able to pay for the insurance and, in practice, the following barriers to healthcare access have been reported:

- Several surveys and research studies show that the majority of undocumented migrants (80% to 90%) have no health insurance. Based on practical experience, it is assumed that many of them sign up for health insurance only when they fall seriously ill.

- Although health insurance companies are required to insure undocumented migrants, available information indicates that they sometimes complicate the process administratively, or that they delay the procedure for so long that it discourages the applicant from continuing.[7]

In general, healthcare costs are the same as for nationals, but for undocumented migrants living in modest economic situations and ineligible for subsidies, the real cost of regular contribution can be higher than for other persons in comparable circumstances. In some cantons, undocumented migrants who are gainfully employed and paying taxes are entitled to reduced health insurance premiums if their income is low. However, apart from seven cantons (including the Cantons of Vaud and Bern), most cantons do not allocate subsidies to undocumented migrants.[8]

Special exemptions

Children and adolescents up to their 18th birthday do not pay a standard deductible (*franchise*), and their maximum retention fee is CHF 350.

Barriers to obtaining entitlement

None.

[6] Public Health Insurance Law, articles 84-86.
[7] Assurance-maladie et accès aux soins des sans-papiers, Rapport du Conseil fédéral en réponse au postulat Heim (09.3484). http://bit.ly/2jXeOgS
[8] Ibidem

6. POLICIES TO FACILITATE ACCESS

Score 85 Ranking ●●●●●

Information for service providers about migrants' entitlements

Service providers in Switzerland know that all insured persons have the same rights with regard to basic health insurance, regardless of their nationality, or migrant status. They are also informed about formal procedures (e.g. billing, access to specialists) to access medical care for asylum seekers. However, the exact extent to which these institutions inform their employees is unknown.

On the national level, an information project - ***migesplus.ch***[9] - has been set up by the Swiss Red Cross and the Federal Office for Public Health within its national Migration & Health Programme. This platform aims to inform and assist professionals and institutions in facilitating nationwide access to health information and services for migrants.

Information for migrants concerning entitlements and use of health services

In order to reach migrants who live in Switzerland more effectively, information providers focus primarily on improving dissemination methods. Disseminating information in migrants' languages, plus the diversification and multiplication of dissemination channels, are important components of the current information practices in Switzerland. Written and audio-visual information are disseminated through professionals (i.e. health and social professionals) and in places that migrants usually frequent (for example, mosques and migrant associations). This manner of dissemination complements outreach efforts via websites and interpersonal communication.

Additionally, information providers try to adapt the content by using simple language, more pictures, choosing images and words corresponding to the characteristics of the target audience, and taking in consideration the appropriateness of the information vis-a-vis the target group. *The Health Guide to Switzerland. The Swiss healthcare system in brief: a guide for immigrants to Switzerland*, which is published by the Federal Health Office and the Swiss Red Cross, and which explains rights and duties of patients and the legal basis of the healthcare system, is a good example. It provides information about the healthcare system, prevention, health insurance and medical care. The booklet is also available on the ***migesplus.ch*** website.

Health education and health promotion for migrants

According to the Foreign Nationals Act, the federal government, cantons, and municipalities are required to inform migrants of their rights and obligations as well as of the living and working conditions in Switzerland. This also implicitly includes information about the healthcare system (health insurance, access to health services, choice of the GP, available interpreters or interpreter services, emergency services, health promotion and prevention, mental health, etc.). To carry out this duty, the cantons act in different ways by combining various information channels (brochures, websites, special brochures, meetings, etc.).[10]

[9] http://www.migesplus.ch/en/
[10] Source: http://www.admin.ch/opc/en/classified-compilation/20020232/index.html

Several cantons, among them Vaud and Bern, have created a booklet entitled *Welcome to the Canton* to provide migrant newcomers with useful information and addresses of various institutions to assist them in their daily life, including healthcare (i.e. health insurance, subsidies, accident insurance, finding a doctor, maternity, sexual health counselling such as family planning, etc.).

