

MIGRATION AND HEALTH: DIFFERENCE SENSITIVITY FROM AN ORGANISATIONAL PERSPECTIVE

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Edited by
Carin Björngren Cuadra and Sandro Cattacin



MALMÖ UNIVERSITY

MIGRATION AND HEALTH: DIFFERENCE SENSITIVITY FROM AN ORGANISATIONAL PERSPECTIVE

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**MALMÖ UNIVERSITY
IMER
MIM**

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Malmö University

International Migration and Ethnic Relations (IMER)

Malmö Institute for Studies of Migration, Diversity and Welfare (MIM)

SE-205 06 Malmö

Sweden

www.imer.mah.se

www.mah.se/mim

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December 2006

Carin Björngren Cuadra and Sandro Cattacin

PREFACE

Björn Fryklund

The faculty of IMER at Malmö University consciously tries to contribute to the development of research in Migration and Health and therefore welcomed Professor Sandro Cattacin's initiative to arrange three workshops in the topics during his Guest Professorship in Malmö in autumn 2005. The first theme was entitled "Barriers to Healthcare Access", the second "Migrant Friendly Hospitals – The Amsterdam Declaration", and the third "Health Strategies of Marginalised Groups: Migrant Prostitutes, Illegal Workers and Asylum Seekers". All three workshops were organised by Dr. Carin Björngren Cuadra, a researcher from IMER, in co-operation with Sandro Cattacin.

The three workshop themes deal with different processes – legal as well as illegal – regarding the exclusion and inclusion of migrants in healthcare from a European comparative perspective. For a huge number of migrants living in Europe, the consequences of these processes, together with how healthcare is organised and run, are often a matter of "life and death" in the more dramatic cases, and of good or bad life quality in those that are not quite so dramatic. For that reason, the research results presented in this book and representing a broad spectrum of critical analysis into the exclusion and inclusion of migrants in the healthcare system are very important, particularly for those migrants living in an insecure and vulnerable life situation in many European countries.

The authors of this book on migration and health have chosen to focus on organisational perspectives. That is where the book's main strength lies. They place the organisational challenges facing a health system confronted with new migration trends firmly at the centre. This is only fitting, as one of today's central issues is how to handle differences in the healthcare system, instead of handling homogeneity and likeness as before. From this viewpoint, the contributors approach the disparities as well as point to solutions related to challenges confronting the healthcare sector by social and demographic changes in the wake of migration. In their conclusion

PREFACE

they say that while organisations are a problem, finding a solution to the question of how to integrate differences in general and migration and ethnic diversity in particular is also vital. They further underpin that a universalistic healthcare system that is not orientated towards difference actually excludes needs that do not represent the norm. Hitherto, the healthcare system is unable to work with difference, and instead approaches it as an anomaly, an exception, something strange and out of mainstream. The authors of this book are not only critical of the failings of the healthcare system, but also point to alternative possibilities to act reflectively. They introduce and advocate the model of *difference sensitivity*, which juxtaposes a multidimensional approach against exclusion tendencies. Difference sensitivity can be said to be a form of relativisation of universalism, based on reflexive rationality in the healthcare organisations. This can be done by introducing elements of pragmatism and is another important result of their empirical research, especially at the micro level.

In my view, the work undertaken by the researchers and presented in this book is of a pioneer nature. It breaks new ground for research on migration and health, especially from an organisational perspective. I hope that it will serve as inspiration to further research within the field, as well as provide starting points for reflection among healthcare professionals and students preparing for professions in healthcare. My hope is that this book will be used as a textbook in education programmes for nurses, social workers and other professionals working in the healthcare and in other social sectors. I believe that it will contribute to a more professional and reflective care of a diverse population and, in the long run, lead to a better life for migrants living in an insecure and vulnerable situation in Europe as a whole.

Björn Fryklund
Professor at IMER
Director of MIM
Malmö University

INTRODUCTION: MIGRATION AND HEALTH POLICIES IN PERSPECTIVE

Sandro Cattacin in collaboration with Carin Björngren Cuadra

In Europe, the policy field of migration and health has developed as a set of measures of control. Indeed, throughout the 20th century the question of the health of migrants has only been tackled as a problem of border control. Such a control was partially and epidemiologically justified as the control of tuberculosis. Particularly after World War II, the main goal was the selection of healthy workers for the Fordist industrialisation of Europe. Migrants were accepted as a workforce for a limited period. The “Guest-workers” or “Fremdarbeiter” were healthy, and the policies concerning migration oriented towards the idea that their stay in the host countries was limited in time. A consequent result of such a “referential”¹ was the lack of inclusion policies.

Not much research was launched during this period with regard to the field of migration and health. The main orientation was rather in terms of class analysis (Castelnuovo-Frigessi 1977), or the study of psychological problems related to migration². The political and scientific consciousness of migration as a phenomenon, something that is not particular or marginal in the host societies, only began in the 1970s. The economic crisis shattered the image of migrants as healthy workers having short stays in the host countries.

Migrants settled, with or without jobs, and became items on the list of unemployment policies. Similarly, their children represented a real challenge for the school system (Van Amersfoort et al. 1984). The field of “integration policies” began to be elaborated, and research into settlement dynamics, consequences that migrants might have on the social security system and risks to any harmonious internal reproduction of a society with

1 We use the concept “referential” in the sense of Pierre Muller and Bruno Jobert as the value system behind a policy (Jobert and Muller 1987); similarly the concept of “core value” of Sabatier (Sabatier 1999).

2 See, for instance, the researches of Abdelmalek Sayad (Sayad et Gillette 1976) on the risks of “being uprooted”.

a high rate of immigration (the topics of racism and discrimination) was developed.³

The political and scientific description of migrants started to become more realistic, indicating in particular the change from a mobile to a settled existence. In general, since the 1960s and until the beginning of the 1980s migration in Europe had been characterised by a relative homogeneity of national origins,⁴ the phenomenon of asylum seekers that was more cyclical than continuous, the organisation of large communities of small families and finally by their healthiness. Despite this dawning of consciousness of migrants' settlement in the host country, the question of their integration was still regarded as a linear and one-way process. For a long time researchers have relayed this process as normal under the concepts of assimilation or acculturation: time integrates (Hoffmann-Nowotny 1985). These characteristics explain why the first measures aimed at the inclusion of migrants did not include relevant elements concerning health, but were instead orientated towards school and professional training (Mahnig 1998). Other aspects of everyday life – such as access to healthcare or quality of care – are not perceived as needing specific measures. Indeed, it was assumed that these issues would be resolved automatically through the duration of stay.

The 1980s, and in particular the 1990s, completely changed the dynamics of migration and migration policy in Europe. A new tendency emerged with the process of European unification. This coming together of Europe not only diminished the disparities and simplified the migration movements inside Europe, it also initiated a process of economic reorganisation of the European territory that followed the principle of the selective advantages of a territorially defined division of labour. Through the creation of a unified economic territory organised by a division of labour, the new European open space of migration has spread its wealth and *diminished internal migration* (Buzelay and Hannequart 1994). As the advantages of migration diminish, potential migrants from the traditional migration countries now either find work in their own respective countries or decide not to emigrate at all.

But this process of economic integration in Europe does not stop migration completely. The international reorganisation of migration flows leads to divisions between migrants differentiated as a result of criteria relating to knowledge and working skills, origins and legal status (OECD 2005). In particular, the world of asylum seekers of the 1980s and before that has been transformed from a marginal and cyclical phenomenon to

³ See for instance: Hoffmann-Nowotny 1976.

⁴ Created by the main orientation in a host country's decision, which was for family or networks from the same region of origin; see Dahinden 2005a and Dahinden 2005b for an exemplification and discussion of this traditional dynamic.

one of continuous flow. For people from developing countries, seeking asylum appears to be the only way of entering Europe. (Efionayi-Mäder et al. 2001). This augmenting complexity in the composition of the migrant population leads to views within politics and the public administrations of the need to search for a new orientation to integrate these differences into concrete policies.

This search for new orientations in migration policy concerns all the European States. Discussions concerning new migration laws started with enormous polemics, for instance in Germany, France, Italy and Switzerland. It's a sort of European "migration crisis", as Weiner (Weiner 1995) calls it, that indicates the difficulty in finding viable solutions for new migration regimes. But which solution adequately addresses such a complex migration? Since the beginning of 2004, many local, regional, national and international⁵ commissions have been searching for answers to this very question.

What is surprising about these discussions is the multi-dimensional view of migration that can no longer be seen as an isolated phenomenon, but instead has to be regarded as a societal dynamic of the differentiation of life worlds. Sensitivity to difference is currently more in demand than a specific knowledge of migration. This sensitivity to difference not only implies different cultural ways of living (Cattacin 2006), but also that European States are challenged by the differentiation of social rights affiliations that are partially de-linked from a specific territory and that are claimed through a series of multiple interlocking relations to local, national and international rights as the discussion on health services for illegal workers exemplifies (Chimienti and Cattacin 2004).

In this changing context, the new migration is represented in complete contrast to the old – Fordist – migrants. National origins are no longer homogenous, which means that the primary consequence is the change from large community organisation of the old migration to new small communities. The acceleration of migration through better methods of communication has also meant that settlement and acculturation is no longer a question of survival. Nomadism, continuous contact with the home regions, transnationalism and organised diasporas are rather regarded as normal. The exception to this is the will to assimilate somebody into a local culture.

As the consequences of inclusion dynamics and policies become apparent, and society is confronted with the spreading out of migration and diversity as a state of normality, this complexity challenges not only the

⁵ In December 2003, a new "Global Commission on Migration" was launched by the United Nations. It started work in March 2004 and published its first report to the international community through in October 2005, which was later critically commented on (GCIM 2005, critical: Bhagwati 2005).

school system and social security schemes, but also the health system. The health system in particular is faced with weaker and more differentiated communities that, because of their weakness, partially lose the capacity to help themselves. Legal questions related to migration also cause difficulties in terms of regular service delivery. The issue of illegality introduces barriers to healthcare access, as well as a new precariousness, bad working conditions and risky health conditions. To this complexity we also have to include those dynamics related to the world of asylum seekers, such as the treatment of the trauma of war. While it is true to say that the healthy migrant still exists, he or she is no longer the only kind of migrant. We increasingly see the appearance of the unhealthy migrant in the world of asylum or illegality, which the health system has somehow do deal with.

In this book, we put the organisational challenges of a health system confronted with these new migration trends at the centre of analysis. Even though the perspectives of the texts assembled in this volume are different, they focus on the organisational level, which, in the current literature is rarely addressed. The first and introductory chapter analyses this literature (Jenny Maggi and Sandro Cattacin) and focuses on the question of power relations in the relationships between insiders and outsiders – the migrants – in the health system (Sandro Cattacin).

The second chapter includes two texts dealing with organisational inclusion and exclusion processes. Isabelle Renscher and Sandro Cattacin report on a comparative research on barriers to healthcare access in European cities, while Ursula Karl-Trummer analyses how hospitals consciously deal with differences related to migration and ethnic communities. She bases her analysis on the recently concluded international project, “Migrant Friendly Hospitals”.⁶

The third chapter presents research projects working with an empirical confrontation of concepts and which try to understand organisational dynamics in the field of migration and health. In particular, the texts of Milena Chimienti, Christin Achermann and Ramin Baghir-Zada focus on the dialectic relationship between health systems and the life world of people in vulnerable situations. Here, vulnerability is mostly explained by a lack of entitlement and resources, and is not only analysed as a problem, but also as a field in which migrants can develop specific strategies to stay healthy. The authors work with concrete examples of vulnerability related to asylum, undocumented migration and migrant prostitution.

A specific point of convergence of these texts is the role of health experts as services providers outside the mainstream health system, and as bridges between systems and life worlds.

⁶ For detailed information about research instruments and outcomes see the final project report by Krajic et al. 2005 at <http://www.mfh-eu.net/public/home.htm>.

INTRODUCTION

The final chapter (IV) introduces a different angle of view on organisations. Carin Björngren Cuadra and Linda Lill both actualise the discursive dimensions in micro-oriented studies on patients and colleagues respectively. These studies help to foster an understanding of processes of exclusion enacted in language use that have an impact on clinical understanding and care. Their common theoretical frame is anchored in discourse analysis, which states that the understanding of language use and discourses not only provide a ‘worldview’ (a common sense codification of knowledge), but also an entry point for the comprehension of identities and conventional social rules.

The book’s conclusions point out that an understanding of organisations in all their dimensions is of vital importance to the analysis of migration and health. Organisations might be part of the problem, but they are equally part of the solution to the question of how differences in migration and ethnic diversity can be integrated.

CHAPTER I

UNDERSTANDING DIFFERENCE SENSITIVITY IN ORGANISATIONS

ORGANISATIONAL RESEARCH IN “MIGRATION AND HEALTH”: A RESEARCH AGENDA

Jenny Maggi in collaboration with Sandro Cattacin

Nowadays, the major challenge faced by the healthcare system in pluralistic societies characterised by an important immigration history is that the pluricultural composition of the population demands a health system that takes differences in the needs, beliefs and practices concerning health and healthcare delivery into account. In order to respond to a society and clientele whose nature and needs have changed as a result of migration, it is necessary to improve access to the healthcare system and to provide specific services. These organisational adaptations are at the centre of the evaluations and research that we report on in this overview article.

International scientific literature concerning the health of migrants is relatively recent (for a systematic review see Weiss 2003) and therefore rarely considers the organisational perspective. Based on a systematic literature review, this essay will indicate⁷ research issues that need to be investigated in the future as well as recommendations for priority research in this field. Research organisational matters have been divided into two broad thematic areas: (1) the health system, and (2) barriers and disparities in healthcare. For each thematic area, specific research issues that need to be developed will be presented.

As for terminology,⁸ the terms ‘migrants’ will be used to indicate those people who have either migrated from another country (external migration), or have a direct migration background in their family (offspring of

⁷ In this text, we focus more on necessary research issues rather than on a discussion of existing findings in international literature. This essay is based on a previous publication: Maggi 2003.

⁸ There is no universally accepted terminology with which to describe migrants and their offspring. As Bollini and Siem (1995) have pointed out “According to historically and socially determined views on migration, the terms migrants, immigrants, ethnic minorities and ethnic communities may sound perfectly legitimated in one country and offensive or biased in another” (p. 819).

migrants), although this does not necessarily mean that they all have a similar level of entitlements (e.g. legal status), length of stay (short-term or long-term migration), or health status.

Understanding the Healthcare System's Reaction to Pluralistic Societies

This thematic area is expected to highlight research issues that could better illustrate the ways in which the healthcare system reacts to the pluralistic composition of societies. Several research issues are linked to this thematic area: the doctor-patient relationship; interactions and communication between care providers (medical and non-medical professionals) and patients; patients' and care providers' decision-making and factors affecting the decision-making process; psychosocial issues and emerging interdisciplinary paradigms.

At this level, a literature review shows that it is essential to better acknowledge how ethnicity and social factors (e.g. gender, legal status, social class) influence patients' interactions with the range of healthcare professionals (medical and non-medical profession) with whom they come into contact. A large amount of research, especially in the US (cf. Murray-Garcia 2002; Smedley et al. 2003), has been focused on the impact of ethnic concordance/discordance between physicians and minority patients on communication, decision-making and mutual perception, and the impact of these variables on health outcomes and satisfaction (Cooper-Patrick et al. 1999; Saha et al. 2000; Cooper and Roter 2003). Just as in Europe, ethnic providers are a small percentage of the overall healthcare force, and ethnic concordance/discordance research may not appear to be a priority. However, these studies highlight the importance of better documenting those social and ethnic factors that affect communication and mutual perception as well as decision-making and service delivery (Bischoff 2006). Further studies should focus on decision-making by patients and care providers, on the assessment of care management at different points along the continuum of care, and on the impact of patient-provider interactions on diagnosis and treatments (Smedley et al. 2003). For instance, additional research is needed on the provider decision-making heuristics employed in diagnostic evaluation (Wennberg 1999), and how patients' ethnicity and other social factors such as gender, social class, legal status, etc., may influence these decisions. Experimental research that assesses the extent to which physicians' treatment recommendations differ according to patient ethnicity and gender (Schulmann et al. 1999) has been conducted.

This research could and should be expanded to explore how social cognitive processes (e.g. bias, stereotypes, cf. Dovidio 1999; Mackie, Devos and Smith 2000; Operario and Fiske 2001) might affect patients' and providers' conscious and unconscious perceptions of each other and thus influence the structure, processes and outcomes of care (van Ryn and Burke 2000; Balsa and McGuire 2001). Attention should also be focused on the impact that ethnicity and social factors have on the quality of patient and provider relationships, communication and interaction (Krupat et al. 1999; Cooper-Patrick et al. 2000; Cooper and Roter 2003), for instance, in terms of symmetrical or asymmetrical relationships, empathy, mutual comprehension, the observance of treatments, the expression of symptoms and mutual trust (cf. the reference to 'patient-centeredness' in medical communication research, Mead and Bower 2000; Sullivan 2003). In this respect, an improved definition of communication and interaction quality criteria is needed that matches both providers' and patients' perceptions and needs and that also identifies the extent to which particular characteristics of the interaction/communication process affect diagnosis, treatments and health outcomes. In addition, further research should determine whether structural, institutional and organisational factors of healthcare settings affect the content of care and quality of communication for migrant patients (Weiss 2003).

As Smedley and colleagues (2003) have pointed out, it is worth noting that within the vast majority of research that documents ethnic disparities in care, decision-making and communication processes have been focused on the role of the physician. This fails to take into account that a lot of healthcare is provided by non-physician professionals (e.g. nurses, occupational and rehabilitation therapists, psychologists, social workers). The roles of other hospital and clinical staff (receptionists, community interpreters, intercultural mediators, etc) are also central in contributing to the 'climate' in which care is delivered. These professionals play a significant role in conveying messages of respect and dignity, and in influencing how patients feel about the healthcare setting (Habermann 2000; Kingsley 2001). Research that assesses how these individuals perceive, interact and communicate with migrants, and how patients respond to them, is also necessary.

Further research should also assess how educational programmes could help to improve staff (physicians and non-physicians) attitudes, behaviour and communication with migrants (e.g. transcultural communication, Luckman and Tindell Nobles 1999; transcultural education, cf. Donini-Lenhoff and Hendrick 2000; Nunez 2000). The development of questionnaires or other forms of self-assessment that measure care providers' atti-

tudes and stereotypes is also recommended (Paniagua et al. 2000). Research that studies interactions, forms of communication and problems of contact between migrants and the range of healthcare professionals (Smedley et al. 2003) is also vital. In this respect, it is also essential to clarify the legal, structural and financial possibilities of the healthcare system for the improvement of communication processes with migrants (Weiss 2003). Furthermore, strategies that increase and improve migrant patients' ability to participate in treatment decisions and empower them as self-advocates within the healthcare system should be studied (Roter et al. 1998). It is important that such research is conducted in active collaboration with ethnic communities and representative associations, in order to match cultural knowledge and traditions that may serve as sources of strength in the effort to empower migrant patients.

Another major challenge facing the healthcare system is how to deal with mental suffering and the psychosocial problems of migrants. First of all, a lack of data concerning the psychosocial health problems of migrants is observed (Chimienti and Cattacin 2001). In fact, hospital discharge records and physicians' reports do not generally yield data concerning migrants' specificities; something that does not permit a clear view of the most frequent psychosocial problems of migrant patients. Research is therefore needed so that statistical data concerning migrants' most common psychosocial health problems can be set up and that takes a pertinent range of variables differentiating these groups of patients into account (cf. Bischoff and Wanner 2003). Representative surveys concerning the psychosocial health of different groups of migrants are also required. A lack of psychosocial and medical case-control studies on specific risks linked to migration for different groups of migrants is also noticed in the literature (Weiss 2003). In addition, research aimed at verifying the impact on mental and psychosocial health of a series of variables linked to migration (e.g. language proficiency, legal status, integration, motivation of migration, expectancies and attitudes relatives to the host country, social policies) is required (Zenker 2000).

Research is also desperately needed for the culturally sensitive diagnosis and treatment of psychosocial suffering, as well as the comprehension of their causal factors (etiology). Concerning diagnosis, a further development of innovative multidisciplinary lines of research is demanded in order to assess an early diagnosis of psychosocial morbidities related to migration (Riecken 2001).

As for psychosocial treatment and assistance, it is important to better analyse the possibilities and difficulties of care given to migrants in the realm of medical and hospital practices (Weiss 2003). Innovative and multi-

disciplinary models of psychosocial treatment and assistance should be further developed (Eberding and Schlippe 2001; Faltermeier 2001), thus matching migrants' cultural needs and practices as well as their health perceptions (development of a culturally sensitive therapeutic concept). With regard to research aimed at studying the etiology of migrants' psychosocial problems, it is necessary to take a variety of variables linked to migration into account (e.g. language proficiency, legal status, origin, integration, motivation of migration, expectancies and attitudes relative to the host country, social policies), and to differentiate migrants in distinct and relevant demographic categories (e.g. origin, age, gender, social class). In addition, more attention needs to be devoted in the future to the development of holistic approaches of diagnosis, etiology and treatment of migrants' psychosocial problems (Watters 2001). A holistic approach suggests that rather than impose a dualism that seeks to define whether the client has a physiological or a psychological problem, it may be more appropriate for clinicians to ask patients for their own views regarding both the etiology of their conditions and their choice of treatment.

Emerging interdisciplinary perspectives (e.g. medical anthropology, cultural epidemiology, integrating anthropology and epidemiology, cf. Weiss 2001; transcultural psychiatry, a psychological approach of migration - situated at the frontier of psychology, intercultural psychology and health), that take the pluricultural population's composition into account, also need to be further developed. An analysis of their potential for interdisciplinary research and intervention in the domain of healthcare and health prevention (or promotion), at both the conceptual and methodological levels (Weiss 2003) is recommended. Finally, the significance of changes in healthcare systems and practices for professionals (e.g. the necessity of collaboration and coordination between medical and social sciences derived from migration and the pluricultural composition of modern societies) should be carefully studied in order to assess and manage any potential professional identity crises or conflicts (Rossi 2002).