Except for some information practices such as meetings addressed specifically to newcomers in the cantons of Vaud and Bern, legal migrants, asylum seekers, and undocumented migrants usually have access to existing information materials such as booklets and internet portals in different languages. This also applies to the information provided by the ***migesplus.ch*** website supported by the Federal Health Office. In Vaud and Bern, the *Welcome to the Canton* leaflet is available in more than 10 languages of migrant origin. Similarly, most of the information materials on ***migesplus.ch*** are also presented in several migrant languages.

For large nationwide campaigns such as the national campaigns against smoking, only linguistic adaptation and translation is performed. Some projects in certain cantons (like Zürich, Basel, Bern, and Geneva) use an interpersonal approach to adapt the contents of health promotion and prevention information to the needs of their target group.

The evaluation of cantonal health promotion programmes, which has been funded by the Federal Office of Public Health, contains many examples that indicate the tendency of cantonal programmes to vary methods of dissemination and adapt the content of their health promotion programmes to better reach and influence migrants.[11]

Cantons use different information channels such as booklets, websites, and special brochures about diverse health promotion topics and interpersonal communication (i.e. information meetings). Migrant media are also used, although on a small scale, in disseminating information, including migrant health promotion. The chief migrant languages for dissemination of information are Turkish, Spanish, Portuguese, Bosnian, Serbian, Croatian, Tamil, and Albanian.

In principle, when health education and health information are designed, no distinction is made between migrants according to their legal status or other factors. However, when it comes to particular topics such as, for example, female genital mutilation or posttraumatic stress disorder concerning refugees and victims of war, health promotion and related practices are designed and disseminated in the languages of the groups concerned. In both the Canton of Bern and the Canton of Vaud, like in many others cantons, there are health centres for helping undocumented migrants who have no insurance.

Provision of 'cultural mediators' or 'patient navigators' to facilitate access for migrants

As an outcome of established practices, cultural mediators are provided only in certain ad hoc circumstances where this kind of intervention is needed, for example in situations where health professionals cannot resolve a conflict obstructing medical treatment. No distinction is made between migrants by legal status when cultural mediators are assigned to assist.

[11] http://bit.ly/2lnXuUG

Is there an obligation to report undocumented migrants?

As mentioned earlier, health providers may not report any personal data of undocumented clients to a third party.[12]

Are there any sanctions against helping undocumented migrants?

In Switzerland, even undocumented migrants have right to take out an insurance; moreover, there is no legal sanction or visible pressure on professionals to deter healthcare professionals or organisations from giving care to migrants who cannot pay. Insurance companies cover the costs. In both the Cantons of Bern and Vaud, as in many others, there are health centres for helping undocumented migrants who have no insurance.

[12] Source: Swiss Criminal Code, article 321: persons bound by professional secrecy (e.g. health staff) may not report any personal data of a client to third parties.

7. RESPONSIVE HEALTH SERVICES

Score 63 Ranking ●●●●●

Interpretation services

Although in reality different options can be found, the general tendency is that interpreters are mostly required in university hospitals, and that the costs for the provision of their services are borne by the same hospitals. This is also the situation in both the cantons of Bern and Vaud, but practice is sometimes different in small regional hospitals where migrants may have to pay a substantial part of the costs. The costs of interpreting are not, however, covered by basic health insurance: health institutions have to set aside some funds for covering these costs, which in turn creates practical problems.

Depending on the context, different methods are used for professional interpretation - including face-to-face and telephone interpretation, employment of cultural mediators, and competent bilingual or multilingual staff.

Requirement for 'culturally competent' or 'diversity-sensitive' services

Standards or guidelines for 'culturally competent' or 'diversity-sensitive' services exist in Switzerland and require that health services consider individual and family characteristics, experiences and situations, respect for different beliefs, religion, culture, and competence in intercultural communication. Professional ethics of nurses and doctors also mandate an assessment of each individual patient's situation. In all Swiss hospitals, a standardized anamnesis has been adopted for this purpose. This rule is also valid for other health professionals, independently from the acquisition of transcultural competences. Culturally competent services are provided in the *Migrant Friendly Hospitals* programmes (renamed as *Swiss Hospitals for Equity*).

These standards and the related guidelines are monitored by each institution in the framework of their quality management.