Understanding Barriers and Disparities in Healthcare

In contrast to a country's native population, migrants tend to have limited access to healthcare in the receiving societies. There are a number of political, administrative and cultural reasons for this, and these vary in different societies and for different minority groups. Language, different concepts of health and disease, or the presence of racism and xenophobia are examples of such selective barriers. Barriers to healthcare and an under-utilisation of services by migrants are often observed in the literature, both

in the USA and in Europe.⁹ The limited availability of interpreter facilities or cultural mediation services in most host countries is believed to pose considerable linguistic and cultural barriers to appropriate medical services, particularly for the most disadvantaged segments of migrant groups (e.g. newcomers, women and the elderly). The existing evidence shows that economic and administrative barriers to healthcare prevail in those countries that do not readily grant citizenship, and thus full social and political rights, to settled migrants (Bollini 1993). In addition, xenophobia and discrimination within the health services is often reported in the literature (Schulman et al. 1999; Smedley et al. 2003), both in the employment of personnel from ethnic groups and in the delivery of services. Prejudice often assumes that the alien culture is inferior and somehow pathogenic, and that the patient's behaviour is inappropriate (van Ryk and Burke 2000). The presence of discrimination (and perceived discrimination) creates additional barriers in the utilisation of healthcare services. The level of entitlement for migrants in receiving societies (which is believed to vary according to their legal status in the host society, their social and political rights, and according to the degree of institutional and social discrimination against people of different ethnic backgrounds), is believed to affect both health outcomes and access to healthcare (Bollini 1997). Indeed, data that documents the relationship between the level of migrants' entitlement in the host country and their access to healthcare, as well as health outcomes, is needed in order to promote effective countermeasures.

The prevailing attitudes and politics toward immigration in receiving countries not only influence migrants' social status and entitlements in the host society, but also how the healthcare system responds to their specific needs. As Bollini and Siem (1995) have pointed out, two broad categories of reactions can be observed in host countries: a 'passive' attitude, in which migrants are expected to make use of the existing health system with no major modification (also if actions are taken for cultural differences and linguistic barriers), and an 'active' attitude, in which the special health needs of migrant communities are acknowledged and actions are taken by the health authorities to ensure that linguistic and cultural barriers are minimised. Research evidence (Bollini 1993) suggests that an 'active' attitude, or in other words, the adoption of specific health policies (and the creation of specific services) for migrants, could remove many economic, administrative and linguistic barriers to access to healthcare. This plura-

⁹ In Switzerland, Wicker and colleagues (1999) reveal that among refugees and asylum seekers of the Canton of Bern, there is an over-utilisation (in comparison to the general population) in somatic medicine and an under-utilisation of psychiatric services. In Sweden, as reported in a study undertaken by Hjern, Haglund et al. (2001), migrants (in particular victims of organised violence) use the health services much more than Swedish-born residents. See also the study of Chimienti and Achermann in this volume.

listic (or multicultural) approach¹⁰ has been accompanied in some receiving countries (e.g. Australia, Canada) by the development and improvement of services for migrants, and an increased recognition of the need for services to cater for the cultural diversity of the population.

Nevertheless, an overemphasis on culture at the expense of other social determinants of health and access to the health system, such as socio-economic status, gender or the broad social policy context (Watters 2001), is criticised in the literature (Ahmad 1996; Eastmond 1998; Dozon and Fassin 2001). Focusing on the idiosyncrasies of different cultures in a stereotypical way is believed to lead to situations where culture is seen as the cause of health disparities, which in turns results in a tendency to blame the victims. In addition, it is argued that variations within cultures may be greater than variations between cultures. This literature should not be interpreted as minimising the importance of culture, however. Instead, it suggests that effective services will depend on taking the actual, rather than perceived, sources of diversity within and between communities into consideration. Specific health services should be developed in accordance with an analysis of community needs, rather than on any assumption of primary differences between populations on the basis of culture. Research that aims at recognising and assessing a diversity of needs within and between communities is expected to lead to a more evidence-based approach to specific service design that matches communities' needs, health perceptions and current pattern of utilisation (Kelaheer and Manderson 2000). As Watters (2001) has suggested, the establishment of a focus group may be a useful means of prioritising proposals for the setting up of specific services relating to communities' health and social needs, thus countering the prevalence of stereotypical ways and assumptions regarding the needs of particular migrant groups or communities.

That language is an important barrier to healthcare has been largely documented in the literature (Bischoff, Tonnerre et al. 1999; Toscani, Loutan and Stalder 2000; Bischoff, Loutan and Stalder 2001; Bischoff 2001; Graz et al. 2002; Bischoff 2004; Morales et al. 1999; Pitkin and Baker 2000; Bowen 2001; Robinson and Gilmartin 2002; Murray-Garcia 2002). However, less research attention has been devoted to assessing intervention efforts than to understanding the extent of barriers to healthcare. More research efforts should therefore be focused on intervention strategies such as transcultural education and communication training for healthcare providers (Purnell and Paulanka 1998; Canales 2000; Robins, White et al. 2001; Smedley et al. 2003), community interpreting and intercultural mediation (Jacobs, Landeral et al. 2001; Nierkens, Krumeich et al. 2002;

¹⁰ A debate between the defenders and detractors of a pluralistic or multicultural approach exists in the literature (Schnapper, 2000; for an articulation cf. Kälin, 2003).

Singy, Weber and Guex 2003). As Bischoff (2001) has pointed out, research is expected to not only assess the effectiveness of these interventions in reducing gaps in appropriate care delivery and healthcare access (as well as health outcomes), but also their cost-effectiveness, and the extent to which these interventions result in organisational and institutional changes to improve care for migrant patients. Qualitative research is also needed with input from medical anthropology and the social sciences. In the area of communication, an adequate quantitative/qualitative mix is essential in obtaining reliable data. Moreover, patients' psychosocial aspects influencing understanding and communication should be more closely analysed, since they also shape the translation of meaning.

In addition, research is needed to clarify the concept of transcultural competence (Domenig 2001; Donini-Lehnoff and Hedrick 2000; Nunez; 2000) and its related elements, and to determine the content and forms of transcultural education for the entire range of health professionals (medical and social care providers, nurses, therapists, interpreters, cultural mediators, and so on). Comparative studies on different existing models of transcultural or cultural competence (see also the concept of 'cultural humility' which is intended to replace 'cultural competence' in incorporating a lifelong commitment to self-evaluation, self-critique and non-paternalistic interaction instead of a finite body of knowledge, cf. Trevalon and Murray-Garcia 1998) should also be conducted in order to assess their impact on both health outcome and access to healthcare (and on patients' and care providers' levels of satisfaction).

The impact of economic and legal barriers to healthcare access (e.g. immigration law restrictions, legal status, insurance system) should also be documented in greater detail (Weiss 2003).

Moreover, it would seem necessary to improve the understanding of the extent to which perceived discrimination and hostility experienced by migrants (both in society and in the healthcare system) influences healthcare utilisation and access (Geiger 2003). Identification of any unequal treatment and discrimination in the healthcare system, and particularly the structural barriers to prevention and care, is also considered an important, future research issue (Weiss 2003). Finally, it is worth noting that patient mistrust of care providers (or health treatments) may affect their decision to seek care (Smedley et al. 2003). Investigations should therefore assess migrant patients' attitudes towards healthcare providers and services, and examine the influence that such attitudes have on the healthcare system's utilisation. For instance, according to patients of different cultures a high reliance on technology to diagnose illnesses may be less positively perceived than other health assessment skills such as touching the body (Van Dongen and Elema 2001), pulse taking or discussing the patient's relationships and

current circumstances (Sung 1999). Further research should also assess appropriate means of addressing possible negative cultural beliefs about care seeking and any mistrust of healthcare services, treatments and providers.

Conclusion

It is clear that research is needed to illuminate how and why ethnicity influence patients' communication and interaction with a whole range of health-care professionals (medical and non-medical professionals alike). Specifically, research is required to:

- Illustrate the key factors that affect communication, mutual perception, decision-making and service delivery. Further studies should focus on decision-making by patients and care providers, the assessment of care management at different points along the continuum of care, and the impact of patient-provider interactions on diagnosis and treatments.
- Further understand provider decision-making, the heuristics employed in diagnostic evaluation, and how patients' ethnicity (and other social factors such as gender, social class, legal status, and so on) influences these decisions.
- Explore how social cognitive processes (bias, stereotypes, prejudice) affect patients' and providers' perceptions of each other and influence the structures, processes and outcomes of care.
- Focus on the impact of social factors (e.g. ethnicity, gender, legal status, social class) on the quality of patient and provider relationships, communication and interaction. An improved definition of communication and interaction quality criteria is needed in order to identify which characteristics of interaction/communication affect diagnosis, treatment and health outcomes.
- Determine the structural, institutional and organisational factors of healthcare settings that affect the content and quality of communication and care.
- Assess how educational programmes can improve care providers' communication (and attitudes and behaviour) with migrants.
- Conduct action-research to study the interactions, patterns of communication and problems of contact between migrant patients and the range of healthcare professionals.
- Clarify the legal, structural and financial possibilities of the healthcare system for the improvement of communication processes.
- Study strategies that help to increase migrant patients' ability to participate in decision-making and empower them as self-advocates within the healthcare system.

Research is also required to increase knowledge about migrants' psychosocial problems, and improve psychosocial treatment (and assistance) for migrants. In particular, research efforts should be focused on:

- Setting up statistical data concerning the most common psychosocial health problems of different groups of migrants.
- Developing representative surveys on the psychosocial health of different groups of migrants.
- Verifying the impact on psychosocial health of a series of variables linked to short-term and long-term migration (e.g. language proficiency, legal status, ethnic origin, ethnic group identification, acculturation, migration motivation, expectancies and attitudes relatives to the host-country).
- Further developing innovative and multidisciplinary lines of research to facilitate the early diagnosis of psychosocial morbidity linked to short-term and long-term migration.
- Analysing the potentials and difficulties of psychosocial treatment and assistance to migrants in the realm of medical and hospital practices.
- Developing innovative and multidisciplinary models of psychosocial treatment and assistance that match migrants' cultural needs, beliefs, practices and perceptions (the development of a culturally adequate therapeutic concept).
- Continuing to study the causal factors of psychosocial problems. For instance, taking into account a variety of variables (e.g. primary socialisation, motivation of migration, length of stay, legal and socio-economic status in the host country), and differentiating migrants in distinct and relevant categories.

As the pluricultural composition of host societies has contributed to the emergence of innovative and multidisciplinary perspectives of research and changes in professional practices, research is needed to:

- Further develop and analyse the potential of emerging perspectives for interdisciplinary research and intervention in the domain of healthcare and prevention, both at conceptual and methodological levels.
- Study the significance and consequences of change in professional practices within the healthcare system (e.g. collaboration and coordination between the medical and social sciences).

Research is needed in order to improve an understanding of the barriers and disparities in healthcare.

In particular, research into the following issues is required:

- Documenting the relationship between the level of entitlements (which vary according to one's legal status in the host society, social and political rights, degree of institutional and social discrimination, etc) for migrants and their access to healthcare.
- Considering actual rather than perceived sources of diversity within and between communities. Recognition and assessment of differences, both between and within communities, is expected to lead to a more evidence-based approach to culture specific services and to a real respect of communities' perceptions and needs.
- Efforts should be focused on intervention strategies that reduce the barriers and disparities in healthcare, such as cross-cultural education and communication training for healthcare providers, language interpretation and cultural mediation. Qualitative research is also needed, with significant input from medical anthropology and the social sciences: an adequate quantitative/qualitative mix is essential in obtaining reliable data.
- Patients' psychosocial aspects influencing understanding and communication should be more carefully analysed.
- Research is also required to measure the cost-effectiveness of interventions that reduce barriers, and the extent to which these interventions result in organisational and institutional efforts to improve care for migrant patients.
- It is important to determine the contexts in which interpreters versus cultural mediators respond to both care providers' and patients' needs.
- Clarify the concept of cultural competence (and culturally competent care) and its related elements, and define the content and forms of cultural education for the entire range of health professionals. Comparative studies into different existing models of cultural competent care should also be conducted in order to assess their impact on access to healthcare, health outcomes and patients' and providers' satisfaction.
- Further document the impact of economic and legal barriers on healthcare access (e.g. immigration law restriction, legal status, insurance system).
- Improve understanding of the extent to which perceived discrimination and hostility (both in society and in the healthcare system) influence healthcare utilisation and access. Further identify effective unequal treatment and discrimination in the healthcare system (particularly any structural barriers to prevention and care).

Finally, investigations should assess migrant patients' attitudes toward healthcare providers and services, and examine the influence that such attitudes have on healthcare system utilisation. Further research should assess the means of addressing potential negative cultural beliefs among migrants about seeking care and any potential mistrust of healthcare services, treatments and providers.

MIGRATION, POWER AND HEALTH: AN EXPLORATION

Sandro Cattacin

In this essay I focus on the sociological perspective of the relationship between caring agencies and migrants or ethnic minorities, and particularly on the power relations in the pluralistic context of healthcare. I argue that we not only need to foster a goodwill to work against exclusion tendencies, but also the look at the rights and advocacy structures from an institutional point of view and assess the position of patients and their relatives that find themselves in positions of weakness.

Three Faces of Power

Conceptually, we can distinguish three forms of power existing in all organisations. First of all there is decision-making; an indication of who holds the power or which power coalition is applying a decision to a minority. This is the classical perspective of the pluralistic approach to politics.

Secondly, as Bachrach and Baratz (1970) point out, a number of rules exist that are not subject to any decision being taken, and which are applied without the possibility of discussion by people from outside the organisational structure. Following this logic, Foucault (1975) analysed the rules of prisons, which are not defined by law but by the internal prison staff on the basis of their privileged positions.

Thirdly, and with Steven Lukes (1974), we can identify a sort of structural power in the patterns that describe elements that are outside people's influence. Structures are not only formed by strong rules and laws, but also by previously decided constructions and infrastructures that act as some kind of restriction and limit possible options.

These three faces of power can also be found in the context of healthcare, especially in the patient-physician relationship and in hospitals. Through an analysis of the relations between patients and their medical doctors, we are in fact confronted with different asymmetries that influence their interactions; even more so when the migratory context is added to

this relational complexity (Weiss 2003). The medical system of the Western world is organised in such a way, that it gives huge powers of decision to the physician. It is a matter of fact that he (or she) is the only person responsible for the diagnosis and thus also for the corresponding therapy, even though the possibility of obtaining a second medical opinion has today become a recognised right of the patient (one that they often ignore). Then, the medical doctor has the choice of listening to the patient and, depending on the doctor's willingness, of either discussing the matter with the patient or not. Finally, in the context of this relationship, the structural element is determined by the existing offer. While it is often impossible to avoid this asymmetry, there are ways in which health systems can be partially opened to weaken the potentially harmful consequences of such power differences. I will explore these three faces of power in the following paragraphs, with special reference to the field of migration and health.

The Power to Decide

The biomedical approach that dominates the relationship between doctor and patient is oriented towards the individual and its disease (Renschler et al. 2005). It is also founded upon a presupposition that is seldom questioned by the medical doctor, i.e. that the patient is automatically considered as being integrated in a social network of support. But that is not always the case. New migrants who have only lived in the host country for a short period of time are particularly affected by situations that differ from this presupposed model: their family is often structurally diminished (e.g. the grand-parents and a part of the larger family have often remained in the home country) and the neighbourhood is hard to mobilise (since such a network may not necessarily have yet been created). A person's life conditions also play an important role. The more precarious a person's situation is, the more the presupposition of an existing network becomes problematic.

There is not the slightest doubt that the efficiency of a treatment can be connected to the existence of an agreement inside the therapeutic relationship. A medical decision which is neither understood nor shared always presents a high risk of having only partial results, or even no effect at all. Here the primo-migrants are again at a disadvantage in that their comprehension of the language and/or the culture are far from being ensured in their relationship with the health practitioners.

A study conducted by Weiss and Stuker (Weiss and Stuker 1998) has, for instance, showed that the more a patient has problems in expressing him or herself, the shorter the period of the anamnesis (or medical history). Such a reduced time of discussion logically leads to less knowledge of the patient

being acquired, which in turn increases the risk of inappropriate therapeutic decisions being taken. The “platonic” model then becomes the major orientation of care givers, based on the idea that higher education and a considerable experience of caring and time restrictions legitimate an isolated and paternalistic decision as to the relevant therapeutic process or ad hoc care. These decisions are based on a simple model that categorises the condition of a patient. Even if these decisions are taken by using an evidence-based approach,¹¹ it is questionable whether scientific conclusions based on research of mainstream populations (non-minority) can be generalised and applied to minority populations.

So, one of the central questions is to whom does the patient’s body belong? In any case, it appears to be evident that the weaker the communication, the more a person’s destiny lies in the hands of the doctor. Alternatives to this model of medical supremacy do exist, however; ones that introduce more dialogue and a closer connection to the patient. The ethnical choice and the discursive choice are two such models, which can be likened to the “Socratic” perspective of putting the communicative construction of a diagnosis in the centre of the health-relation; one that is sensitive to culture and for patients’ consent on choices. As Bischoff (2006: 21) suggests: “Patient-centred interviewing is associated with greater patient satisfaction and better medical outcomes than traditional encounters”.

The Power of Definition

In an attempt to increase the participation of the migrant patient in therapeutic decision-making, new forms of transcultural mediations have recently been developed (Bischoff 2001). This evolution started in hospitals by making use of staff, often cleaning or kitchen employees, who spoke the language of some of the patients with whom communication was difficult. Although they were generally used informally, and on a voluntary basis, they soon started to feel uncomfortable with these new responsibilities and began to question their role in this practice. The alternative, which is still widespread today, was to use a member of the family that was more fluent in the local language than the patient. This practice has severe limitations, however, since there is no guarantee that a complete and precise translation is being given and, in addition, the patient loses their right to confidentiality. The person charged with the translation can also become emotionally involved in the situation of the person seeking treatment and thus may, whether consciously or unconsciously, only translate what is considered as being important to him/her. The frequent use of children in this role (as

¹¹ There is general acceptance of the concept of “evidence-based medicine” as the underlying philosophy for quality of care.

they learn the language much quicker at school) is clearly one of the most problematic aspects of this field.

Due to the problems encountered with such informal solutions, the use of professionals, educated in transcultural mediation, has started to be organised on a large scale. One major problem is the financing of such mediators. The health system and health insurance schemes are generally unwilling to pay for such services, even though a global and long-term analysis would probably establish that such a practice would actually reduce the cost of healthcare among migrants.

Western medical logic is largely based on the standardisation of suffering. For each person consulting a doctor, there is a kind of necessity to find a name for the disease and administer the appropriate treatment. Here again, the case of the migrants is exemplary. This kind of population, even if it is impossible to characterise it homogeneously, is confronted with very specific situations of life. For refugees who have fled from violence, the traumas related to their homelands, and their forced migration, are often important. In the case of many migrants, one also has to consider the life conditions of the host country (e.g. the economic, social and cultural precariousness). These elements all affect the health of the migrant, but are generally not taken into consideration in the doctor's diagnosis. A problem defined as a depression may, for example, be treated with anti-depressants. In many cases, however, a more thorough discussion with the patient would indicate other – and better – ways of solving the problem. The specific migration anamnesis is a tool that allows the doctor to assess the situation of the migrant much more accurately. This comprehensive way of taking care of a patient is based on a different set of guidelines, such as the use of trained independent interpreters and a Socratic model of discussion. One could question here whether there is a necessity for the doctor to have specific ethnical or cultural competences. The main thing, though, is that it is important that the doctor has a specific, human-being related competence for dialogue and contact, rather than any theoretical knowledge about the patient's cultural origins which might make any decision not to act – a non-decision – justifiable on the grounds that the specific cultural dimension are unknown and that a physician therefore thinks that he or she does not understand the patient.

Structural Power

Many different elements can be mentioned in an analysis of the structural framework and its effects on the relationship between the doctor and the migrant patient. One basic problem encountered by the migrant is related to his understanding of this new (to him) health system. The information

that he or she has received is often insufficient and, above all, informal. The social and cultural codes are not always explicitly unveiled, and it is at this level that differences of behaviour become apparent. Migrants coming from southern Europe are, for instance, known to resort to doctors, and especially to the emergency services, more readily than resident citizens. This often gives ground for critique on the part of the resident population, but this habit has to be connected to how things function in their home countries and to a lack of information on the functioning of the new context of residence.

Another problem concerns the place where a particular therapy is being implemented. For migrants, the trauma experienced in a specific context, namely in the country they have fled from, must be overcome in a different context; that of the host country. The consequence of this particular situation of decontextualisation of the trauma (as compared to a patient whose trauma is related to the same geographical and cultural context in which he is treated) is that the patient is caught in a sort double-trauma: the trauma of the departure and the trauma of having to overcome this in another context. But these circumstances may also be used by the patient to their advantage. If we take asylum as an example, the fact that one has experienced trauma significantly increases the chances of obtaining a permit of settlement and even facilitates the procedure. Once in possession of this information, one can only consider it rational and logical that the asylum candidate will invent a story of a traumatised past in order to sound convincing.

Such aspects show that it is necessary to analyse the behaviour of the patients - in this case the migrants - in the light of how the health systems in the new countries of residence are structured. Any analysis of health and migration will hardly be credible if these points of view are not taken into proper consideration.

Conclusion

Through this explorative discussion of power games between the medical doctor and the patient, it would appear that, for the migrant entering the health system of the host country, there are significant obstacles. The behaviour of the doctor, based on a decisional superiority and the standardised logic behind all diagnostic and therapeutics acts, contributes to depriving the patient of much of the power that should be in his hands. One might add that the general complexity of western health systems represents a supplementary obstacle that even the local population often has difficulty in understanding. The consequences of these facts do not only have repercussions upon the patient, but also on the effects of the therapies and on the global costs of healthcare.

Thus, in order to guarantee a differentiated healthcare, it is necessary to open up therapeutic possibilities. In order to be both respected and understood, migrant patients need much better access to overall information about their rights and what is available. A country's medical services should be evolving towards the adoption of alternatives to the sole biomedical approach currently on offer. The goal is not to achieve a State organised and ethnic-based medical service, such as that in Canada, but rather the officialisation of differentiated approaches. An important step should also be taken to normalise both mediation and transcultural translation in the context of the relationship between patients and doctors. In addition to other means, this should be accomplished through the creation of specialised and professional networks of reference and the training of doctors (at least some of them) in the field of specific anamneses for the migratory context. In the meantime, a vital problem that needs addressing is that concerning the funding of services inside specific health schemes, so that a more efficient medical approach can be provided for certain groups of migrants.

But difference orientation is not only a question of organisation or solidarity. It also concerns power distribution. In order to improve the difference orientation of asymmetric care relationships, we need "counter-power". This can be achieved by giving migrants the possibility to act autonomously – by providing them with empowerment strategies. But even this is not sufficient. The health system will probably also need to introduce rights and non-discrimination policies, and formal representations of difference in decision-taking bodies inside the health system. And finally, at the societal and political level, a sincere policy of recognition of difference needs to be developed. We would do well to heed Ricoeur (2004) when he says that this is the only way to build up a fair and respectful society.

CHAPTER II

BARRIERS AND LEARNING PROCESSES IN ORGANISATIONS CONFRONTED BY DIFFERENCE

COMPREHENSIVE “DIFFERENCE SENSITIVITY” IN HEALTH SYSTEMS

*Isabelle Renschler and Sandro Cattacin*¹²

Social changes, demographic evolutions and the increasing diversification of society are some of the transformations that the healthcare sector is confronted with today. Health policies, as well as institutions of healthcare, have to face increasingly diversified patient needs – often without any structural preparation in handling diversity¹³ or responding to such changing requests and conditions. The sector is therefore faced with important challenges that can represent real problems for the internal organisation in that improved communication and language skills are required, new information strategies have to be set up, the accessibility of services increased, the quality of services adapted to new needs, and innovative action incorporated in the regular procedures. In the present system, non-productive contradictions are taking up both resources and time. For example, increasingly unmet health needs tend to converge in emergency departments; unmet language needs tend to slow procedures down and an uncoordinated adaptation of services to specific needs creates uncertainties for staff, management and the institutional setting alike.

How might such a rapidly changing environment be adapted to and managed? How do you prevent people being excluded from the standard healthcare services they are entitled to? Such questions have become more pertinent in recent years, as have the claims for more coordinated strategies. But the healthcare sector is still dependent on patterns of Fordistic logic to overcome problems, which assumes that problems are standardised and that diversity is a danger rather than an opportunity. Current organisational difficulties confirm the need for a fundamental change of approach.

¹² The authors are currently working on a project on barriers to access the health systems in European cities.

¹³ Diversity is considered in this article as a vision, a commitment that includes leadership for systemic change. Doing diversity has to do with the openness and the closeness of organisations.

Given today's societal circumstances, organisational adaptations have become especially important. They are vital to maintain performance and the carrying out of tasks that have been handed over to the public health system, i.e. to fulfil society's interest in ensuring conditions in which people can stay healthy. This includes core public health functions, such as the assessment and monitoring of the population's health to identify health problems and priorities; formulating public policies designed to solve identified local and national health problems and priorities; ensuring that people have access to appropriate and cost-effective care (including health promotion and disease prevention services) and evaluating the effectiveness of that care (Rosenbrock and Gerlinger 2000). To accomplish its functions comprehensively, the health system must be permeable to change. In this article we specify some of the critical points and give examples of how the health sector might become more open to diversity.

As has already been mentioned, the question of how we can deal with diversity needs to be addressed, and not only at the level of a person's behaviour. Diversity goes hand in hand with major changes and societal developments that the modern welfare state and the health system have to tackle jointly. As society and lifestyles have changed dramatically in recent decades and become much more diversified, the challenges are also more varied. For instance, the general trend of labour or social policies affecting all sectors of public life is that policies and implementing agencies alike are increasingly expected to adopt *flexible* measures. Uniform strategies adhering to the principle of "indiscriminate all-round distribution" cannot cover the varying needs of the population and simply do not correspond anymore to the diversity of life circumstances. While in the field of public health the constellation is the same, the healthcare system has either not changed much over the decades or adaptations have not been able to keep pace with the ongoing changes. By and large the structures remain rigid, and any moves to meet the new and diversified needs are more the exception than the rule.

What is commonly acknowledged, for instance, is that there are problems in the provision of healthcare for minorities. As shortcomings also exist in the field of gender and the needs of the disabled, a first step in taking diversity into account should start here. Some adaptations exist already to respond to specific needs, for instance those of the disabled, although this seems to be dependent on the institution's philosophy. But much more needs to be done to introduce effective measures that foster a health system capable of working with difference, rather than difference being classified as something unusual, as it is still largely now.

But can such a situation be changed, and if so, how? The dynamics of opening up the field of health can be operated at different levels: at the decision-making level as well at the level of implementation and in the provision of health services and care. A starting point for introducing difference-sensitivity is at the *policy level*, where structural decisions are made and where health sector guidelines and core principles are established. These guidelines can then be communicated to the different services in the health sector. In this context, manageable yet persuasive forms of information brokerage through dialogue are necessary, rather than cumbersome administrative information mechanisms. The services that communicate the “corporate identity” of a given health structure can, for example, promote new orientations within an institutional setting and increase not only the acceptance of these new orientations, but also widen their comprehension. We have observed that an outline of difference sensibility can easily be included in administrative guidelines. A practical example is the concept of empowerment. Anchored in the Ottawa Charter, this concept is one of the main guidelines in Western countries’ public health manifestoes. It is considered as being an important aspect for both the individual and society, in that people that are well informed and can base their decisions on knowledge will not only be more satisfied, but also more accurate in their choices (and by this have a positive impact on the health sector, particular in reducing its costs). But how is this concept implemented at a practical level in a country’s health service? While different levels of society are involved in the implementation (schools, vocational training, etc.) of such measures standardisation is difficult, since a person’s skills and knowledge vary, as do people’s capacities to find the way through the health system, not to mention their individual preferences. Implementing such a concept accurately and justly thus includes interpreting the nature of diversity. A reflexive approach makes it possible to both adapt the measures and question them and verify that the initial aim is being attained. In this case, we not only see that the potential of such a concept is important, but that the policies must also include a clear orientation.

Another aspect of a difference sensitive approach is *quality assurance*, i.e. organised procedures to insure that the services are adapted to the requirements of the clients. One way of approaching this is by the introduction of *brokers* within public health institutions, hospitals and general medical services. They can bridge the different backgrounds (cultural, etc.) at management-level as well as at the level of the implementation of services and service delivery where contact with the patients takes place. At the management-level this means that representatives of minorities or genders must be included in all major decision-making in order to systematically

anchor these gender and minority-related topics. In the Anglo-Saxon tradition this is already largely acknowledged as an important principal and the regional hospital in Bradford, UK, is an example of such methodical implementation. Minority communities are represented on the advisory boards of the city's hospital, together with a director for equality and diversity. The promotion of employees belonging to minorities is supervised in order to include diverse experience in the different hierarchical degrees. In addition, the city's health department has appointed a manager to take charge of equality and diversity issues. His mission is to make sure that continuous efforts are made to ensure that all levels of the health system are responsive to diversity, together with the level of the access to the medical professions. In this way, diversity sensitivity is introduced to the system at all levels.

At the patient-level, we observe that there are patients with communication problems (not only migrants). In some institutions, the use of translators constitutes an important component in the contact with patients. This measure aims at lowering the occurrence of incorrect diagnoses; something that often happens when communication is insufficient or deficient. Germany, for example, is investing in intercultural competencies, and in some places – such as a large hospital in Munich - hospitals recruit people with language skills from among the medical staff. Although these translators work on a voluntary basis, they receive internal recognition from the management along with a special status within the team and the time spent on translation is convertible to additional spare time. However, many experts state that there must also be a more fundamental change within the medical services themselves in terms of quality control. As in other fields where such procedures exist, once quality controls have been comprehensively established – within the different structures, with regard to the quality of procedures and results¹⁴ - and been fully recognised, the diversification of needs becomes more apparent and can thus be tackled. Through the use of patient questionnaires, individual requests and experiences can be mediated into the system and services and, in the long run, contribute to *difference sensitive care*. Some authors maintain that the best way of meeting the needs of minorities, migrant groups, the disabled and different genders is by improved quality assurance measures, rather than sectoral measures that are less efficient. This orientation of course necessitates certain flexibility on the parts of the services and institutions. Such flexibility could be achieved through a regular scrutiny of the structures on the quality improvement of a service. Assessment would naturally have to be based on instruments of quality assurance and drawn up by a management board that is able to direct or execute the necessary structural adaptations.

¹⁴ See especially Rosenbrock and Gerlinger 2004: 219ff.

Finally, and at the very different level of health monitoring and research into the supply of medical services, many reporting systems exist that provide policy makers with information about where possible shortcomings within the health system are situated (for the general population or groups of populations). The monitoring of health problems facilitates the detection of different types of illness and their distribution. Through this, information and knowledge is generated that helps in the formulation of public health objectives and strategies. But, this instrument is only efficient if, on the one hand, a thorough re-coding of information in the language of policy makers is operated and on the other, monitoring systems are closely associated with the agencies' determining health policy. What remains problematic is that the collection of data is mostly directed towards the needs of the majority. This has the effect that data about specific groups of the population are only partly available, or that the perception is either limited or distorted, especially when it concerns minority groups. (see Bischoff and Wanner 2004). For instance, in order to evaluate the health risks related to migration accurately, systematic comparisons should be made between foreigners and the local population of the same social background to adapt interventions. When this procedure is followed differences often disappear such as a lower vaccination rate and lower use of other preventive measures among migrants (Weiss 2003). A preoccupation of another kind within health reporting where data is rarely collected is the question of the degree of health literacy and skills among the population or groups of the population. Thus, knowledge about people's existing resources and their competencies is almost inexistent.

To conclude, a higher sensibility to difference in the health sector could be an efficient anti-discrimination measure at all levels of the health system. It is therefore necessary not only to overcome institutional difficulties and increase efficiency, but also to encourage and help institutions to adapt to changing realities and needs.

MIGRANT FRIENDLY HOSPITALS: ORGANISATIONS LEARN SENSITIVITY FOR DIFFERENCES

Ursula Karl-Trummer and Karl Krajic

Migration, Health and Hospitals

Numerous studies prove that there is a relationship between migration and ethno-cultural diversity on the one hand and health status and healthcare quality on the other.

Due to worldwide migration, globalisation and European expansion, communities in Europe are becoming more and more diverse – and posing challenges for health systems and services alike. Both service users and providers are facing problems: language barriers and misunderstandings due to cultural diversity, a scarcity of resources and low levels of minority purchasing-power and entitlements (Bischoff 2006). On the provider side, this emerges as new challenges for professionals and for the management as well as for quality assurance and improvement – especially for hospitals which play a particularly important role in serving this segment of the population.

In order to cope with consequences of migration and increasing diversity, hospitals have to change. Like any other organisation, hospitals have a natural tendency to preserve existing structures and processes, but a significantly changing environment forces them to change. As Cattacin and Björngren Cuadra state in the introduction of this book, the first reaction is blindness and the development of strategies to mask this blindness. Using cleaning staff as “random” interpreters to compensate communication problems is an example for such a strategy. But as the pressure increases, organisations eventually get to a point where problems caused by staying the same in a changing environment start to “feel” worse than the difficulties of actively adapting to the new situation.

Systemic transformation management talks about the “Energy for Transformation” necessary to cope with change and that develops through

three factors: a deficient presence, an attractive future, and a realistic way from one to the other (Janes, Prammer and Schulte-Derne 2001: 19)

How Can Hospitals Learn to Deal with Diversity?

Individual and Organisational Learning

In the discussion of migration and health, interventions concerning the development of personal resources are often stressed as important elements of improvement. At the provider level this includes language skills and the cultural competence of staff members, while at the client level empowerment issues like health literacy are mentioned. These are important attempts to influence personal priorities, knowledge and skills and make changes of individual behaviour possible. Nevertheless these attempts are insufficient, as individual behaviour is not only dependent on individual preferences and resources, but also on preferences and resources in the social situation or setting. Social situations are not only influenced by general political, legal and cultural environments, but also more directly by organisations that define the concrete and specific relevance of structures: What is expected? What will be positively valued, what will be sanctioned? Organisations also decide on the resources available and the specific opportunity structure.¹⁵

Sustainable development in healthcare must therefore systematically address the level of health organisations and thus include organisational development strategies. Development requires processes of learning. How organisations can develop and learn is an issue of ongoing discussion within the different communities, and several models have been proposed (Argyris and Schon 1978, March and Olson 1975, Kim 1993, Nonaka and Takeuchi 1995, Nick Bontis et al. 2002), all of which try to distinguish between learning processes at the individual and organisational levels.

Following Richard Beckhard's definition (Beckhard 1969), organisational development is a planned, organisation-wide effort managed from the top that aims to increase organisational effectiveness and health through planned interventions in the organisation's processes, and that uses the theory and technology of applied behavioural science. It involves organisational reflection, system improvement, planning and self-analysis.

A variety of concepts and related tools have been made available with the development of quality management. In terms of quality improvement, they basically relate to the need for a circular process that has to be run through. A prominent model is the Shewhart Cycle (PDCA) for quality

¹⁵ See Lewin and Coleman for a brief description of a theoretical model following basic distinctions in the context of healthcare and health promotion, see also: Pelikan and Halbmayr 1999; Trummer, Nowak and Pelikan 2002.

improvement, made popular by Deming and which formulates four key elements that should be repeated over and over again for continuous improvement (Tague 2004):

- Plan: Design or revise business process components to improve results
- Do: Implement the plan and measure its performance
- Check: Assess the measurements and report the results to decision makers
- Act: Decide on changes needed to improve the process

Quality management procedures and tools provide appropriate measures with which to steer and conduct organisational development and learning processes. All methods need a starting point, however, and in this case the starting point is a decision about what is relevant for the organisation and a statement regarding what the organisation is willing to observe and consider. Everything else is a consequence of these first statements.

The MFH Project Starting Point: A Definition of Sensitivity for Differences Concerning Migration and Ethnic Minorities

“Migrant Friendly Hospital” (MFH) is a name inspired by the WHO idea of “Baby-friendly hospitals”. There was a lot of discussion about this name, and it was especially questioned by partners from countries with a long immigration history where minorities had fought to be accepted as full citizens, albeit with a different ethnic background and a different cultural identity to the “natives”. But the project did not only want to look at cultural diversity, but also at acute issues raised by “fresh” migration, which was why the title was accepted as a compromise on condition that it was accompanied by a sub-title that also provided clear reference to ethnic minorities¹⁶.

A working definition of the MFH project was developed that consisted of three components. According to this definition, a Migrant Friendly Hospital:

1. values diversity by accepting people with diverse backgrounds as principally equal members of society;
2. identifies the needs of people with diverse backgrounds and monitors and develops services in accordance with these needs;
3. compensates for disadvantages arising from diverse backgrounds.

¹⁶ The Task Force in the WHO Health Promoting Hospital Network that has been engaged in the project work since 2005 has explicitly included “Cultural Competence” in its name, so that it now reads “Task Force for Migrant Friendly and Culturally Competent Health Care”.

Referring to the key elements of organisational development - organisational reflection, system improvement, planning and self-analysis – the difference sensitivity of an organisation means to:

- define differences in their relation to a desired outcome: good care and good health for people who are different
- actively monitor/analyse for differences
- develop/adapt strategies that cope with difference in a way that the desired outcome is supported
- evaluate measures taken in relation to the stated objectives

A precondition for taking these measures is that sensitivity to difference becomes a central value in an organisation. This is a very different process than that where a single person decides whether or not to put a high value on something - even if that person is the hospital's director.

The Migrant Friendly Hospital Project

The process of developing a European project was initiated by an Italian local health authority from Reggio Emilia (Region Emilia Romagna) in 2001. The Ludwig Boltzmann-Institute for the Sociology of Health and Medicine at the University of Vienna, WHO Collaborating Centre for Health Promotion in Hospitals and Health Care, supported by national and regional networks of the WHO Network of Health Promoting Hospitals (HPH), managed to get a group of 12 hospitals together from 12 European countries in what came to be known as the “Migrant Friendly Hospital Project”.¹⁷

The 2½-year project formally began in October 2002. Partner hospitals came from Austria, Denmark, Finland, France, Germany, Greece, Ireland, Italy, The Netherlands, Spain, Sweden and the UK. The participating hospitals represent a wide range of different types, from large metropolitan university teaching hospitals to small-town community hospitals, and range from public, private and non-profit ownership. Some of the partners already had a long-standing record in serving ethno-culturally diverse communities before they participated in the project. Several of the migrant/minority communities served are well-established and homogeneous, while others are very diverse and comprise a large number of undocumented migrants.

In the project, the hospitals collaborated with a group of high-profile experts, while a wide range of international and European organisations

17 Financially supported by the European Commission, DG Health and Consumer Protection, Public Health Programme, and co-financed by local sources like the Austrian Federal Ministry for Education, Science and Culture.

acted as “Supporting Partners”. The project partners agreed on the following aims:

- To locally initiate a process of organisational development towards becoming a Migrant Friendly Hospital and implement pilot interventions selected in a stakeholder approach.
- To regionally/nationally support other hospitals in their quality development towards migrant friendliness by compiling practical, transferable knowledge and instruments.
- To actively contribute to putting migrant friendly, culturally competent healthcare and health promotion higher up on the European health policy agenda.

The “Overall Project”: Organisational Development Towards “Migrant Friendly Hospitals”

The project was organised on two closely interlinked levels. The so called “overall project” was started at the general approach level of organisational development and had three main objectives:

- To develop a basic structure within the participating hospitals that could systematically work on the issue of migrant friendliness and link those organisational activities to work at the European initiative level
- To raise awareness for the importance of migrant health within the hospitals
- To provide a first diagnosis of needs, problems and existing structures and process regulations related to migrant health

Project teams were established in all partner hospitals in order to develop a basic structure. While these project teams were necessary for the partner hospitals to participate in the European project, they also formed the nucleus of an organisational development to integrate project activities in existing organisational structures and cultures of decision-making and practical day-to-day work. Project groups were therefore created in line with local definitions of quality management and local roles and responsibilities. These teams took responsibility for all further project related activities within their hospitals, acted as focal points for the European project coordination, and took the lead in marketing the idea and raising awareness at the local level. The “overall project” provided background information, guidelines and tools for local activities.

For a first diagnosis of problems and needs, as well as existing solutions - structures and process regulations - within the partner hospitals, a needs assessment was conducted that integrated the perspectives of clients,

staff and the hospital management. Results showed that there was widespread consensus that the main problems are language barriers in communication with patients, patient education and the cultural competence of staff members.

Along with the needs assessment, a literature review on available knowledge relating to problems and possible solutions of health and healthcare related to migrant/minority status was provided by the Swiss Foundation for Migration, University of Neuchâtel, Switzerland (Bischoff 2006). This review grouped interventions into four specific areas – communication, responsiveness, empowerment and monitoring – and highlighted the relevance, principle options and evidence for the effectiveness of interventions in these areas.

A generic assessment instrument was developed in order to obtain a first diagnosis on structures and process regulations at the organisational level. The Migrant Friendly Quality Questionnaire (MFQQ)¹⁸ assesses the status quo of overall “migrant-friendliness” (see the definition above) of services and (quality) management structures. MF Indicators are defined on two levels: The level of services and the level of facilitating quality structures. The MFQQ is available in two versions: the original English version, consisting of 163 Items, covers basic items and specific items of special interest for single partner hospitals. A short German form consisting of 67 items was developed in the framework of an initiative of the Austrian Ministry of Health (Karl-Trummer, Schulze, Krajic et al. 2006).¹⁹

The results were used to monitor the project’s progress and to allow for benchmarking within the group of participating hospitals. The MFQQ was used for two assessments (2003 and 2004) within the 12 European Partner Hospitals.

The main dimensions of monitoring at the Service level included:

1. Interpreting services available at the hospital
2. Information for hospital access and information in hospital
3. Hotel services
4. Medical/nursing treatment
5. Discharge Management
6. MF patient education/health promotion/empowerment

18 Available via the MFH website www.mfh-eu.net and the website www.hph-hc.cc.

19 Both forms were included in the Manual for Swiss Health Care Institutions (Saladin et al. 2006).

At the level of facilitating quality structures, the main dimensions included:

1. General quality systems in hospitals
2. MF budget
3. Written MF policy
4. Management Structure
5. Marketing of MF
6. MF training and education for staff
7. Monitoring of migrant clientele
8. Partnerships and partner alliances

One central result was that monitoring itself makes a difference. The process of using the MFQQ and discussing the results fostered awareness of crucial elements of organisational structures and processes. It also provided directions of where to go and created energy for change. Some hospitals used the results of the first assessment as an engine for further action. They integrated migrant-friendliness criteria into their strategy development (definitions of common values, EFQM self-assessment, strategic aims and Balanced Scorecard), improved hotel and religious services for an ethnically diverse clientele, and implemented adequate information material (translation of relevant information about the department, discharge and follow-up procedures, improving signposts using pictograms).

Results of the second assessment after one year of project work also showed that considerable progress is possible in a rather short time-frame. One project hospital used the dynamics of the European project to implement a comprehensive interpreting service practically “from scratch”. Changes related to engagement in thematically focused “sub-projects” of the MFH project were apparent in all the hospitals. These sub-projects were defined on the basis of the results of the needs assessment, the first MFQQ assessment of structures and quality systems, and the review’s identification of the most common problems and solutions.