Training and education of health service staff

Transcultural competence is part of a mandatory programme of study for nurses and midwives, but not for medical students. For the latter, ad hoc interventions on 'clinical transcultural competence' are organised in several cantons.[13]

Additionally, similarly to many hospitals in Switzerland, those in the cantons of Bern and Vaud offer trainings in transcultural competence for their staff, but participation is not mandatory. Training courses of many professional health schools contain a module on transcultural competences or diversity management. Several NGOs such as the Swiss Red Cross, Caritas, and the Swiss Organisation for Refugees also offer training courses on transcultural competences. All these training courses organised by professional health schools or NGOs are open to anyone, including professionals of other cantons, and participants usually cover their own training costs.

[13] See, for example, the interventions of the doctor and researcher Patrick Bodenmann at the Centre hospitalier universitaire vaudois (CHUV/PMU) in the Canton of Vaud.

Involvement of migrants

In certain situations, migrants are involved as intercultural mediators or interpreters, as well as evaluators of patient satisfaction levels in hospitals. These evaluations are, however, carried out in writing and only in the local language, which can lead to an exclusion of some migrant patients (Stotzer et al 2006, Bischoff & Dahinden 2010). There are no procedures, practices, or policy measures - either in the Canton of Bern or in the Canton of Vaud - which explicitly stipulate the involvement of immigrant organisations or their representatives in service design or service delivery. The same can be said of the other Swiss cantons.

Encouraging diversity in the health service workforce

In Switzerland, there are no campaigns or special recruitment efforts aimed at hiring migrants (or people with a migrant background) in the healthcare workforce. In 2005, almost 24% of health care professionals (29.8% in hospitals) had foreign nationality; in fact the percentage of foreign workers in the healthcare sector is higher than in other sectors.[14] This can partly explain the absence of specific recruitment measures in favour of health professionals with migrant background.

Development of capacity and methods

Policies exist to encourage the adaptation of diagnostic procedures and treatment methods to sociocultural diversity; they consist of various guidelines, meetings for diagnosis, and treatment of special cases such as, for instance, psychiatry consultation in a migration context, treatment of torture victims, tropical medicine, and counselling of female genital mutilation victims. In principle, complementary or alternative medicines such as homeopathy and herbal medicine are also available in Swiss hospitals.

[14] Source: Bundesamt für Statistik, BFS Aktuell, Beschäftigte im Gesundheitswesen 1995-2005, November 2007.

8. MEASURES TO ACHIEVE CHANGE

Score 54 **Ranking** ●●●●○

Data collection

Collection of information about nationality is compulsory in Switzerland. The National Ordinance Population Census clearly states that the distinction between foreign citizens and Swiss citizens should be recorded in the census. Therefore, data on country of origin must be included in national surveys.[15] The Swiss Health Survey, the Thematic Survey (carried out in the framework of the national census,) and patient medical records in general, all include variables on the country of origin (citizenship), but not on ethnicity and migrant status (i.e. legal status concerning the type of residence permit).

The Swiss OASI Number (Old-Age and Survivors' Insurance number) is used as personal identification in different series of surveys and records of data. Therefore, any national survey can be linked to the register survey through the Swiss OASI Number. The register survey is not a direct survey of the population, but it uses the personal data recorded in the communes and cantonal population registers, as well as in the all-important federal registers of persons. It provides information about the entire Swiss population, including age, sex, civil status, country of origin, place of birth, citizenship at birth and migrant status, but not ethnicity. Additionally, the National Migrant Health Monitoring, which has been done twice since 2004, includes variables on country of origin (i.e. nationality) and migrant status.[16]

Support for research

There are two main funding bodies on the national level that support research on migrant health related topics: the Swiss National Science Foundation and the Swiss Federal Office of Public Health. A general review of research projects in the past five years reveals that health problems among migrant or ethnic minority groups, social determinants of migrant and ethnic minority health, issues concerning service provision for migrants or ethnic minorities have been some of the research topics covered so far.[17]

"Health in all policies" approach

On the national as well as on the regional level, a 'health in all policies approach' (i.e. a multisectoral policy) is applied to some meta-topics such as transport, mobility, route security, and air quality or noise reduction. At this level, however, policies in sectors other than health do not take into consideration impacts on migrant health.