Three Implementation Areas: Communication, Client Empowerment and the Cultural Competence of Staff

Based on the results of the needs assessments, the literature review on problems and promising interventions and the MFQQ assessment, the partners decided to systematically work on improvements in three specific intervention areas:

- Facilitate communication: improve the interpreting services
- Empower clients: migrant friendly information and training for mother and child care
- Facilitate understanding: staff training towards cultural competence.

Three so called “sub-projects” were started in these three intervention areas. Hospitals chose to participate in one or more of the sub-projects according to their problems (indicated by the results of the needs assessment) and available resources. Development and planning was started in European Sub-groups, managed by LBISHM as the project co-ordinators and supported by international experts. The European project level developed fact sheets and pathways for the implementation of common solutions and provided materials, such as manuals and guidelines, developed outside the project.

In view of the limited time-frame, these instruments could thus be used for both local planning and implementation in a soft benchmarking approach and allow for local adaptation. Evaluation design and instruments to assess the implementation of interventions (and where possible their effects) were either developed or adapted from international examples provided by the European Sub-groups and used at local level. The Sub-groups also served as a social framework for benchmarking and mutual consultation in the various stages of implementation and eventual joint assessment/evaluation. This mutual consultation took place in both face-to-face meetings and electronically, thus involving all the groups and the partner hospitals.

Sub-project A: Improving Interpreting Services in Clinical Communication

Patients that are non-local language speakers or who come from migrant populations or ethnic minority groups are not always able to communicate effectively with their clinicians to receive comprehensive information about their care. At the same time, clinical staff are not always in a position to understand the patients’ needs or to elicit other relevant information from the patient. Correspondingly, the MFH needs assessment results show that language and communication is regarded as the most important problem area when dealing with migrant populations and ethnic minorities in clinical routine.

Nine Pilot hospitals (DK, EL, ES, FI, IR, IT, NE, SW, UK) participated in this sub-project to improve clinical communication with migrant and ethnic minority patients, which had the following four aims:

1. Professional interpreting services should be made available whenever necessary to ensure good communication between non-local language speakers and clinical staff.
2. Patients should be informed which language services are available and how to obtain them.
3. Clinical staff need know how to how to work competently with interpreters to overcome language barriers and obtain better outcomes.
4. In addition, education materials for patients should be made available in non-local languages to assist with communication.

Measures were both developed and implemented to improve clinical communication through telephone interpretation, face-to-face interpretation, intercultural mediation and the use of written material as supporting communication. In a benchmarking evaluation design, a pre- and a post-intervention staff survey and patient survey were conducted. General evaluation results show that the implemented measures were effective:

- The rate of responses stating that interpreters were available in a timely manner (always or often) increased by 17%.
- Improvements were observed in all the defined quality indicators of interpreting services, such as the interpreter's introduction and role explanation, an accurate transmittance of information, the interpreter's clarification, clarification of cultural beliefs and the interpreter's identification of patients' further needs.
- The overall rating of interpreting services improved, with the number of responses rating them as either excellent or very good increasing from 26% to 47%.
- 55% of staff members identified an improvement in their work situation as a result of the measures implemented in the context of the sub-project.²⁰

Sub-project B: Migrant Friendly Information and Training in Mother and Child Care

Mother and child healthcare for migrants and ethnic minorities has been highlighted as an area of particular concern for health policies and programmes, since the birth rates of migrant populations are significantly higher and the incidence of health problems among mothers and their children is also above average. Improvements in the health of mothers and children require a high level of awareness among the parents-to-be concerning which services are available, what is important in pre- and postnatal

²⁰ For a more detailed description see Novak-Zezula, Schulze, Karl-Trummer and al. 2006.

care and which behaviour is relevant for the health of both mother and infant. The importance of awareness and self-management ability - by raising health literacy levels and increasing their ability to act – makes the empowerment of clients a key intervention.

Sub-project B aimed at empowering women and families in parental care by providing culturally adequate information and training programmes. Six hospitals (AT, IT, FI, NL, SP, UK) developed information materials such as brochures and videos, and, on the basis of a needs assessment conducted among migrant women about what kind of information they felt they needed concerning pregnancy and early motherhood, also provided training courses tailored to meet these needs. The courses and information materials were developed in line with four quality dimensions: (1) appropriate access to services, (2) relevant information, (3) culturally sensitive design and format of information, and (4) an empowering and culturally sensitive relationship between providers and clients.

Evaluations showed that women who attended the courses and used the information material were very satisfied with all the quality dimensions and experienced a remarkable improvement in their knowledge. Access is an issue that needs to be worked on further, however, because even though the courses were free of charge and women were supported by various measures including child care, participation rates were low. One hypothesis is that influence from husbands and/or family, who often decide whether such courses are taken or not, might have led to low participation rates. Further development should therefore take the important role that men play in mother and child care into account.²¹

Sub-project C: Staff Training in Cultural Competence: enabling hospital staff to better handle cross-cultural encounters

Within the framework of the MFH project, a lack of cultural competence among hospital staff – identifiable as cultural unawareness and misunderstandings and prejudices that inhibit communication – was identified as a significant problem by the needs assessments in the participating European hospitals. On the basis of a systematic review of international literature, the solution chosen to help to solve this problem focused on an intervention in which a staff training course was held to improve cultural competence. This intervention is widely acknowledged by experts as a quality improvement measure for healthcare services. Training courses are widely practised, especially in classical immigration countries like the USA, Canada and Australia. The aims of this intervention include improving hospital staff's awareness, knowledge, skills and comfort levels relating to the care of a diverse patient community.

²¹ For a more detailed description see Karl-Trummer/Krajic/Novak-Zezula et al. 2006.

Nine pilot hospitals participated in the staff training project (AT, DE, ES, FR, IR, IT, NL, SV, UK). Several tools – a fact sheet, a pathway and modules for implementation and instruments for evaluation – were developed by LBISHM in collaboration with experts (all the tools are outlined in this report). Results and experiences are summarised according to 5 criteria (for details see the evaluation report and the keynote speaker presentations at the final conference):

- Feasibility could be demonstrated; acceptability among staff varied in the hospitals but altogether a total of 149 staff members participated.
- Quality was operational in terms of the following dimensions: content, structure, number of training units, qualification of trainers, composition of participating staff, management support, systematic needs assessment at the department level, integration in ongoing quality assurance, etc. Quality was measured as “conformity with the recommendations of the pathway” and, so defined, varied extensively, mainly due to a very narrow project time-frame that forced hospitals to rely on readily available resources.
- Effectiveness could be confirmed by improvements in the staff’s self-rated awareness, knowledge, skills and comfort levels concerning cultural diversity issues, as well as by increases in interest levels regarding cultural competence and in the staff’s self-rated ability to cope with work demands.
- Cost-effectiveness: while external training costs were low, developmental costs were rather high, despite personal costs being mainly covered through voluntary work.
- Sustainability: training was recognised as an effective way of equipping staff with important competencies and although this will be continued, it will be modified in all the participating hospitals.²²

Prioritising the Issue on European Agendas: The Amsterdam Declaration

In December 2004, European recommendations for a migrant friendly health policy at hospital level and for other stakeholders were launched as the “Amsterdam Declaration Towards Migrant Friendly Hospitals in an Ethno-culturally Diverse Europe”.²³

²² For a more detailed description see Krajic/Straßmayr/Karl-Trummer et al. 2005.

²³ On the occasion of the closing conference of the project, December 2004, Amsterdam.

The document starts with a summarised analysis of the current situation of hospital services for migrants and ethnic minorities in Europe and highlights quality-related problems for patients and staff. It assumes that improving quality for migrants and ethnic minorities as specific vulnerable groups would also serve the general interest of all patients in more personalised services, which is an issue high on the agenda of healthcare quality development and reform and especially the WHO Network of Health Promoting Hospitals. The Declaration argues that everybody would benefit if hospitals became more responsive to the ethnic, cultural and social differences of patients and staff.

In the second part of the Amsterdam Declaration, recommendations are made for specific contributions from the main stakeholders - hospital management, hospital staff and professional associations, health policy and administration, patient and migrant/minority organisations and the health sciences. The Declaration was welcomed at the MFH project's closing conference by a large number of European and international organisations: the European Commission, DG Health and Consumer Protection, WHO Centre for Integrated Care (WHO), International Labour Organisation (ILO), International Organisation for Migration – IOM, International Alliance of Patients' Organisations (IAPO), Standing Committee of the Hospitals of the EU (HOPE), International Union of Health Promotion and Education (IUHPE), Migrants Rights International, United for Intercultural Action, PaceMaker in Global Health. Partners expressed their expectation that the Amsterdam Declaration would serve as a European platform for improving hospital and healthcare services for migrants and ethnic minorities.²⁴

Supporting Sustainability and Facilitating Ongoing Networking: The WHO Task Force on Migrant Friendly and Culturally Competent Healthcare within the Framework of the WHO Network of Health Promoting Hospitals

In order to sustain the European momentum created by the MFH project, a Task Force on Migrant Friendly Hospitals has been established within the WHO Network of Health Promoting Hospitals (HPH). The Task Force brings together practitioners, managers, scientists and community representatives with specific expertise and competence in policy-relevant knowledge in the field. It aims at keeping the issue on the agenda of the HPH network by providing inputs at workshops and conferences at European, national and local levels. It also aims at the development of specific tools

²⁴ The final text is available in this report in eleven European languages (German, Greek, Danish, Spanish, Finnish, French, English, Italian, Dutch, Swedish and Portuguese): http://www.mfh-eu.net/public/european_recommendations.htm.

(like the MFQQ form) that help the implementation and evaluation of policies, services, research activities and practices addressing migrant friendliness/cultural competence issues at the local, national and European levels. The Task Force is coordinated by the Emilia-Romagna Network of HPH, represented by the Health Authority of Reggio Emilia.

Concluding Remarks

For a migrant and ethnically diverse population, healthcare is not only influenced by political or culturally defined social frameworks on the one hand and individual preferences and skills on the other. The organisational level plays a major role and thus has to be specifically addressed. The MFH project has demonstrated that healthcare organisations will take action if they understand that cultural diversity and migration related issues impact on their core processes of healthcare delivery. Consequently, this should lead to changes in the self definition of the organisation and account for the inclusion of cultural diversity in the organisation's vision and quality criteria for monitoring and improvement.

APPENDIX: The Amsterdam Declaration: Towards Migrant Friendly Hospitals in an Ethno-culturally Diverse Europe (December 2004)

Migration, diversity, health and hospitals

Migration, ethno-cultural diversity, health and health care are closely inter-linked in many ways. Due to worldwide migration, globalisation and also European enlargement, European communities are becoming more and more diverse on the local level as well.

The health status of migrants and ethnic minority groups is often worse than that of the average population. These groups are more vulnerable, due to their lower socio-economic position, and sometimes because of traumatic migration experiences and lack of adequate social support. Thus, it seems only rational that human rights activists argue that access to health care services must be seen as a basic right for everyone and that they are supported therein by international conventions (e.g., the International Convention on the Elimination of All Forms of Racial Discrimination and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families)

Even beyond this human rights aspect, increasing diversity is an important quality assurance and development issue for health systems and services.²⁵ Minority groups are at risk of not receiving the same level of

²⁵ World Health Organization (WHO): Report International Migration, Health and Human Rights, Iss.No.4, 2003.

health care in diagnosis, treatment and preventive services that the average population receives. Health care services are not responsive enough to the specific needs of minorities. There are many challenges facing both service users and providers. Examples include not only language barriers and cultural diversity, but also scarcities in hospital resources and low levels of minority purchasing power and entitlements. All this poses new challenges for quality assurance and improvement in health services especially for hospitals which play a particularly important role in serving this segment of the population (Bischoff 2006).

Lower levels of health literacy among migrants is also relevant, especially as concerns the appropriate use of health care systems. Migrants in Europe often lack information about available hospital and ambulatory care services or about general health matters in the specific context of European societies. This is one of the reasons migrants often give for not using health services effectively and for not taking action themselves to prevent illness.

The current situation is thus one which poses challenges to hospitals and their staff, a staff which is itself at the same time becoming more diverse, thereby presenting an opportunity, a resource and an additional challenge for hospital organisations.

To work on these challenges, a group of hospitals from 12 European countries came together as Pilot Hospitals to participate in the Migrant-Friendly Hospital project (for details see below). National and regional networks of the WHO Network of Health Promoting Hospitals (HPH) played an important role in bringing the partners from Austria, Denmark, Finland, France, Germany, Greece, Ireland, Italy, the Netherlands, Spain, Sweden, and the UK together. They represent a wide range of hospital types, from large metropolitan University teaching hospitals to small-town community hospitals, with public and with private, non-profit ownership. Some of the partners had already had a long-standing record in serving diverse communities before the project, some of these communities being rather well-established and homogeneous, others being very diverse and comprised of a large number of undocumented migrants. Some partners serve their communities in the context of a rather well-integrated health care system, others have had to cope with rather fragmented structures.

The project received financial support from the European Commission and the Austrian government. European and international organisations joined the initiative as supporting partners (see list at the end of this document).

Project partners agreed on basic principles to be at the core of a Migrant-Friendly Hospital mission statement: valuing diversity by accepting people with diverse backgrounds as principally equal members of society; identifying the needs of people with diverse backgrounds and monitoring and developing services with regard to these needs; and finally, compensating for disadvantages arising from diverse backgrounds.

Based on a needs assessment, the project was able – despite the diversity of health care systems and local situations in European hospitals – to identify many common problems for migrants/ethnic minorities and staff.

For selected issues, knowledge-based solutions were successfully implemented and evaluated in the areas of interpreting, cultural competence training for hospital staff, and empowerment in mother and child care.

The Pilot Hospitals also aimed at generally improving their diversity management by developing their organisational structures and cultures to become migrant-friendly and culturally competent organisations. For the partners, becoming a (more) “migrant-friendly” organisation proved feasible but not trivial: many stakeholders must contribute to these change processes. Project results and tools are available at www.mfh-eu.net.

In order to guarantee the sustainability of the initiative a “Task Force on Migrant-Friendly Hospitals” was set up in the framework of the Health Promoting Hospital Network of WHO Europe. This task force will serve as one focus for further initiatives, organise workshops, maintain the MFH website and conduct other activities.

Recommendations

Based on the experiences of the MFH project partners, international discussions and the scientific literature, the following crucial points for the successful development of services and organisational cultures can be identified:

- 1.1. Developing a migrant-friendly hospital is an investment in more individualised and more person-oriented services for all patients and clients as well as their families.
- 1.2. Increased awareness will be needed of migrant population experiences and existing health disparities and inequities, including those that are gender-related, leading to changes in communication, organisational routines and resource allocations.
- 1.3. Focusing on ethno-cultural diversity implies the risk of stereotyping – but migrant status, ethnic descent, cultural background and religious affiliation are just a few of the many dimensions of the complexity of human beings.

- 1.4. Developing partnerships with local community organisations and advocacy groups who are knowledgeable about migrant and minority ethnic group issues is an important step that can facilitate the development of a more culturally and linguistically appropriate service delivery system.

Like any other form of organisational development, the success of becoming a “migrant-friendly” hospital willing and able to serve its diverse communities in an equitable way will depend on the complementary contributions of a number of different stakeholders.

Hospital owners / Management / Quality Management

Hospital owners, management and quality management should put the quality of services for migrants and ethnic minorities on the agenda of hospital organisations:

- 2.1. It will be important to define aims and objectives (mission, vision and value statement, policies and procedures)
- 2.2. Adequate resources (working time, financial resources, qualification) must be provided if changes are to be realised.
- 2.3. An organisational development process should be initiated, supported and monitored by leadership, management and quality management.
- 2.4. As an important step, the needs and assets of stakeholders – users (patients, relatives, community) and providers (staff) – should be monitored.
- 2.5. Outcomes as well as the structures and processes that influence outcomes should be monitored.
- 2.6. Concerns, complaints and grievances related to service delivery should be tracked and appropriately addressed.
- 2.7. Investment in capacity building with regard to staff’s cultural and linguistic competence is needed (selection, training, evaluation).

Staff / Health professions

Hospital staff and the professions and professional organisations of which they are part should acknowledge that the issues are relevant and they should be prepared to invest in achieving competency.

- 3.1. An important step will be to find consensus on criteria for migrant-friendliness/cultural competence/diversity competence adapted to their specific situation and to integrate them into professional standards and enforce that they are realised in everyday practice. The principles applied in the MFH project can serve as starting point for this development.

- 3.2. Professionals and other staff will have to build capacities concerning cross-cultural and communicative and diversity-related competencies
- 3.3. Clinical practice, preventive services and health promotion action should be appropriately tailored for use with diverse populations. Preventive services and health promotion that rely strongly on communicative interventions are especially dependent on the cultural and linguistic competencies of professionals if they are to be effective.
- 3.4. Taking the literacy and health literacy of users systematically into account at all levels of services will be an important prerequisite. This implies monitoring, the development of adequate orientation systems/information material as well as patient education programmes.
- 3.5. Potentially traumatic migration experiences mean that heightened awareness of mental health issues is important in hospital care for migrants.

Users (actual and potential patients, relatives) / Representatives of community groups

Patient organisations and community groups can make most important contributions to the process by putting diversity and health and health care on their respective agendas.

- 4.1. Patient organisations should incorporate the diversity of their clientele into their strategies and policies and should act as advocates for these diverse patient populations.
- 4.2. Migrant/minority community representatives can contribute not only by advocating but also by mediating. They should act as advocates for adequate access to and quality of services, and they should also become agents for the development of greater health literacy within their communities.
- 4.3. By investing in improvements in their health literacy, all members of migrant/minority communities can contribute to their own better health and better use of health services.

Health policy and administration

Health policymakers and administration are responsible for quality standards in health care and have the final responsibility for the health of the population in their geographical areas of authority. In most countries, they are also responsible for financing health care services and are thus also interested in the effectiveness and efficiency of these services.

- 5.1. Health policy should provide a framework to make migrant-friendly quality development relevant and feasible for each hospital (legal, financial, and organisational regulations).
- 5.2. A framework for health-oriented community development for migrants and ethnic minorities has the potential to be most helpful in developing these groups' health literacy.
- 5.3. Policy and administration have an important role to play in facilitating knowledge development – for example in initiating and funding research, reviews, standards development and dissemination (networking, education, exchange of experience).

Health sciences

Scientific knowledge and expertise can be very helpful in the process. By moving diversity issues in health and health care higher up on their agendas, by including them in their theory-building and the development of systematic evidence, health science disciplines can make important contributions.

- 6.1. Ethnic and migrant background information should be included as a relevant category in epidemiological, socio-behavioural, clinical, health service and health system research.
- 6.2. Scientific experts should be prepared to assist other stakeholders in planning, monitoring and evaluating their efforts by providing reviews, assessment tools, designs and tools for evaluation.
- 6.3. Scientifically based efforts can contribute to combating racism, prejudice, discrimination and exclusion by providing information on the negative consequences of these processes.
- 6.4. Participatory, multi-method research and evaluation efforts should be carried out in partnership and consultation with communities.

All European hospitals are invited to implement the Amsterdam Declaration, become migrant-friendly and culturally competent organisations and develop individualised, personal services from which all patients will benefit. Investments in increased responsiveness to the needs of populations at risk will be an important step towards overall quality assurance and development.

Further contact / Opportunities to communicate and collaborate

- Task force in the Health Promoting Hospitals Network of WHO Europe, co-ordinated by HPH Regional Network of Emilia-Romagna, Antonio Chiarenza, Via Amendola, 2 – 42100 Reggio Emilia, Italy
Email: Antonio.chiarenza@ausl.re.it

- Website: www.mfh-eu.net
- Bradford Teaching Hospitals NHS Foundation Trust, Dilshad Khan, BRI, Duckworth Lane Bradford BD9 6RJ, United Kingdom, Email: dilshad.khan@bradfordhospitals.nhs.uk
- International Union for Health Promotion and Education (IUHPE), John Kenneth Davies and Caroline Hall (IUHPE Europe), Falmer, BN1 9PH Brighton, United Kingdom Email: J.K.Davies@bton.ac.uk, caroline.hall@brighton.ac.uk
- Pharos, Evelien van Asperen, www.pharos.nl, Email: e.asperen@pharos.nl

Who developed the Amsterdam Declaration?

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Project Co-ordinator: Ludwig Boltzmann Institute for the Sociology of Health and Medicine (LBISHM) at the University of Vienna, Faculty of the Social Sciences, WHO Collaborating Centre for Health Promotion in Hospitals and Health Care²

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²⁶ Alexander Bischoff (Basel), Sandro Cattacin (Neuchatel/Geneva), Julia Puebla Fortier (Geneva), Ilona Kickbusch (Bern), Robert Like (New Brunswick), Lourdes Sanchez (Boston). Thanks also go to other experts that contributed to the project with support and advice, like Anita J. Arnold (Doylestown, Pa.), Shani Dowd (Boston), Susan Auger, Ines Garcia Sanchez, Caroline Hall, Evelien van Asperen and many others.

MIGRANT FRIENDLY HOSPITALS

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CHAPTER III

COPING WITH PRECARIOUS HEALTH SYSTEMS

COPING STRATEGIES OF VULNERABLE MIGRANTS: THE CASE OF ASYLUM SEEKERS AND UNDOCUMENTED MIGRANTS IN SWITZERLAND

Milena Chimienti and Christin Achermann

Migration, vulnerability and health; these are the three variables that concern us within the framework of this study²⁷. This interest in the health of migrant populations in a precarious residential situation, be they from the network of asylum seekers or undocumented migrants, finds its origins in two primary observations, namely, the acute vulnerability of asylum seekers and undocumented migrants due to the uncertainty of their situation, and the moral health economy which guides the current administration in migration management and influences migrant groups' living conditions in Switzerland.

Moral Health Economy

For many years migrant populations were recruited specifically for labour purposes. Their value was determined by their work-force potential and any physical weakness was thus perceived as a potential lack of earning power on the part of the migrant. Similarly, it has recently become apparent that health, or more precisely illness, has assumed special significance. This is illustrated in the work of Didier Fassin: "Pathology arouses suspicion and becomes a source of social recognition" and "the body holds sway", to use the title of his own work (2001:7). Under certain dire circumstances and where there is no possibility of the person being treated in their country of origin, the body, or to be more precise, the sick body, facilitates the acquisition of an entry visa on humanitarian grounds. This opens the door to similar arguments for allowing the admission of migrants, such as the miserable living conditions in their countries of origin. In addition to the possibility of obtaining a provisional permit of stay on the humanita-

²⁷ This study was financed by the federal office of public health in the frame of national Migration and Public Health Strategy 2002 - 2007. (Ackermann and Chimienti 2006).

rian grounds of an individual's health status, access to healthcare for migrant populations has become the sole aspect of the debate surrounding admission that cannot be publicly questioned. In other words, the sick body and its need for treatment can determine the right to stay and influence both living conditions and social integration.

In order to understand this situation in its various facets, it is important to specify that not all migrants are affected by this phenomenon in the same way. Indeed, it is relevant primarily for those people whose presence and integration are not favoured by the state, in this case those – be they asylum seekers or undocumented migrants – who have entered the country without a valid work or residence permit and whose presence in the country is therefore perceived as provisional or in some way irregular and precarious. Such increased focus on the health of migrant people comes at a time when the politics of admission have become progressively more restrictive across the whole of Europe; a phenomenon that has effectively served to increase the number of people migrating illegally or having to face uncertain legal situations. In Switzerland, this has increasingly been the case since the introduction of the so-called “Two Circle Model” at the beginning of the 1990s and the federal order of 1998 (still in place) on the measures of urgency in the domain of the asylum and migration of foreign nationals. Since then it has become even more difficult for non-EU and non-EFTA migrants to obtain a permit of stay in Switzerland. At present, for example, only highly qualified people can expect a positive response to their permit applications. As a direct consequence, clandestine forms of migration have increased, notably in order to circumvent these legal barriers. Another form of irregular migration of foreign workers can be directly connected to the politics of “The Two Circles”. More numerous and diverse than the irregular migrants of the 1970s - that in the main were the wives and children of seasonal migrant workers moving illegally to join their husbands - the undocumented migrants of the 1990s were principally either seasonal workers who overstayed their visas (“overstayers”) or newcomers who had never obtained legal permission to enter the country. Since the introduction of new restrictions relating to the admission of asylum seekers in 2002, refused asylum seekers have joined the burgeoning ranks of undocumented migrants (“new overstayers”). Although certain authors assert (Longchamp 2005) that their presence among the so-called *sans papiers* (undocumented migrants) is minimal, it is fair to assume that increased restrictive measures are leading to a rapid increase in their numbers. The number of people without a permit is currently estimated at around 100,000 (Piguet and Losa 2002; Longchamp 2005). In addition to the migration of foreign workers - whether clandestine or legal - Switzerland has noted that since

1990 the number of people seeking asylum has increased. At the end of 2004, for example, some 79,000 asylum seekers were living in Switzerland.²⁸ More than two thirds of these were individuals seeking asylum, of which 23,000 were admitted provisionally (permit F). Furthermore, 17,000 of these migrants were classified as asylum seekers (permit N), 14,000 of whom had their applications refused. The remaining third consisted of 24,000 recognised refugees (BFM 2005).

In terms of age, gender and geographical origin, very diverse profiles have emerged from these new forms of migration that contrast sharply with previous migrant populations mainly composed of healthy, single young men who came to Switzerland to look for work. We now find that many of the health problems are associated with the family. Furthermore, and according to various studies, these health problems are specifically associated with the precarious nature of the new migrants' presence in the host country. In general, the health status of those migrants without legal authorisation to reside in the country is worse than that of the native population and that of more stable migrant groups (for information about permits B and C; see Weiss 2003:112 and 240-258).

Increased Vulnerability

The observation of a difference in morbidity and accumulated risk (compounded effects of multiple risks or situational hazards) in this population can be explained using different factors that distinguish the situation of undocumented migrants and asylum seekers from that of the more stable resident population. Firstly, these two populations experience different levels of vulnerability of varying nature and consequence. In part these are social and economic, and partly related to the migration process and the challenges linked to migrants' legal residential status. While this precariousness and its consequences have often been described in a general way, we have little information regarding the specific challenges faced in this framework. Pauperisation, instability, the breakdown of social structures and future prospects (Bourdieu 1998), and social exclusion (Castel 1995), are elements generally associated with people living in marginal and precarious situations relevant to our study. Otherwise, it can be assumed that they incur greater health risks as a result of contextual factors related to an inadequate recourse to curative and preventive care, and problematic living conditions resulting partly from legal restrictions related to their resident

28 The people included in the broader "sphere of asylum" (this is the expression used by the Federal Office of Migration) include those in possession of N and F permits, as well as refugees recognised as such by "immigration services". In its usage here, the term "asylum seeker" applies as much to people admitted provisionally (permit F) as to asylum seekers (permit N).

status. Finally, we assert that many individual situational factors (e.g. social and economic status, socio-demographic factors and health awareness) are also likely to facilitate their heightened exposure to and risk of illness. This analysis provokes the following questions:

- What possibility is there for individuals living in a precarious situation to maintain or improve their health?
- What role do contextual factors play (e.g. access to state or private support, legislation and cantonal practices in relation to residential status, living and working conditions, etc.) in comparison to individual factors (e.g. social and economic status, gender, age, geographic origin and health awareness) with regard to risk-taking and self-preserving behaviour?

The aim of this study is to identify the means and capacity of vulnerable people to confront and mitigate the problems they face in specific migratory contexts. In the cases of the vulnerable groups in question, are the classic health determinants, such as social and economic status, of equal significance? Or do other migrational factors come into play? The comparison of these groups across two regional and legal contexts, one with and one without legal authorisation, allows us not only to identify the similarities but also the differences between these groups. In effect, the fundamental difference between these two migrant groups lies in their legal migration status: one possesses a permit, albeit provisional, while the other resides illegally in the host country. We assume, based on their resident status, that these two groups experience disparate degrees of vulnerability. We presuppose that the first group should have an advantage over the second group whose presence is regarded as illegal by the authorities. This study seeks to examine this hypothesis by observing the effects that the possession or non-possession of a legal residence permit has on these respective migrant groups.

Methodology

In this study we have chosen to examine the situations of people admitted provisionally (permit F)²⁹ and people without authorisation (the so-called

²⁹ The provisional admission (called the F permit of stay) is a measure of substitution which aims at provisionally admitting people who cannot to go back to their country of origin for different reasons into Switzerland. Humanitarian reasons for this include the fact that going back to their country could be dangerous for them for one reason or other. In this sense, Switzerland's criteria for recognising refugees are more restrictive than those of the Geneva Convention of 1951. This permit of stay was created in the 1980s and started to be granted in the 1990s, particularly to refugees from the former Yugoslavia that had been subjected to violence; something which corresponded to the Geneva Convention. Because of its provisional status, this permit of stay includes restrictions that limit the possibility of integration: access to the labour market is only possible

sans papiers or undocumented migrants). Although the former group has been granted legal permission to stay in the host country, their situation is nevertheless characterised by a high degree of uncertainty, which allows us to compare their case with that of the latter group of undocumented migrants. In effect, both these two groups face similar difficulties in their daily life in Switzerland, which are in turn linked to their residential situation: long term uncertainty of their resident status, low social and economic status, restricted geographical mobility, etc.

The two chosen areas of study are the cities of Geneva and Zurich. According to the available literature, while each comprises large numbers of both groups when compared with other Swiss cantons, there is a marked difference in the way in which the respective local authorities deal with them (Achermann and Efonyi-Mäder 2003), which allows us to estimate the importance of the legal or authoritative context on health seeking behaviour.

Qualitative methods, in the form of comprehensive interviews, have been used in our study. Sixty-three migrants originating from three different geographical locations (Africa, Albanophone regions and Latin America) were interviewed for an average of two and a half hours each.

In addition, thirteen semi-structured interviews with key personnel representing the authorities, social workers, health professionals and others were conducted.

Principal Risk Factors

These interviews made it possible to identify a group of risk factors relative to daily life that have a direct bearing on the health of the migrant people interviewed. As thought, the precarious nature of the situation in which the two groups find themselves provokes one of their most significant concerns: the fear of a sudden, forced return to their country of origin. This fear was expressed in all the interviews, although varied in intensity according to the gravity of the prevailing situation in the interviewed person's respective country, the length of time spent in Switzerland and the migrant's personal reasons for migrating. The insecurity of their resident status not only affects the whole of their daily lives, but also their future plans. Furthermore, their sense of uncertainty of being able to reside in Switzerland on a long-term basis means their prospects and actions are geared towards the short-term.

if such migrants are not in competition with the Swiss; during their stay in Switzerland they are not allowed to leave the country (we interviewed people who haven't seen relatives in their country of origin or in any other host country for more than ten years); they have no right of family reunification; their social assistance entitlement is lower than that of other residents, etc.

This can further help to explain their inability to consider their own future; something that also negatively affects the individual's health status (somatic health above all) and has a considerable effect on their health prospects once a problem arises.

As a result of this acute concentration on the present, these people subsequently become preoccupied with the more immediate and urgent questions in their lives. For the undocumented migrants this signifies that financial investment (e.g. medical insurance) in their health represents a luxury - as long as their capacity to work is not threatened.³⁰ The situation of certain interviewees appeared even more difficult in that it was as though their lives were on hold, thus leaving them in a position of standby.

The more the uncertainty was prolonged, the more the negative effects increased. The limitations (with regard to the possibility of leaving Switzerland, to develop social bonds, to save money, and to have general control over their lives) that individuals in each group face in their daily lives have serious implications for their well-being. People coming from the sphere of asylum (people admitted provisionally and those having already been refused asylum but who stay on illegally in Switzerland) adopt a passive attitude in the face of these various structural limits, and consequently tend to delegate the responsibility for their own health to a third party. The absence of a structured activity on one hand, and a source of revenue on the other, constitutes a serious risk for these people. Those who are admitted provisionally do benefit from some financial assistance, but complain about the lack of activity that would provide structure to their daily lives and means of social inclusion. Undocumented migrants without any paid work and in an urgent financial situation are preoccupied by fundamental needs such as provisional accommodation and food. In order to meet these needs, they are largely dependant on private support.

Resources and Coping Strategies

Although people admitted provisionally and those without authorisation to stay encounter difficulties, the majority manage, albeit in differing proportions, to mobilise their resources and develop coping strategies that minimise the risks (see Lazarus and Folkman 1984). In the best-case scenarios these risks are diminished by means of these strategies, which in turn help to keep them from becoming discouraged. The following factors appeared to be the most significant according to the people interviewed: relative stability and normality achieved, for example, by long-term living

³⁰ The Swiss health care system is insurance based. Every resident – and this includes undocumented migrants – is obliged to be affiliated to a medical insurance. The insurance companies have no right to refuse somebody on the basis of their legal situation, period of stay, or state of health.

arrangements; a place of work; a regular income; a social life; access to practical information; and a linguistic capability that would facilitate their life in Switzerland.

In addition to providing financial resources, an income generating activity gives both structure and meaning to one's daily life. Being able to support the family still living in the country of origin by sending regular contributions reinforces their self-esteem and gives meaning to their sacrifices in Switzerland. It also generates social bonds and the possibility of better social integration. The family, and in particular the children (either in Switzerland or in the country of origin), provide an emotional base as well as a sense of the difficulties endured during migration. Moreover, when living in Switzerland the family can represent practical support with regard to accommodation, the search for structured activity and financial help. Religious faith has often been cited as a source of hope and patience in relation to the vulnerability experienced in a precarious situation. The feeling of being recognised by the society in which they live, and having some kind of goal or prospect of improvement in their living conditions (in the long term), even if only through a paid activity, mean that these people can gain control over their own lives (see internal locus of control Rotter 1966) and in so doing, manage their own well being. If the migrants are unwanted or rejected in some way by the host society, their structural resources will obviously be less developed than those of the rest of the population. They are restricted to those offers of support and care that specifically relate to the undocumented population and to those occupations and integration possibilities accessible to those admitted provisionally. Although this kind of assistance does not exist in all regions, it still represents a level of support conducive to avoiding a downward spiral into crisis and to improving the feeling of recognition.

A Typology of Vulnerability

In terms of risk and structural/individual sources of support, an analysis of the living conditions of both groups leads us to consider four situations (see figure 1). The principal distinguishing factors for these different groups come, on one hand, from the migratory status of the individual (F permit or undocumented) and from the individual's engagement in any income generating activity on the other. From these determining factors we have been able to distinguish four behavioural types - determinist, anomic, fatalist and actor - that allow us to better understand the development or lack of development of health-related behaviour and the resulting strategies.

Voluntarist (provisionally admitted asylum seekers with gainful employment): The people in this group manage to use their provisional

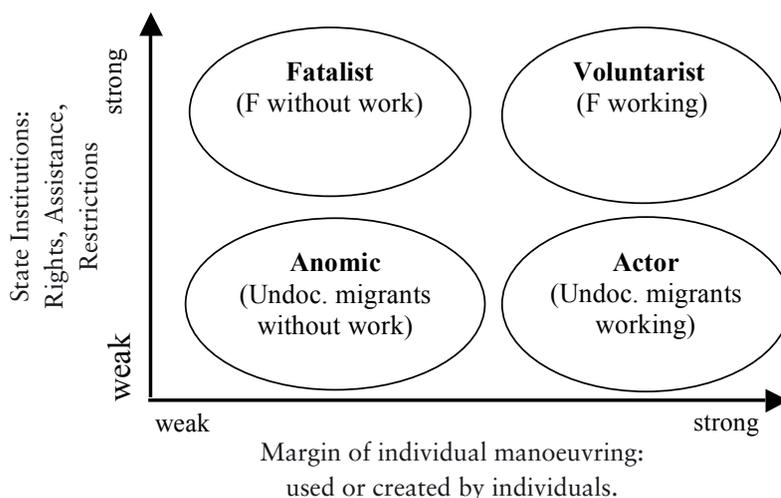
permits in Switzerland to their advantage, despite the considerable limitations imposed. Even though this group constitutes a minority in this study, in comparison with the three others behavioural descriptions, this type facilitates greater opportunity for the migrant in question. The benefits of the determinist position are extended from the economic aspects of their life in the host country to also encompass their health behaviour. Indeed, these are people who manage to develop behaviour that looks at health as more than the mere prevention of illness and a functional perspective of the body. They are not only prone to using available health services but also develop their own resources and coping strategies.

Anomic (undocumented migrants without work): Developed by Emile Durkheim, this concept is used to describe a situation where social norms and values are either missing or not understood and where people feel lost when faced with the choices they have to make. We are using this concept in its broader sense, making reference both to the situation and to the individual behaviour that ensues. This type emerges as a result of the inconsistency encountered by those who, having had the benefit of a provisional permit as asylum seekers and the accompanying rights, find themselves once again deprived of these rights once their provisional permit has expired or been revoked. Having been completely taken care of during their period of legal asylum, they are effectively denied the opportunity to develop the individual resources necessary to their autonomy. They now find themselves in a situation of anomie. Firstly, they are not very familiar with the rules of the society in which they live, which now denies them rights they were formerly afforded, and secondly, they feel propelled into a survival situation for which they are not equipped. In their case, health is considered a luxury they can't afford. In this situation of anomie, they are neither able to create nor put any health strategy into action.

Fatalist (provisionally admitted asylum seekers without work): This group consists of people who are implicated in some way in a structural framework from which they are at least able to draw the minimum resources (e.g. social assistance). Victims of a situation of which they are unable to take advantage, they are paralysed, on "stand by" and in the grip of the problems of the present. As in other aspects of their lives, these people adopt a passive attitude towards their health and allow themselves to be increasingly influenced by external events. As time passes they lose responsibility for their own welfare, which they delegate to a third party; (e.g. health professionals, the authorities, etc). In this way they do not develop a proper health strategy but limit themselves to using the health-care services available to them.

Actor (undocumented migrants with gainful employment): In comparison to the reactive manner (due to war or violence for example) of the deterministic behavioural type, actors are distinguished by the pro-active character of their migration. This type includes people who do not benefit from any structural support (or in any consistent way) and must rely on their own initiatives. In the majority of cases, and even before arriving in Switzerland, they know that they won't be able to rely on state structures and that they will have to adapt to their new living conditions quickly. With regard to their health, these people often adopt an attitude of prevention with the view to being able to pursue their daily activities, particularly those of a lucrative nature. They develop considerable health resources and mobilise daily health strategies. These strategies are usually applied to their present conditions, however, and don't take a more long-term consideration of their health into account.

Figure 1: *Risk and structural/individual sources of support – a typology*



Conclusions

This study of four migration situations where individuals are subject to legislative barriers leads us to observe that individual factors assume considerable importance in situations of extreme vulnerability. Individual resources become essential when structural support is limited to sector specific services, especially with regard to healthcare. In view of these findings we are obliged to question the resources of people living in vulnerability and exclusion. What is the public health literature referring to when using the term 'resources' and how are they defined? Our findings lead us to conclude that 'resources' seem to be a way of compensating for serious and immediate needs, rather than facilitating an individual's capacity to capitalise on a situation. Another obvious distinction concerns the short-term contribution/effect of these resources. At present we have no reason whatsoever to assume that what is positive in the context of this study will be positive in the future. Our study focuses on the circumstances of life in such uncertainty over a relatively short period of time; the people interviewed having resided in Switzerland for between 1 and 17 years. While confirming, today, the health damage suffered by migrant guest workers from the 1960s who are now reaching retirement age, how, we ask, do the migrants involved in this study perceive their own old age? Although our results clearly illustrate the need to embrace the migratory question beyond the sole issue of health, first recommendations can be concentrated on action that can be taken by political actors and decision makers active in this domain, while giving due consideration to the broader future of international migration.

STRATEGIES FOR OBTAINING ACCESS TO HEALTHCARE: THE CASE OF UNDOCUMENTED MIGRANTS IN SWEDEN

Ramin Baghir-Zada

The right of human beings to healthcare is addressed both at the national and international levels. An example of the latter is included in article 25 (1) of the Universal Declaration of Human Rights (1948), which affirms that:

[...] everyone has the right to a standard of living adequate for the health and well-being of himself [or herself] and of his [or her] family, including food, clothing, housing and medical care...

Despite the existence of international regulations concerning health standards, national legislation together with governmental policies nevertheless play a crucial role in determining which groups of people are covered by the national healthcare system and which are not. Undocumented migrants belong to an especially vulnerable group of human beings, since formally they either have limited access to healthcare or no access at all.

This article presents some of the preliminary results of a research project³¹ concerned with the healthcare situation of undocumented migrants in Sweden and their strategies for obtaining access to healthcare. Based on the empirical findings,³² the paper argues that (at least) three main aspects affect/shape the strategies of undocumented migrants in Sweden: ethnicity,

31 This is part of my Ph.D. research project on undocumented migrants and their access to healthcare in Sweden and the Netherlands.

32 So far, over ninety interviews have been conducted during the research in Sweden, of which more than forty were with undocumented migrants. The rest of the interviews were conducted with (1) representatives/members of immigrant associations; (2) representatives/members of religious institutions; (3) representatives/members of NGOs that deal with the support of asylum seekers (including their access to healthcare); (4) doctors, nurses, social workers and other medical professionals dealing with the healthcare of undocumented migrants, and (5) police and immigration authorities.

religion and NGO involvement. These three aspects are examined within the framework of individual characteristics versus external factors.

Undocumented Migrants in Sweden

The number of undocumented migrants in Sweden has not been officially calculated. It is difficult to even make a guesstimate. Perhaps the largest category of undocumented migrants is that of rejected asylum seekers; those who continued to live in Sweden illegally after the rejection of their asylum claims. In 2004, a total of 23,161 people applied for asylum; 10% of them were granted a residence permit whereas 27,876 asylum cases were rejected.³³ When an asylum claim has been rejected in full, the asylum seeker is supposed to either leave the country voluntarily or forcefully through deportation. The police authorities are responsible for the deportation of the rejected asylum seekers – undocumented migrants. As the figures from the Swedish National Police Board (Rikspolisstyrelsen) outline, in certain cases neither of the two options takes place, which means that rejected asylum seekers continue to reside in the country illegally. Up until 31 December 2004, the police authorities failed to deport 14,113 rejected asylum seekers.³⁴ This figure favours the assumption that there are significant numbers of undocumented migrants living in Sweden – even though it is still difficult to estimate their approximate number. Rejected asylum seekers are only one group of hypothetically undocumented migrants, however. Other groups include, for example, “overstayers”; those who did not prolong their residence permit (e.g. students, labour migrants); children of undocumented migrants who never migrated themselves but were born in the country; migrants who entered the country illegally and never “presented” themselves to the authorities (e.g. smuggled and/or trafficked migrants who entered the country illegally, have an illegal status in the country and never applied for asylum, etc). Statistics for these groups are also officially unknown, and even more difficult to trace.

Statement of the Problem

The hypothetical existence of undocumented migrants in Sweden as discussed in the previous section by definition raises questions connected to their undocumented status, such as access to housing, education, employment and healthcare, to name but a few. In this paper, analyses of the hypothetical existence of undocumented migrants in Sweden are narrowed down to the aspect of health. According to the interpretation/guideline of the

33 With reference to information obtained from the Swedish Migration Board (Migrationsverket).

34 With reference to information obtained from the Swedish National Police Board (Rikspolisstyrelsen).

authority responsible for the quality of health and dental care services in the country – The Swedish Association of Local Authorities and Regions (Sveriges Kommuner och Landsting, SALAR), “illegal immigrants” are only eligible for immediate (emergency) health and dental care, and have the financial responsibility of covering all the involved costs *after* the treatment has taken place.³⁵ What is meant by “immediate care” is not specified in the legislation and is therefore open to the interpretation of e.g. medical doctors. Whether a patient has to pay the fee before or after the treatment in cases of emergency is not specified in the legislation either, and is also subject to the interpretation and/or individual understanding of e.g. clinic officials. Considering the ambiguity of the legislation, and the restricted interpretation made by SALAR, the question at hand is how (if) undocumented migrants obtain access to healthcare in Sweden.