Whole organisation approach

In general, concern for migrant health is a priority for social and health departments, cantonal governments, and on the federal level (see, for instance, the role and activities of the Federal Office of Public Health). It is important to add that, in most cantons, there is a special office for migrant integration under the responsibility of a department which varies from one canton to another (i.e.

[15] Ordonnance sur le recensement fédéral de la population : http://www.admin.ch/opc/fr/classified-compilation/20080482/index.html

[16] http://bit.ly/2lfgc2c

[17] See, for instance, the Obsan report - An analysis of hospitalisation of migrants, 2012, Second Health monitoring of the migrant population 2010 - GMM II.

justice department or social/health department, but also the police or military department, as is the case in the Canton of Appenzell). Although these various offices also work on migrant health, the main concern and responsibility for migrant health rests with social and health departments.

Leadership by government

At the federal level, there is an explicit plan for action on migrant health, i.e. the National Programme "Migration and Health."[18] Through the National Programmes, the Federal Office of Public Health has been working since 2002 towards strengthening the migrant population's health literacy and making the public health care system more migrant-friendly - be it by taking into account migrant concerns, or by integrating professional community interpreters and promoting transcultural competences for health professionals. Measures were implemented in the following areas: health promotion and prevention, health care provision and education, community interpreting, research and knowledge management. Cantonal governments and authorities are not, however, obliged to develop policies to support these measures.

As far as the regional level is concerned, several cantons such as the Canton of Vaud and Canton of Basel have also established an action plan on migrant health, but only ad hoc policies have been implemented to support government recommendations or statements.

Involvement of stakeholders

There is no advisory body or agency promoting cooperation amongst stakeholders in the design of national or regional migrant health policies. Therefore, cooperation takes place on an impromptu basis. Stakeholders are involved in the design of the national programme "Migration and Health" through the organization of ad hoc workshops.

Migrants' contribution to health policymaking

There is neither structural nor ad hoc cooperation with immigrant organisations in the design of health policy. Immigrant organisations are consulted only for the completion of projects.

[18] See http://bit.ly/2kfkF1O

CONCLUSIONS

Concern for migrant health represents a priority in Switzerland for institutions at different levels of governance. The ageing of the former guest workers and the more recent arrival of mixed migration flows, including labour seeking migrants and asylum seekers from developing countries, urged a revision of the Swiss migration and asylum policy in which the bilateral agreements with the EU in 2002 represent a turning point. The adoption of the National Programme "Migration and Health" in that same year, coupled with the long-standing role of NGOs in mobilization, mediation, and facilitation of migrants' access to healthcare services, resulted in a relative improvement in Swiss healthcare provision when compared to other fields of immigrant integration. Collection of information on migrant status, adaptation of health services and content to migrants' needs, training of staff in transcultural competences, and dissemination of health-related information are well known procedures for most of the institutions involved in providing care for migrants and asylum seekers in Switzerland. In principle, there are no differences between legal and undocumented migrants living in Switzerland when it comes to healthcare access, but daily practices differ from canton to canton and from service to service.

In the whole country, policy gaps and institutional bottlenecks do appear when existing provisions are implemented, either because of intrinsic institutional differences and policy variations, or political and bureaucratic discretion at the local level. This results in a whole organizational system switching from an officially integrated approach to migrant health to a de facto categorical and specialized approach at the local level, where federal guidelines and regional action plans are implemented only through ad hoc interventions and policies.

Because the extent of the MIPEX Health Strand as limited to only two Swiss cantons (Bern and Vaud), the research does not allow us to extrapolate final conclusions for the whole country, particularly as far as migrants' access to healthcare services is concerned. On the other hand, the provision of responsive health services described in the above two cantons seems to indicate a more general and positive tendency pertaining to those regional contexts with a considerable presence of migrant population in places like Geneva, Basel and Zürich.

However, participation of persons with migrant background or involvement of immigrant organizations in the design, preparation, and implementation of migrant health policy is still very limited. Cooperation between organizations dealing with migrant health at different levels, as well as the factual implementation of policy provisions for vulnerable categories of migrants and asylum seekers – such as those with undocumented status or in need of protection – still need to be either initiated or ameliorated across the whole Swiss Confederation.

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