Underground “Clinics” and Health Networks in Sweden

During the research I located and examined two types of underground healthcare structures that assist undocumented migrants in Sweden: underground “clinics”, and underground health networks. Two underground “clinics” were visited several times; one located in Gothenburg (from hereon referred to as “UCG”), and the other in Stockholm (UCS). UCG and UCS have a similar structure of organisation. On one evening a week they gather a number of doctors and other medical professionals in one place and invite everyone who wants/needs to be treated. The UCG is hosted in one of the churches of Gothenburg, and the UCS in an apartment complex in Stockholm. In both cases the target group is undocumented migrants. Treatment is free of charge, and patients do not need to show any documents in order to be treated.

Apart from the underground “clinics”, there are also underground health networks, which consist of medical professionals who assist undocumented migrants at their own working places. Underground health networks in Malmö (UHNM) and Stockholm (UHNS) were examined during the research. Both networks function in a similar way. Undocumented migrants and/or people calling on their behalf, get in touch with the network by phone. The nurse responding to these phone calls tries to obtain as much information about the medical problem as possible. If there is an available doctor in the network, an appointment is arranged, which generally takes place at the doctor’s workplace – usually a regular medical institution. However, an undocumented patient is not charged any fee, and is only registered in the doctor’s medical journal, which means that the undocumented migrant cannot be traced by the authorities.

35 With reference to information obtained from The Swedish Association of Local Authorities and Regions (SALAR).

Health Problems of Undocumented Migrants

The research showed that psychosomatic and mental disorders were among the main health problems experienced by undocumented migrants. Almost all the interviewed undocumented migrants quoted “depression” together with anxiety and uncertainty as part of their everyday life. Aspects that they found disturbing generally related to their undocumented status, such as how to find a place to stay, how to find food, how to find a job, how to feed a child, how to receive medical treatment and what is going to happen “tomorrow”. In a study of legal asylum seekers in Sweden conducted by Brekke (2004), periods of uncertainty and waiting were also argued to affect mental health. However, one would expect to find more uncertainty among undocumented migrants who, unlike legal asylum seekers, have to hide from the authorities and are not eligible to receive any financial support from the state. Some interviewed undocumented migrants said they have regular nightmares. A large proportion of the interviewed undocumented migrants admitted to having mental health problems even before coming to Sweden,³⁶ but staying in Sweden and being undocumented had made it even worse (as they felt).

Interviews with medical professionals from all four “clinics” and networks showed the same tendency of psychosomatic and mental health problems being among the main health problems of undocumented migrants. Often, clinics and networks experienced a shortage of psychiatrists and psychologists, which meant that other medical professionals (e.g. gynaecologists) had to try to treat these disorders. In addition it was also noted that even doctors from other medical professions had to take the mental health conditions of undocumented migrants into consideration e.g. when prescribing medicine. As it was described by a UCG activist, doctors generally do not give large quantities of medicine to undocumented migrants but prefer them to come to the clinic each week to receive the same medicine. The reason behind this is the believed unstable mental health condition of undocumented migrants, which might lead to an intentional overdose and attempt to commit a suicide.

At the same time, mental health problems proved to be extremely difficult to treat. During my interviews with medical professionals, including psychiatrists, I was told that it is generally a lot more difficult to assist undocumented migrants with their mental health problems than any of their other patients. As the interviewed psychiatrists argued, the reason for this is that undocumented patients lack “stable grounds” by not having a stable legal status in the country. The ineffectiveness of the treatment of

³⁶ Some of them said they have been involved in or lived through a war and had been tortured and persecuted in their countries of origin.

their mental health problems was also argued by the undocumented migrants themselves. From their perspective, “pills” cannot treat the root of their problems, and it is the residence permit what they need the most to feel better.

Apart from psychosomatic and mental health problems, issues such as pregnancy, delivery and abortion have also been often encountered by the underground “clinics” and health networks. There have also been several cases of cancer. Problems related to dental care also proved to be common. In some cases, when it was not possible to contact a dentist to assist an undocumented migrant, other doctors tried to assist.

Survival Strategies: Ethnicity, Religion and the involvement of Non-Governmental Organisations (NGO)

As with any other group, undocumented migrants have both homogeneous and heterogeneous features. The former relates to the fact that undocumented migrants are human beings, have an undocumented status in the country they live in, lack formal access to unemployment and social welfare benefits, healthcare and the labour market. At the same time, like all other humans, undocumented migrants have individual characteristics, and can differ in terms of ethnicity, religion, class, country of birth, citizenship, family status or health conditions, and undoubtedly have different experiences of being undocumented. The latter is also certainly affected by external factors – factors imposed on undocumented migrants from without, such as governmental policies, community of co-ethnics, religious institutions, governmental and non-governmental institutions. So far I have distinguished the three main aspects that shape and affect the survival strategies of undocumented migrants in Sweden, including their attempts to gain access to healthcare:

- ethnicity
- religion
- NGO involvement

Ethnicity and religion are relevant to examine both as individual characteristics and as the basis of external factors (the role of community of co-ethnics and religious institutions). Logically, NGO involvement is an external factor in itself, which nevertheless is based on the individual characteristics of the people engaged in it. Besides, NGO involvement can also affect/be affected by the individual characteristics of target groups – in this case, undocumented migrants.

Ethnicity: What it is and what it does

Ethnicity and ethnic identities are applied in different contexts and defined differently by academia. Blumer (1986: 54) suggests the definition of an “ethnic group” as:

[...] a collectivity within a larger society having real or putative common ancestry, memories of a shared past, and a cultural focus on one or more symbolic elements which define the group’s identity, such as kinship, religion, language, shared territory, nationality or physical appearance. Members of an ethnic group are conscious of belonging to the group.

The last sentence of the above definition is of relevance in showing what ethnicity *does*, rather than what it *is*. The involvement of ethnic communities in the lives of newly arriving migrants (including undocumented migrants) has been outlined in many studies (Portes 1995; Kloosterman et al. 1999; van der Leun 2000 etc.). As my research showed, all the interviewed undocumented migrants have had at least some contact with their co-ethnics, which in a number of cases has directly/indirectly assisted in obtaining access to healthcare.

In certain cases, assistance from co-ethnics was limited to passing on tips, such as how to locate and contact an underground “clinic” or network. In other cases, assistance from co-ethnics was more direct, and included medicine, (free) medical treatment, moral support, accommodation, food, etc.

Overall, external factors based on ethnicity (the assistance of undocumented migrants by co-ethnics) are dependent on the undocumented migrants’ individual characteristics; individual characteristics that one is supposed to be born with, and cannot therefore be acquired.

Religion: What it is and what it does

Like ethnicity, religion is a very broad notion, and is consequently defined in very different ways by different scholars. For example, Rodney Stark (2004: 14) argues that:

Religion consists of explanations of existence based on super-natural assumptions and including statements about the nature of the supernatural and about ultimate meaning.

As in the case of ethnicity, it is relevant to my research to examine what religion *does*, rather than just to focus on what it *is*. Nevertheless, for the purpose of this paper it seems best to narrow the discussion on religion to Christianity and Islam, especially considering that the majority of undocumented migrants I have met have labelled themselves as either Christians or Muslims. Overall, religion proved to be an important aspect to examine.

Two main types of cases were distinguished:

- Cases when undocumented migrants were assisted by their religious co-fellows as a result of their (assumed) shared religious identity. This illustrates the *dependence* of the external factors (assistance from religious co-fellows, religious institutions, etc) on the individual characteristics of undocumented migrants - in this case, their religion.
- Cases when undocumented migrants were assisted by religious persons/institutions within the religious framework irrespective of the religious beliefs of the undocumented migrants. This illustrates the *independence* of the external factors (assistance from religious people/institutions) from the individual characteristics of undocumented migrants – their religion.

The first type related to e.g. several cases I have come across, where ethnic Swedes labelling themselves as “practicing Christians” assisted undocumented migrants on the grounds of their (assumed) shared religious identity. In those cases the undocumented migrants also claimed to be practicing Christians.

The second type related to e.g. the activity of the (Christian) church, which hosted UCG, the underground clinic in Gothenburg, and provided incoming undocumented migrants with free food and clothing irrespective of their religious beliefs.

In contrast to ethnicity, one can acquire a particular religion as an individual characteristic through conversion. Interestingly enough, I have come across several cases of undocumented migrants converting from Islam to Christianity. In some cases, conversions took place immediately following the rejection of their asylum claims.

NGO Involvement

Almost all the undocumented migrants studied had some kind of contact with NGOs. When talking about NGOs here I am borrowing the definition given by the World Bank as:

private [non-profit] organisations that pursue activities to relieve suffering, promote the interests of the poor, protect the environment, provide basic social services, or undertake community development (Maslyukivska 1999).

When talking about “organisations”, it does not necessarily just relate to a registered organisation but to non-registered associations as well. For the purposes of my research, it did not matter whether an organisation had

been officially registered or not. I have come across many NGOs all over Sweden that have been providing assistance to undocumented migrants. Some of them are international and world-known, such as Amnesty International, the Red Cross, Save the Children, Médecins Sans Frontières and Médecins du Monde. Other organisations are locally based and are less/not known internationally.

The type of assistance provided by the NGOs varied. Some NGOs directly provided medical assistance to undocumented migrants – as the description of underground “clinics” and health networks showed. Other NGOs indirectly provided medical assistance by either referring an undocumented migrant to an underground health network or clinic or trying to get an undocumented treated in a regular medical institution, or by a practitioner. When it comes to healthcare, many NGOs were also involved in spreading information about the existing conditions and problems of healthcare access of undocumented migrants, and fighting for their healthcare rights at different levels. In many cases, undocumented migrants were referred to NGOs by their co-ethnics, religious institutions or co-fellows. It has already been argued that NGO involvement is an external factor in itself. As the research showed, assistance of undocumented migrants by NGOs can be both dependent on and independent from individual characteristics of this group. Theoretically, many NGOs strived to assist *all* undocumented migrants, while in practice they often had to prioritise assistance of some undocumented migrants over others due to limited resources (both human and financial). Factors that led to prioritisation included the presence of children and situations of urgency, such as a total lack of money, not having anywhere to stay/sleep, or serious diseases. In contrast to religion, even though such individual characteristics can be acquired (one can become ill, one can spend or lose all the money one has), this is nothing that undocumented migrants will be expected to strive for. Besides, it might not be something that undocumented migrants will be physically able to acquire even if they wanted to.

Summarising and Concluding Remarks

As this article outlines, the existence of undocumented migrants by definition raises questions about their living conditions and the respect of their fundamental human rights, including the right to health. As a result of the restrictive legislation/interpretation of the legislation, undocumented migrants in Sweden often have to rely on underground “clinics” and health networks assisting them free of charge and without asking for any documents. Three main aspects that affect/shape the survival strategies of undocumented migrants have been identified, namely, ethnicity, religion and

NGO involvement. Ethnicity and religion appear to be of relevance both in terms of individual characteristics and as the basis of external factors, while NGO involvement is an external factor in itself.

In the case of ethnicity, external factors proved to be solely dependent on individual characteristics that permit the assistance of undocumented migrants by their co-ethnics on the grounds of (assumed) common ethnic identity. Such individual characteristics cannot generally be acquired, but are supposed to be something that one is born with. In the case of religion, two options were of relevance; the first option relating to cases where external factors are dependent on religion, such as the assistance of undocumented migrants by religious persons or institutions on the grounds of a (assumed) common religious identity. In contrast to ethnicity, such individual characteristics can theoretically be acquired by undocumented migrants, and as the research showed, took place in practice (through conversion). The second option relates to cases where external factors are independent of religion - the assistance of undocumented migrants by religious people or institutions irrespective of the religious beliefs of the undocumented migrants. In such a case, the quality of assistance that undocumented migrants receive is not supposed to be affected by the acquisition of any particular religion.

Finally, in the case of NGO involvement, external factors are generally supposed to be independent of any individual characteristics and embrace all undocumented migrants. However, in practice, NGO involvement can be dependent on individual characteristics (diseases, family status, different needs and urgency) due to, for example, limited financial and human resources. Even though, undocumented migrants may or do acquire such types of characteristics, in general this is nothing that one is either willing or able to acquire in order to receive assistance from NGOs.

THE AGENCY OF MIGRANT PROSTITUTES: EXPERIENCES FROM SWITZERLAND

Milena Chimienti

This article is concerned with the different behavioural tendencies observed among vulnerable populations in a situation of risk. We examine the ability of migrant sex workers to live and survive in a constrained structural setting, in a stigmatised economic activity, and on an income considered modest by economic and social measures. Like Anthony Giddens, we suppose that even in a vulnerable situation people can develop resources that enable them to act and have at least minimum control of their situation (Giddens 1982).

In this study¹ we seek to understand the vulnerable situations in which these people find themselves and the correlation between the degree of risk in a given situation and the observed tendencies for reaction. We are particularly interested in the significance that health assumes for people in vulnerable situations, hypothesising that health, as an essential value, represents a key element in understanding the practical effects of structural constraints. Our final objective is to identify the relationship between conditions at structural (workplace), contextual (working atmosphere), and individual (attitudes) levels and how they predict the specific types of behaviours that these people may develop.

After having described our methods, we will begin by identifying prostitution legislation and the different forms of prostitution in Switzerland. This will allow us to evaluate the institutional constraints with which our target population must contend.

Finally, we will discuss some of the influential factors in the development of health maintenance for the observed behavioural types.

Methodology

For this study, we have chosen to examine the parallels between the situations of people working in three areas of the sex market: cabarets, champagne bars and massage parlours. In Switzerland, these groups are confronted in their daily lives with many similar difficulties associated with

their activities in the sex market and to their migratory status (uncertainty as to their length of stay, low socio-economic status, and/or restricted geographic mobility). These three work settings also include people who have different residential statuses and legal resources to work in the sex market. Finally, we compare the legal contexts and support options available to sex workers in two cantons (Geneva and Neuchâtel). According to the literature, in comparison to other Swiss cantons these two regions have a significant number of sex workers. Present differences in the authorities' management of these populations allow us to evaluate the importance of legislative context (official management) on behaviours effecting health.

This is a qualitative study, with results based on in-depth interviews: fifty-five interviews were conducted with immigrants from four different geographic origins (Africa, Latin America, Asia and Eastern Europe), along with twenty-three informal interviews with key actors (authorised representatives, social workers or health professionals).

Legal Framework and Management of Prostitution in Switzerland

The practice of prostitution is legal in Switzerland as this country has not ratified the 1949 United Nations' Convention on *the repression of trafficking in human beings and exploitation of forced prostitution*. In article 199 of the Penal Code (implemented on October 1st 1992) penalising the illegal practice of prostitution.

Federal law established a standard framework limiting the power of the cantonal government to act with regard to prostitution. For instance, under this article governments are prevented from abolishing prostitution, but are allowed to restrict and regulate its forms. This is the only article of the Penal Code that addresses independent and voluntary engagement in the sex market. Most of the other articles of the Penal Code that legislate prostitution at the Federal level emphasise the abuses to which people can fall victim, and highlight concerns at profits made by a third party in connection with the encouragement of prostitution (article 195 of the Penal Code) or the trafficking in human beings (article 196 of the Penal Code). As a result, Article 195 of the Penal Code implies that a woman who works as a prostitute cannot do so under contract to an employer. The practice of prostitution is therefore legal if it is carried out independently and without salary. However, only women in possession of either a long-term residence permit (the so called C permit) or a renewable short term permit (the so-called B permit, authorised on the enactment of the bilateral agreements of June 2004), have the right to engage in sex work independently in Switzerland.

Sex workers are also obliged to register with the cantonal police (this requirement doesn't exist in all cantons, and the form that this requirement takes varies between cantons). On the other hand, even if this registration requirement is specific to the practice of prostitution, the obligation to declare the activity and related earnings to the fiscal authorities and to the Social Security Administration can be regrouped with all tax obligations related to any earning activity, as all residents are required to pay Social Security. Finally, knowing that prostitutes are, for the most part, of foreign origin, and that as we will discuss later, specific permits exist for nationals of countries outside of the European Union (EU/EFTA) that allow them to work in the sex market in Switzerland (L Permit), it is appropriate to mention that, like all residents, they are subject to the legislation of entry and residence in Switzerland of foreign citizens (article 23 of the Federal Law on stay and residence of foreigners).

This legal framework is relatively liberal to the extent that it recognises sex work as a form of legitimate work. However, it does not go so far as to recognise it as a career as it is not salaried work. The law also leaves the cantons a wide margin of operational control that allows each region to adapt their treatment of sex workers to the reality of the canton and the orientation of their local policy. However, a certain common tendency is observed: in all cantons, support for sex workers consistently focuses on questions of public health. Prostitution has always been subject to debates surrounding health and hygiene. In contrast to the coercive and stigmatising approaches of past centuries (Corbin 1978), today's interventions are more frequently developed in consideration of the perspective of the target community. This type of interaction targets the immediate needs of sex workers without making their rehabilitation a central objective, effectively assigning another status to venal sexuality (Mathieu 2004: 168). This type of approach depends on community outreach, a practical knowledge of the field, and census research (contrary to a passive vision of beneficence, but considering the principal players and their well-being) (Welzer-Lang 1999). This step facilitates the shedding of a moralistic perspective that presents prostitutes either as "guilty" (of the spreading of diseases or of bad morals), or as "victims" (deprived of autonomy of thought and action), thus leaving more room for the voice of sex workers and their subjective definitions of their situation.

Various Forms of Prostitution

Our study concerns prostitution in the modern era. This period is characterised by three major phenomena that have affected changes in the sex market in Switzerland, as in other industrial countries:

- Economic crisis and the opening up of eastern countries: These two phenomena have led to an increase in supply, correlated with a lowering of price and an increase in competition. Amateur and casual prostitution occurs is on the increase and also comprises drug-dependent or foreign women without residential or work permits (Sardi and Froidevaux 2002).

Consequence: A terse competitive and suspicious atmosphere impedes any sense of solidarity among prostitutes. Increased supply, and therefore competition, leads sex workers to take more risks with regard to their health (Sardi and Froidevaux 2002).

- *Internationalism and increasing migration*: Migratory fluctuation is diverse. In Switzerland's current sex industry the most highly represented places of origin are the countries of Eastern Europe. These numbers are on the increase, and women play a significant role in these new migration flows (Anthias and Lazard 2000; Catarinon, Morokvasic and Hilly 2005; Sardi and Froidevaux 2002).

Consequence: The receiving society cannot successfully respond to the rapid growth and diversity of the new migratory populations. Consequently, this not only causes the migratory population problems in accessing healthcare services, which are tied to various structural barriers (insurance, shortage of supply, etc.), but also creates social and individual obstacles (e.g. unfamiliarity with the language of the host society cf. [Bischoff et al. 2000]). The fact that new arrivals often come from regions with limited information on matters of prevention also raises public health concerns (Haour-Knipe 1995; Haour-Knipe and Rector 1996). These people have specific needs that require specialised approaches, most notably in the areas of information and social support. The case of people of African origin living with HIV/AIDS is a particular example in. As the stigma of this illness is very prominent in the African population, HIV positive women therefore find themselves completely isolated from their community. These people are subject to more discrimination related not only to the practice of prostitution, but also to the greater visibility of their foreign status due to the colour of their skin (Thorbek and Pattanaik 2002).

- *New types of sex work and the increased mobility of sex workers*: A diversification of locations and practices of prostitution has been observed: "While before, women worked in specific areas, they are presently scattered across the town, in the salons, the champagne bars and the cabarets" (Sardi & Froidevaux 2002:70). These changes resulted

from the practice of illegal prostitution which, in turn, necessitated a more discrete working location than the street (Brussa 1996; Demleitner 2001; Koser 2000).

Consequence: This dispersion of activity makes the work of organisations that support sex workers more difficult, as they are more isolated and more dependent on their manager or pimp. The unstable nature of their residence permits or the illegal status in which they find themselves also leads them to take more personal health risks.

We have observed this plurality in studying the work conditions in three work settings of the sex market that we will address in the following section.

Cabarets

According to Swiss law, cabarets are considered as public establishments where adult performances such as striptease acts are held. Developments over the last ten years (Sardi and Froidevaux 2002) have demonstrated the increase of this type of establishment in Switzerland: the suppression of “clause need” (before the law stipulated that a new establishment could only be created when an old one was closed), and the arrival of immigrants from eastern countries with a provisional permit as cabaret dancers (L permit) identical to that held by musicians and artists, thus permitting them temporary residential status in Switzerland.

Officially, people working in such cabarets as employees, without the benefit of any long term permit of stay or residence (B or C permit) that allows them to operate independently, are not authorised to work as prostitutes. Our study shows that in actual fact the law no longer corresponds to current working conditions. During the past several years, cabarets have become places of hidden prostitution.

The dance or striptease act that is performed several times during the evening by the employee is nothing more than a kind of alibi for obtaining the work permit, while their principle task consists of enticing the customer by various means to purchase large quantities of alcohol for himself and the dancers he chooses to associate with. Currently, the most common method of getting the customer to drink is to drink with him. In effect, practically all the employees say that they are required to drink. If not, they either incur the risk of not having their contract renewed or, according to some evidence, losing their salaries.

This inconsistency between the law and de facto practice is known by the general population (several newspaper articles denounce this reality), as well as the interviewed authorities and support associations for sex workers who find themselves in a dilemma. For some, cabarets constitute a

form of controlled prostitution because the dancers possess work permits (Bianchi 2000). For others (cf. notably associations in the defence of sex workers), the work and residential permits issued to allow employment in this dubious activity also bring several risks of abuse, of which forced prostitution would be the most extreme case. In other words, it isn't possible to know for certain whether the cabaret dancers' L permit protects them by facilitating decent working and living conditions under state control, or whether it promotes abuses in which the State is complicit.

Most of the people we met spoke easily of their early training in the consumption of alcohol and venal sexual acts despite the illegal character of these activities. The high consumption of alcohol associated with their activities is, at least for the group of respondents interviewed, one of the most difficult elements of their work, partly because it is compulsory - as opposed to prostitution, which is mostly voluntary. The consumption of alcohol is the means by which cabaret managers avoid being directly implicated in prostitution: the time that the client spends with the dancer and the service that she provides is reflected in the price and the quantity of alcohol recorded as being purchased by the customer (i.e. the sale of sex is recorded as alcohol consumption). The women interviewed said that if they were not drinkers before, they were forced into it by the confines of the cabaret world.

The first time that you work in a cabaret, you know what type of work you will do, but you don't think that it is like that. You don't think that it is so hard! The real problem is that you have to drink alcohol. Above all, if you are Moroccan, you are not used to it, because you have never drunk alcohol before. At home, women don't drink, you know. It is difficult. The first time that you come here it is hard, because you have to get used to it (NE cabaret 5-Africa).

Most of the people interviewed knew before coming to Switzerland that they would be obliged to become prostitutes in a cabaret. People mostly come to Switzerland to work as prostitutes for the attractive wages they can earn, and, perhaps paradoxically, it is by way of these wages that they succeed in accomplishing their dreams of migration.

I knew how the system worked. It is always tied to prostitution in every country. If you don't want to be a prostitute, you don't have to do it (...) I was in agreement, and I have always tried to earn money by prostitution (GE cabaret 10-Est).

On the other hand, they are usually ignorant of the exact details of their activities, the commission imposed on them by the cabaret and the obligatory passage into prostitution by the consumption of alcohol. These are the most problematic constraints for them, which they may attempt to

deal with by adopting a passive attitude towards their circumstances as a coping mechanism.

Champagne Bars

Champagne bars are tolerated by the authorities, even though there is no apparent legal authorisation for the services they provide. From a legal perspective, the women who work there are considered as employees of the bar and are not authorised to work as prostitutes. Furthermore, only foreign women in possession of a stable residential or C permit may be employed there. This does not include people with an L permit such as the cabaret dancers.

We have documented a significant diversity of working conditions in these champagne bars, mostly due of the wide variety of residential status of the population frequenting these, largely ambiguous places. The absence of any work contract is a condition found specifically in champagne bars. Even if the residential status of our informants reflects a different reality, their conditions of employment are similar. Not one single woman among those interviewed had signed a work contract or received a document that certified her engagement by the employer – which means that their activities are not declared to the authorities. Most women realise that the bars are the only places in the sex market where employers allow them to work without a residence permit. That is why they work there, despite the abuses and the fact that the patrons are reported to the authorities more often than in the two other types of prostitution sites. It is therefore not astonishing that we encountered more people with an irregular residency and work status in this type of establishment. These venues are overwhelmingly characterised by the informality of the legal and working conditions therein.

As in the case of cabaret dancers, the income of bar hostesses is generated in principle by engaging in paid sexual activity. It is thus by prostitution that they succeed in saving money, while their other wages (their salary and commission on alcohol consumption) are often used to cover daily expenses. Beside a fixed daily pay and commission on alcohol sales, prostitution constitutes a third source of earnings. As in the cabarets, sex acts are recorded and reflected in the amount spent on alcohol consumption. This indirect benefit allows the manager to avoid an obvious implication in prostitution (in case of police control the employers can argue that any prostitution is the matter of the individual sex worker as there is no proof that he or she receives any benefit from sexual transactions). But as working conditions and earnings are more unstable in this venue, the more pressing problems are not associated with alcohol but with the system of ‘on call’

working, threats of dismissal, withheld wages, and, less often, the right to sexual favours assumed by some owners, as this witness illustrates:

It is hard to work in the bars, I don't have problems with the women but with the bosses. At X Bar [where she worked previously] the boss made the girls sleep with him, if someone didn't want to, he targeted you or he mistreated you. I wouldn't do it. Suddenly, he demanded that I work everyday, from Monday through Sunday, a sort of punishment, and to stand-in for a girl who was absent, and finally, saw that I still refused to sleep with him for nothing, he called me one day and he told me that he didn't need me anymore. At Y Bar [where she worked at the time of the interview] the boss always made a scene about paying, they always held the money for one extra day because they said that otherwise, we wouldn't come back, and if we earned nothing during the evening on drinks, they made a big stink about paying us. They pay us, but always later. (GE bar 9 – Africa).

The champagne bars represent one of the types of places where it is easier to practice prostitution without residential authorisation, which is an advantage for people with an irregular residential status. The perverse effect of this informality (absence of legal and social protection) is that it weakens and impedes these clandestine employees from defending themselves when confronting an employer.

Massage Parlours

Massage parlours are private establishments (in contrast to cabarets and wine bars) where prostitution is authorised. Almost all the women encountered in these types of places had a regular residential status. The women working in the massage parlours, generally as independents with stable residential permits, demonstrate a larger realm of negotiation in the case of problems. If they are unsuccessful in negotiating satisfactory conditions within the establishment, they have recourse to solutions other than having to find another place to practice, even if that often turns out to be their only resource. Most of the informants we met practicing in small-scale parlours did not complain about their work situations. Other than the quest for earnings, most of the complaints were essentially about clients who didn't behave properly (verbal and physical violence) and about their private lives (the difficulty of reconciling one's private life with a life of active prostitution).

Almost all the women interviewed appeared to have problems with this way of life, and above all with having a life on the side in terms of having and keeping a regular boyfriend:

(...) With boyfriends, it is hard. In the beginning, he is accepting, because he is not in love and then after, he falls in love and becomes jealous. That causes problems. I tell him my job right away, because it is better that he

knows right away instead of finding out later. I have had boyfriends that I met in the bars, as clients. It is hard, to meet him in this type of place, because you think all the time that he is going to return to this sort of place because he is already in the habit. My last boyfriend, I met him at a discotheque. Now, I don't have a boyfriend. I would have wanted to have a family and children. That is why I would like to stop (GE parlour 1-Brazil).

In the literature, work conditions are described as a principal factor in health behaviours (cf. notably European Commission 2001). This report has crucial significance for people who work with their bodies and in a constrained setting. When prostitution is practiced independently, the fact remains that this activity is still strongly stigmatised, precarious and complicates one's private life. If these described structural conditions can constitute obstacles, they can also represent opportunities. As Anthony Giddens (2005 [1984]), we think that while social structures are constraining they are also enabling agencies that both produce and reproduce the social structures. In the following section, we observe the manner in which women adjust to specific workplace constraints and look at the health behaviours they develop.

Typology of Behaviours

The residence permit and working conditions are the two principal influences observed in this study. One sees the working conditions of the sex market as an important aspect of sex work that takes place outside the authorised legal parameters; working conditions that turn out to be the most direct determinants of health-related practices or behaviours. The degree of restrictiveness observed in different working settings includes imposition, arbitrariness and negotiability. Faced with these structures of working conditions, the attitudes exhibited vary according to attributes derived from diverse future projections of the individual. These personal attributes materialised if people had reason to believe that they could realise their goals, even if they had already only improved their situation by the smallest degree.

In addition to these factors, we have identified five behavioural patterns (fatalistic, rebellious, apathetic, wilful and acting) which are associated with three identified workplace structures (imposed or forced, stable and negotiated). These behavioural patterns offer an explanation as to why certain individuals develop positive health behaviour and why others appear to be incapable, not only of initiating or adopting such behaviour, but of even thinking about their own health or well-being (see table 1).

Constrained contexts. Cabarets represent an area of the sex market that is subject to the most detailed legislation. On the one hand, external regulation of cabarets by the State facilitates the regularisation of employees

by giving them recourse to a temporary residence permit (L permit) and, on the other hand, internal regulation – most notably the rules regarding alcohol consumption – allows them to circumvent the law that prohibits dancers from prostituting themselves. These two phenomena, and, especially the mode of a cabaret’s operation, result in significant constraints for sex workers employed there. In the face of this constrained setting, their degree of manoeuvrability is very limited. In this case, people generally adopt two different types of behaviour. Some tend to resign themselves to these constraints but do not adapt themselves to them, either because they don’t accept them or don’t understand them. Their resignation therefore signifies that they are no longer seeking ways in which to resist the conditions imposed on them as, at least to some degree, they find them acceptable. Such *fatalistic* behaviour does not lead to the development of any particular personal resources. Those who attempt to react to this imposed situation do so by skirting the internal and, indeed, the external rules of the establishment. In a sense, they adopt *dissident* behaviour which employs survival tactics as a mode of action against external events. This attitude has several stages at which the women begin to understand both the system and the rules, and learn to manipulate and disregard the latter. Particularly in the case of cabaret dancers, fatalistic behaviour has a greater impact on their health than dissident behaviour, because it entails greater risk. Fatalistic people will tend to resign their health to exterior actors and, consequently, follow the internal rules of the cabaret (for example, a high consumption of alcohol), while the dissidents will try to break and disregard the rules.

Arbitrary contexts (champagne bars). In comparison with the previous cases this situation has the greatest proportion of insecurity. Champagne bars place people in an arbitrary context where prostitution is not authorised, and the sex workers, who have neither work contracts nor (for some) residence permits, can see their situation deteriorate as a result of an unexpected police intervention, an unscrupulous bar manager, or a violent client. This lack of security leads to two types of behaviour. The situation, which is perceived as anonymous, unmanaged and misunderstood, may lead to feelings of apathy. In this case, the degree of manoeuvrability is almost non-existent in that people are almost entirely restrained by external events. But the arbitrary setting is also interpreted by a minority as a sort of freedom that they, in a sense, succeed in managing (not without effort) to their advantage. The advantages in this case are the result of resourcefulness and a sense of agency. Their outraged determination to “get out” is one of the motivating feelings behind their “voluntarist” behaviour. For this group of people, their behaviour seems to be as favourable to healthy behaviour as the last group. According to our study sample, apat-

hetic people take more risks; the most extreme risk being that they have no interest in their health. Like dissident actors, the “voluntarists” have a tendency to take better care of their health and, in all the cases we looked at, be more preoccupied with their health condition. Even if in this case, little difference is noted in their behaviour because in different contexts dissident people tend to be more vulnerable.

Negotiated context (massage parlours). Massage parlours are characterised by balance, in the sense that prostitution there is authorised and, in the majority of observed cases, the people working there have the security of a regular resident statute. In other words, they participate independently in the sex market. In this setting, relations are negotiated (as much between salon managers and workers as between workers and clients) and, consequently, the sex workers may benefit from their situation. However, these negotiations don't come easily and in order to succeed people have to exhibit resistance and develop strategies. This type of behaviour is particularly noted in women working in massage parlours. Possessing some sort of security, such as their residential permits, they can concentrate on future projections for their lives and work to maintain a balance. As agents with control over their lives, they also possess agency in relation to their health status. They adopt preventative behaviour and even promote good health.

Table 1: Types of Health Behaviour

	Cabaret (sex workers with provisional permit of stay)	Massage parlours (sex workers with long term permit of stay or established)	Champagne bars (from undocumented migrant sex workers to diversity of permit of stay)
Contexts	Constraint : Imposition	Negotiation : Balance	Arbitrariness: Anomy or freedom
Room for manœuvre	To resign or to side-step the rules	To play with balance	From lack of room for manœuvre to adaptation or reduction of instability
Behaviour	From fatalistic to dissident	Actors	From apathetic to voluntarist
Type of resources	Tactics, tricks	Resistance and strategy	Short-term tricks, anger

Conclusion

These results show that, in situations of vulnerability, the global context (i.e. association of supports, local legislation) has little effect on the behaviour. As the activity of migrant sex workers is still (and even in a country where this activity is permissible) at the intersection between legality and illegality, the context of interaction or labour might have more impact on behaviour: either enabling as in massage parlours or being very constraining as in cabaret. Furthermore, we highlighted that in situations of vulnerability individual factors take on considerable importance in personal strengths, and turn out to be of fundamental importance when the structural contribution is limited to proposing sectional measures relating mostly to health. When there is almost no way of changing the structural context, the only solution that people are faced with is to change themselves; in other words their ways of reacting to a given situation. For people in a context of stability, these reactions can barely be associated with resources as instead they represent a way of surviving. In order to understand these reactions as resources, we have to be aware of the structural context of people living in vulnerable situations. This understanding does not mean accepting this instability without doing anything, however. On the contrary, this understanding is essential to the proposal of helpful interventions.

CHAPTER IV

DISCOURSES FORMING REALITIES IN HEALTH SYSTEMS

REPRESENTATION OF DIFFERENCE IN ORGANISATIONS: DISCOURSE ON MIGRANT PATIENTS IN CARE

Carin Björngren Cuadra

Problematic relationships between healthcare organisations and migrant patients have been discussed in terms of the barriers to care on equal terms. One central aspect of care access is enacted in the very encounter with the care provider. In this respect, stereotypes and images of patients have been shown to influence the provider's clinical understanding (Bischoff 2004; Mulinari 2004) and also to have an impact on the patient's possibility to enact his/her patient hood (Öhlander 2004). One critical issue in the discussion involves the notion of culture, generally understood as static coherent entities, determinant for the individual's action or reduced to manifestations in actions and artefacts, i.e. in a simplistic way and with reference to migrants as a marker of Otherness. This notion of culture is problematic as it has been – and still is – used in organising differences between ethnic categories with regard to historical legacy, racial and ethnical hierarchies and nationalism. It has been argued that there is an historical continuity in written and spoken discourses on patients regarding otherness, deviance and foreign cultures (Öhlander 2004). This implies that focusing on the discourse of patients in care might be fruitful when approaching care providing organisations. This focusing on healthcare experts is motivated by an overarching interest regarding how the healthcare system (understood broadly) responds to the pluralistic society (see Maggi and Cattacin). The external frame for this interest is based on the leading principle of the healthcare organisations and their all-embracing goal, i.e. to combine equality and an acknowledgment of diversity. How these organisations succeed might, in the end, be understood as a matter of quality of care (Bischoff 2004).

This article is based on interviews with experienced dental hygienists working in the public dental service in Sweden. The essential question involves how their work is influenced by questions related to diversity, and

how it is approached and enacted in discourse. The main interest involves how the dental hygienists conceptualise their patients. Do they consider ethnicity and culture as being relevant in relation to institutional practice? What meaning is ascribed to difference in terms of culture? The focal point is discourse expressing “knowledge” of patients with experience of migration. Through a presentation of a narrow sighted reading of parts of the empirical material, the aim is to identify patterns in the discourse regarding migrant patients.

I will venture to advocate the interpretation that the dental hygienists’ understanding of their patients and their assessment of the patients’ attributes and characteristics that is expressed in discourse is intertwined with images regarding of culture, and ethnicity as well as with structural social stratification/subordination. My main argument is that we can conceptualise this convergence as two simultaneously converging dynamics of intersections between, on the one hand ethnicity and social class, and on other hand, morally grounded considerations (assessments) involving an understanding of culture, cultural difference and ethnicity. This is particularly salient in reasoning regarding “immigrant patients”. A more far-reaching conclusion is that pluralistic societies bring a re-negotiation of the meaning of *professionalism* to the fore. This re-negotiation is on-going, *inter alia* within healthcare practice in the tension between universalistic principles and recognition of (ethnic and cultural) diversity.

Theoretically, approaching discourse implies investigating speech and/ or text as more or less consistent accounts of a certain topic based on certain suppositions. The analysis aims to investigate how used concepts are given meaning and how reasoning and representations are called forth and related to each other. Hence, discourse is used in the Foucauldian overarching and abstract sense, where the most basic idea is that subjectivity is created in discourse (Foucault 1971) as power, i.e. power relations and knowledge become interlinked (Foucault 1976). In a historical perspective, man has been made both an object *to* knowledge and a subject *with* knowledge. One crucial form of subjectivity in this vein is the formation of the knowing or moral subject; the transformation of self in the process of *subjectification* (Foucault 1991). This process is closely linked to human service organisations’ activities as they enact sciences concerning man - the inherent normative “moral sciences” (Beronius 1994).

When applied to human service organisations and their representatives, we can position human service workers’ discourse on patients as situated within the institutions of both nation and welfare state. Continuing in Foucauldian mode, experts appear to be *actors of governmentality*, thereby forging a practical link between the societal level and individuals at micro-

and meso levels. Governmentality is understood as specific forms of enacted power, practices and procedures which have population as its object and are carried out by different kinds of professionals and experts. From the perspective of human service workers, in which they appear as 'part and parcel of governmentality' and situated in 'social embeddedness' (Ming-cheng 2005), we can bring the societal roll of professions into the context of the nation state, as well as how experts put social relations based on ethnicity, class (and gender) to work in their concrete enacted practice to the fore. This approach thus shapes a framework for an investigation into the intersecting dynamics between human services and migration related processes.

Empirical Observations

The main empirical observations will be presented here; the following section synthesising the analysis and main conclusions.

Cultural and Moral Boundaries

The first empirical observation regarding discourse on patients deals with the dimension of the notion of *culture*, namely, drawing near a geographical entity and synonymous to 'country' and/or continent. In discourse, patients from different 'cultures' have different 'patterns' of oral caries and tartar. This use of 'culture' as an 'organising device' (Hannerz 1996:23) is common in everyday discourse. What is of particular interest here is that these different 'patterns', in terms of culture, do not give rise to different treatments. Regardless of 'cultural differences' all patients are said to get the same scientifically neutral 'basic programme'. Culture can thus be said to be levelled out by the given care, although the pace and tempo may differ depending of the patient's experience. As one informant puts it:

[...] you have to take it easy to build trust so they feel that this is not dangerous and then next time [...]

The dental hygienist describes how it might take a couple of encounters for the patient to '*mature*', get acquainted and '*learn*'. She describes an embodied process in which the patient undergoes a transformation of self and develops a knowing or moral subject (Foucault 1991). The level of brought about subjectification is a main concern in determining the treatment.

Other central topics in the discourse on patients concerns patterns of 'expenditure' (i.e. seek care), appointments and schedules. The dental hygienists conceptualise these topics in terms of 'their culture' when the patient's behaviour is not congruent with the organisational norms and routines, i.e. not interested in preventive programme and keeping a definite

time schedule. In the discourse, 'culture' is separated from 'treatment' and 'care'. Dentistry is conceptualised as non-cultural, based on science and thus neutral.

At the same time it is linked to Sweden, not in terms of culture but in terms of nation and welfare state. Furthermore, the concept culture is strongly associated with and used to express problematic situations and relationships to dentistry. However, the notion of culture does not imply determining the patient's behaviour. The dental hygienists express a parallel possibility of changing behaviour such as eating habits and habits of hygiene through information. As two dental hygienists express it:

You have different opinions [...] and then you try to present a new way of thinking.

[...] many come, that is to say migrants with small children where the parents have been in Sweden for years, and their children are really nice [in the mouth].

What is expressed might be interpreted as that the patients have changed their dental related behaviour due to the given information and transmitted knowledge.

With this backdrop, the dental hygienists relate in discourse to patients of migrant background in terms of culture in a fairly complex way. The notion of culture is situated at the interface of the patient's life-world, touching upon that part of their life-world that is relevant to the situation (Habermas 1984). That is to say, that when 'culture' is used as a framework for understanding, it involves a certain aspect (or tangent point) where the patient's life-world comes into contact with the dental organisation's norms and knowledge system. This interface is conceptualised in moral terms. The patient is *maturing*, *learning* and being *fostered*. On the other hand, dentistry appears to be a neutral authority which through counselling, information and treatment can have an impact on the patients' behaviour. Behaviour that diverges from institutional norms is thus conceptualised as based in cultural norms and possible to 'develop' through culturally neutral information. In this way a dynamic arises in which moral boundaries are expressed in terms of culture, i.e. as cultural boundaries.

Socioeconomic Aspects and Power Resources

A second empirical observation is that the dental hygienists' reasoning follows a specific line as ethnicity and migrant-hood intersects with socio-economic aspects and power resources. Theoretically speaking, this involves a linkage between ethnicity and social class. Power resources refer to the

ability or possibility to make demands for care. These resources vary depending on the patient's knowledge of the organisation, their rights and their linguistic skills (Songur 2002). One illustrative example is of a dental hygienist working at a clinic within a relatively high migrant density recruitment area with low socioeconomic status. She remarks that in other clinics, a dental hygienist might experience a higher degree of insecurity in their professional role in relation to their patients. She says that at clinics:

[...] not with the same social problems as here – with the language – here a lot depends on the language – but [if] you sit there with another clientele and many are maybe doctors and many might doubt a lot.

She adds that at such a clinic you might:

[...] find yourself in a bit of a spot.

Her current patients, though, do not doubt or question her because they lack linguistic or other power resources. She compares this with her previous clinic in a wealthy municipality, which attracted '*many nice ladies and gentlemen who knew better ... or so they thought*', and almost tried to bring the dental hygienist '*into question*'.

She referred to the difference between the two clinics as '*purely social*'. In the same line of reasoning, another dental hygienist indicates that patients she had when she worked on a private clinic related to her as a '*service person*'. They could say:

There is a rough edge here. Could you please remove it?

She attributed the main difference to '*consciousness*' and that these patients

[...] have sort of been brought up with Swedish dentistry.

Compared to this situation, her present patients in a high migrant density recruitment area:

[...] have different demands as they did not have that opportunity so they are very grateful for the help they get.

She also adds a statement to the effect that:

[...] they do not really know what they can demand and then they might think that it is very good as it is – meanwhile other patients might have very, very high demands.

In the discourse on patients, the line of reasoning that 'native' patients have higher demands and also ask questions much more frequently and

which in turn requires more professional skills was widespread among the dental hygienists. This makes salient that the relationship constituted between the dental hygienist and the patient differs as a function of, among other aspects, the patient's power resources.

In the discourse on patients not making claims, the dental hygienists make no demarcation between any unpretentiousness as a result of what might be seen as migration related processes or due to social and economic issues. They rather conceptualise the occurrence of not making claims simultaneously in terms of an economic and socially weak position and 'migrant-hood'. My interpretation is that when a patient who has actually migrated has power resources in terms of being acquainted with the dental organisation, knows his/her rights and has the relevant language skills, the 'problematic patient-hood' is abolished. The dental hygienists thus bring migrant-hood or ethnic dimensions and socioeconomic dimensions together. One manifestation that stands out within these different thematic themes is an association between migrated patients and social allowance (welfare). For example, one dental hygienist states that her experience of working with a diverse group of patients was limited when she worked in a private clinic, as the social welfare services do not pay these clinics more expensive fees. That is to say, that she presupposes that migrants are poor and claim a social allowance. I again advocate that 'migrant-hood' has to do with power resources emerging from the patients' social and linguistic resources. In the discourse, the dental hygienists use 'immigrant' and 'immigrant patient' as a sign for a person with few power resources, a weak socioeconomic situation, insufficient linguistic skills (i.e. in Swedish) and without full knowledge of what to expect from dental care – which means that they make no or few demands. When a patient does not correspond to these characteristics, he or she is not considered as an 'immigrant'.

Concluding Discussion – Intersecting Discourses

I now intend to synthesise the interpretation. My point of departure is that discourse supplies a specific position for subjects. The determining of these subject positions implies a range of different processes, which I account for and in which I denote a *movement direction* towards a specific subject position. From this I indicate that in the dental hygienists' discourse, an on-going dynamic is enacted; understood as a movement direction in which the knowing/moral subject is influenced by images of ethnicity and culture. Parallel to this, a dynamic between ethnicity and power resources/social class emerges. They are merged and enacted in the conceptualisation regarding 'immigrant patients'. In the following I approach these two movement directions as being analytically separated but simultaneously interweaved.

At their intersection they form a space in which the position of the subject is determined by its social attributes. The space can be understood as a topological formation constituted by coordinate axes (X, Y and Z). A specific position appears as a function of three intersecting dimensions (moral, ethnicity and class) and corresponds to the axes in the model.

In discourse analytical wordings, investigating the empirical material deal with studying what kind of position the discourse offers through its regulative framework for talk and knowledge regarding subjects. This analysis owes its complexity to the fact that the movement direction towards a specific subject position can be both hindered and made possible in intersection with other social positions (Skeggs 1997).

A fruitful interpretation is that the positioning of the knowing/moral subject intersects with the modern notion of subjectivity. According to Goldberg (1993), in a historical perspective, understanding of 'race' and ethnicity is intertwined in this notion. Moral subjectivity intersects with a formation and enactment of ethnic markers differentiating the Other. This is the prerequisite for discursive determination of the knowing/moral subject. In discourse, a subject position as a knowing/moral subject is available which implies an understanding of both ethnicity and culture. This involves that a movement directed towards a specific position is either made possible or hindered in intersection with understandings of ethnicity and culture. The movement direction is, however, influenced and made (im)possible not only by an ethnic dimension, but also by other social relations among which social position in terms of class appears as salient in the material. The subject position as 'immigrant patient' is hence conditioned by a patient's socioeconomic situation. It refers to a patient with few power resources.

What I want to stress is that the deviant Other is engendered in a dynamic that could be understood as a manifestation of a mutual dependence between structural social subordination and discursively aroused processes of deviance. The deviant Other, denoted 'immigrant patients', arises in the intersection between simultaneously structural relations and institutional discursive practices. To pay attention to this dynamic offers an opportunity to understand the noticeable circumstances that patients with migrant experience who are not perceived as troublesome are practically invisible in the material. It can also explain why these patients are understood as exceptions, as atypical 'immigrants' or as 'Swedes' in the established discourse on patients within (dental) care. The underlying reason for this process is to be found in that the discursively formation or space does not offer a (patient-) position that is able to amalgamate a possible knowing/moral subject with experience of migration, which denies patients

from embodying such a possibility and makes them (invisible or) misrecognised. A contradiction is thus constituted within the discursive formation which can be experienced in practice as being a 'patient-in-care' and being an 'immigrant in-care'. This excludes the possibility that patients, regardless of ethnicity and migration experience, can share common characteristics, experiences and needs in different respects. The use of one-dimensional and counter positioned categories stalemate and fragmentise social attributes and hereby conceal the social course of events and power relations contributing to the differences.

The motive of analysing governmental processes and discourses is to point to alternative ways of structuring power relations and interpreting institutional 'truths' and conceptualisations. As mentioned, the (dental) care professionals can be understood as actors of governmentality. They have a crucial part to play in the social classification and stratification of sick, poor, foreigners and other 'deviants'. That is to say, they put social relations based on gender, ethnicity and class into work into the context of nation- and welfare state. I have intended to show that in order to grasp these dynamics in more detail and deepen the understanding of how the discourse of (dental) care professionals (experts) intersects with social relations, we need to analytically separate how these categories are produced and re-produced in governmental processes. To pay attention to governmental processes implies to investigate the scientific discourses' ability to produce normality and deviance, to create and enforce the 'moral boundaries'. These boundaries are conceptualised as cultural boundaries (i.e. differences), acquiring their name in intersection with social relations, in the actual empirical case with ethnicity. However, I advocate an understanding of the deviant Other; the 'immigrant patient' as a manifestation of mutual dependence between social subordination (social class) and a discursively formation of deviance. Without such an approach in which the three dimensions of moral/knowledge, ethnicity and class forge a matrix for the interpretation of intersections, these simultaneous processes would be withheld. From this perspective, 'immigrants' do not appear as a specific group, but one of various emergent realms of scientific expertise (Johnson 1995). On the basis of the pretension of (dental) care to provide qualitatively equal care actualises a critical perusal and reassessment of the moral boundaries of (dental) care, boundaries of normality and deviance that, due to historical legacy, are understood and expressed in terms of ethnicity and culture. The analysis of different dimensions in intersection is thus relevant in relation to the leading principle of equal care, the endeavour for worthy and ethical treatment and the possibility to enact one's patient-hood. It appears as crucial that professionals consider the social contextualisation

of patients' attributes. This naturally raises questions involving inequalities relating to resources and access to (dental) care and welfare services in the wake of migration. It appears to me that the discourse on patients has a capacity to 'explain away' social determinants of differing access to care. Structural conditions can be conceptualised as cultural actions and choices. With a critical approach, it would be conceptualised as patients' experience of (dental) care and a matter of distribution of welfare resources.

REPRESENTATION OF DIFFERENCE IN ORGANISATIONS: DOING ETHNICITY IN ELDERLY CARE

Linda Lill

There is no consistent way of approaching the concept of ethnicity. Within the health sciences, however, ethnicity is generally essentialised, i.e. believed to be the embodiment of a set of authentic social and cultural characteristics which are shared by all members of a specific ethnic group (De Marinis 1998, Ekblad, Janson and Svensson 1996, Hanssen 1998, Leininger 1995, Sachs 1983, 1992). Arguably, such a conception of ethnicity has a profound impact on the ways in which health and elderly care professionals are trained to relate to the notion of ethnicity. But the essentialisation of ethnicity within the health sciences overlooks the ways in which ethnicity above all concerns social classifications and hierarchies of various kinds, where ethnic specificity is malleable and dependant on historical and social context. Rather than being an essence of some sort, ethnicity is continuously created and altered depending on changes in the social relations in general. Ethnicity may thus constitute an important factor in the formations of groups and classes, without having any essence or core in itself. Specific ethnicities are thus constructed through the ways in which ethnicity in general is imagined and constructed. From this constructivist point of view, the essentialised conception of ethnic identity has been criticised as a Eurocentric and colonial discourse in which ethnicity simply represents an aboriginal or non-modern formation of identity. When viewed as essences, the concepts of ethnicity and ethnic identity function as practices of demarcation where the boundary between what constitutes the societal self, whose behaviour is supposed to be rational and associated with the concept of the human, and its other, whose actions and thoughts are believed to be determined by ethnicity alone, are fixed. The present article has a twofold purpose: firstly to introduce the concept of ethnicity as a doing action and secondly to elaborate on what the doing of ethnicity may

mean in terms of the work of healthcare professionals. Empirically, the article is based on a case study of elderly care in Sweden.

Method and Research Questions

Ethnic relations in elderly care and the ways in which elderly care professionals deal with ethnicity have been the main concerns of the present study. The empirical material is constituted by recurrent group discussions in which six female care assistants have been involved. The group discussions have been of great value to the researcher because they have allowed for a more dynamic access to the field than the commonplace method of the interview. The group discussions also become an arena for the exchange of experience and knowledge between the informants.

An interaction with the informants is relevant in relation to the discussion of what constitutes fieldwork within the human and social sciences. In the present study, both the researcher and the informants are seen as important actors for the formation of the field. The choice of method has been influenced by this consideration, and group discussions have been used to open up an arena for dialogue. Specific cases have been used as a starting point for the discussions.

The article primarily deals with the complexities of professional care, without specifically focusing on the relationship between the assistants and the clients. The purpose of the text is rather to address certain structural phenomena pertaining to ethnicity in the social relations described by the informants. The production of ethnicity is analysed through the concept of “doing,” whereby the ethnic relations are seen as constructed through the intersectionality of discourses on care, age, class, gender and ethnicity. These discourses are “performed” in a continuously repeated set of practices (Butler 1990, Davies 2001, 2003, Fenstermaker and West 2002, Smith 1987, West and Zimmerman 1997). The term “doing” describes the actions and activities that follow from the discursivity surrounding elderly care. The main questions are:

- How are cultural representations regarding ethnicity made visible in the discussions by the informants?
- How is ethnicity “done”?

Background and Theory

The question of why ethnicity has become important in the area of care and healthcare is relevant. Prior research in the field shows that immigration and ethnicity are seen as problems for the care-givers and the healthcare institutions that provide the care. The research often proceeds from the proposition that giving care to elderly migrants is a separate activity

from the routine work with the clients. This distinctiveness is essentialised resulting in an idea that immigrants of ethnic backgrounds other than Swedish have special needs and have to be treated accordingly. This position is to be criticised and instead I will argue that ethnicity is a socially constructed and historically conditioned idea about identity, and not an essential core. This is why I see ethnic relations as the way in which we imagine each other's identities.

The workforce of the public care institutions is mainly female, and the description of care is often concentrated on women's role and concern for their families. This gendering influences the ways in which the work of the caregivers are described and presented. To be a care assistant is a profession in which care is given for the exchange of a salary. This basic fact concerning the professional situation is at odds with the discourse surrounding care, in which the supposed female propensity for warmth, love and comfort is a strong and disparate contrast to the salaried reality of professional care giving.

The gendered attributes of the care assistant is nevertheless established and produced by way of the subject positions that the assistant has to adopt in order to become a reliable care professional (Skeggs 1997). The discourse of care conditions and creates the work of the care assistants. This is why the concept of care must be understood as an object without a solid semantic core. Care as well as insanity is given meaning through the various discursive relations in which it is produced. The theory in this article builds on the discursive analysis of Michel Foucault, such as his study on the birth of the clinic (Foucault 1969, 1972).

The Unseen Discrimination

Language difficulties are often seen as the most immediate and evident problem in ethnic relations between colleagues as well as towards clients. Language is not only a problem in encounters with the clients and their families, but can also become an issue in relationships between colleagues. Conflicts within the working team, irregular management practices and unequal working conditions are examples of how the idea of ethnicity operates outside the language-based difficulties in organisations. In this context, the discourse of care intersects with notions of ethnicity and gender.

Discourses have a substantial influence on the way we categorise people into different groups. There are people that always will fall into the "immigrant" category, and they will constantly be seen as different. In the group discussion, the care assistants meant that how the leading staff deals with ethnic relations at work had a great impact on the working climate as a whole. They also distinguished people among the staff as divided into sepa-

rate ethnic groups at their working places and there was, as they saw it, conflicts between “Swedes” and “Immigrants”.

The care assistants assumed that it is extremely important that the chief talks openly about ethnicity and meant that a chief should not be anxious of dealing with ethnic conflicts, which was something they believed some leaders had a problem with. One of the Swedish assistants told the discussant group about a work situation where she thought the chief dealt with a conflict involving “Swedes” and “immigrants” incorrectly. She felt that her boss took the part of the immigrant group and was convinced that this had something to do with the leader’s apprehensive approach to ethnicity and the fear of being accused as a racist. She said:

I can really imagine that people in charge take the part of one group just because they cannot mediate peace and if they can’t do then it’s quite possible they will be accused of being racists.

The staff considered that the conflict might be larger and more difficult to handle in situations like this. Another participant in the discussant group said:

It’s exactly the same with my boss. She protects all the immigrants and for me it’s precisely like our boss thinking that we (the Swedish staff) are stronger and can deal with everything.

Conflicts at work can be laborious for all involved. It can also be difficult for the people in charge to pinpoint what the quarrels are about. However, the statement illustrates an interesting dichotomy between the groups because the “Swedish staff” is assumed to be stronger than the “immigrant staff” and better qualified. Consequently, distinctions between groups like this can be analysed as an ethnic conflict with a tone of ethnic discrimination. The discrimination, or in other words the exclusion, is subtle and is an example of institutionalised racism (Wellman 1993, Balibar and Wallerstein 1991). Racism must be analysed as more than concrete circumstances of violence and threats against racialised groups or individuals. When people in charge “protect” a particular group of individuals at the workplace, they do not just save the “immigrant” group from harm but rather create a specific position for the “protected” group. This position isn’t profitable for the “immigrant” group, because in the workplace context, they are different from the “Swedish” group. Therefore circumstances like this are the outcome of structural racism. The meaning of ethnicity is thereby made possible and limited by the way in which we imagine and perform identity. So, when the staff and their leaders interact in the way they do here, ethnicity acquires an essential meaning and these interactions generate a *doing ethnicity*.

Race has a Social Meaning

Sometimes people are so scared of being blamed as racists that they even help the wrong side. That's why they don't get into conflicts but have the same opinion so they won't be called a racist [quotation from the group discussion].

One potential understanding of the chiefs' "protecting" behaviour is that they are anxious about being identified as racist. This was something that even the assistants themselves seemed to be concerned about and one of them said:

I can't even think about being called a racist. I really don't think I am.

In the group discussions, the racist concept also included all those feelings that being recognised as a racist could bring. The assistants identified the word racist as an insult that immigrant people could use in conflict filled situations. They also thought that using the word racist produced demarcations between different groups and individuals.

However the word racist was distinguished as being a very strong expression and the care assistants represented it as something that shaped powerful reactions among the staff. One said thoughtfully:

But what does the word racism stand for? What does it mean? I think it's a word you use when you don't have something else to say.

The care assistants suggested that when the word racist was used it wouldn't necessarily indicate a racist act. Instead they thought of the word as an insult, frequently applied in disagreements.

In most European countries, the word race isn't used in official discussions by politicians, academics or journalists. The word race is more or less connected to specific groups who identify themselves as racists. However, in English-speaking countries for instance, the word race is used more frequently. In those contexts the concept of race does not primarily signify that people belong to different racially identified groups, but rather indicates the fact that people are treated as if they were. In circumstances like this, race becomes socially real to people (Omi and Winant 1994, Anthias and Yuval-Davis 1992, Wallman 1996). We all, in one way or another, define ourselves and others in terms of race and social processes. It is academically interesting to analyse these definitions from a critically ideological perspective. For example, the French philosopher Etienne Balibar (2003) declared racism as a discourse concealed by class interests, social privileges and political power.

Nevertheless race becomes significant in the manner of how we form an opinion about each other. A care assistant related to several incidents at her workplace where black colleagues had been discriminated. One of her clients had once said to her:

We have been cleaned by the ape family.

This came about after two black staff members had done the cleaning for them. Even though the care assistants were mainly tolerant of older people's discriminatory treatment, they occasionally thought it could go too far. They also found it difficult to deal with some of the older people's racism, but said that under such conditions they really tried to make it clear that they didn't like his/her statement. The assistants reflected on numerous episodes where especially black colleague had been the subject of clients' prejudice. Another said:

There are some of our colleagues that are adopted and they are as Swedish as I am because they've lived here since they were four months old and don't have anything else to go to. But when some of our clients see their looks they express: 'Black... he is from Africa' and then it's hopeless and that's that!

Our bodies (skin-colour and looks) represent specific connotations in relation to imaginations concerning each other's identities. Imaginations can therefore constitute discriminating behaviour.

The care assistants also experienced that there are immigrants who can be excused from racial harassments just because they not are dark skinned. One of them said:

There actually are differences among immigrants. At our job there's someone from ex Yugoslavia and the clients think she's from another part of Sweden. They're not thinking of her as an immigrant at all.

Race has therefore a major impact on social relations and, for some people, it generates factual social consequences. This demonstrates how important the body is in encounters between individuals. It also indicates that race as a social practice is created by discourses of ethnicity and ethnic relations.

One central aspect of debates concerning race and ethnicity is the construction of whiteness. Whiteness is fundamental because it gives balance to asymmetric power relations within the ethnicity discourse. Ruth Frankenberg (1993: 6) writes:

To speak of whiteness is, I think, to assign everyone a place in relations of racism. It is to emphasise that dealing with racism is not merely an option for white people – that, rather, racism shapes white people's lives and identities in a way that is inseparable from other facets of daily life.

In taking a critical position, Frankenberg wants to form a discussion that turns the complex problems within the ethnicity discourse the other way round. This means that she criticises the general notion of ethnicity as a basically non-white concern. In other words, individuals who are ethnic are acknowledged as non-white people. Frankenberg sees ethnicity as processes that create identities and also argues that white individuals create their identity in relation to this discourse. Accordingly, this means that prevailing discourses become central within everybody's identity work and are also when we visualise each other.

Discussions about race have frequently been a question of skin colour, but within race theory, a perspective on race does not straightforwardly focus on black and white individuals. Omi and Winant (1994: 22-23) write:

But this issue cannot be confined to blacks. Similar problems can be discerned in ethnic-based treatments of other racially based categories: Native Americans, Latin Americans, and Asian Americans. The aggregation of Americans of Filipino, Japanese, Korean, Chinese and now Vietnamese, Laotian, Thai and Cambodian descent into a category 'Asian American' for example, is clearly a racially based process. Ethnicity theorists might object that this is an improper exercise of 'race-thinking', that there should be no recognition by the state of such category, that these various groups should be able to maintain their ethnic identities and thus avoid 'racialisation'. But the majority of Americans cannot tell the difference between members of these various groups. They are racially identified - their identities are racially constructed - by processes far more profound than mere state policy formation.

Theoretically the race concept constructs an understandable meaning to the concept of ethnicity, or the connotation of being "racialised". "Racialisation" is a word used to give explanation to concrete situations, such as when individuals, because of their skin colour and looks, are categorised or seen as specific types (Balibar and Wallerstein 1991; Essed 1991; Fanon 1965; Gilroy 1993 and 2002; Young 1997).

Doing Ethnicity

Theoretically, ethnicity is elementary to an understanding of how human interactions contribute to the reproduction of social structures and how, in practice, ethnicity is a part of daily life. Under those circumstances, ethnicity is neither an attribute nor an activity. This means that ethnicity has a crucial meaning to us all and at the same time creates ethnic inequality, subordination and different kind of dominance in society. Inequality, subordination and dominance are related to our imaginations about each others identities.

These imaginations are especially created via the multitude of representations of ethnicity that surround us and produce indispensable knowledge concerning identities. Imaginations regarding ethnicity, race and racism therefore function as preconditions for how ethnic relations will be expressed in society. This means that, fundamentally, ethnicity is not a question of the subject of the Other; rather, ethnicity has more to do with those who, so to speak, mirror the Other and it is this distinction that is crucial.

Furthermore, it is the interactions and the activities that expose interesting connections to the doing concept. Doing gender indicates how we construct an essentialised relationship to gender. The essentialism is also to be found in terms of ethnicity. The problem is, what is distinguished as essential is not always fundamental, because the specific masculine, feminine or ethnic is always in a state of change. The doing concept therefore tries to capture this constant construction work. The basis of the doing analysis is that ethnicity is produced by social processes and that imaginations about each other's identities transform ethnicity into a doing activity. This means that we become "natural" men and women when gender is done, and "real" "Muslims", "Africans", "Swedes" and "Immigrants" when ethnicity is done.

Doing ethnicity involves a complex weave of socially governed, observable interactions and micro political activities that are primarily an expression for our imaginations about each other. Doing ethnicity is to be understood as actions created by discursive formations, although can at the same time be distinguished as a product of human interactions (Fenstermaker and West 2002). This means that ethnicity is a doing activity produced via discursively governed, practical interactions between individuals. The created meaning of ethnicity will have different connotations in diverse contexts and identities cannot therefore be seen as fixed constructions.

Even if individuals are doing ethnicity, it doesn't stand for individually bad qualifications. So when the chiefs "protect" the "immigrant" group in conflicts, it doesn't mean that they are bad people with bad attitudes. Doing ethnicity is about activities that we form together, both in actions and thoughts influenced by collectively governed discourses. To be "ethnic" is not just something you *are*, it is something you *become* in relation to and in interactions with others. Therefore, ethnicity is not a specific behaviour, qualification or role, but instead a doing of several social kinds.

When ethnicity is done, a plethora of consequences will become evident. One consequence is the way that some literature reproduces essential knowledge within the care-sector with specific information about different cultures and religions. When care-professionals are educated in the

different “cultures” and “ethnicities”, it is likely that they will have less flexible imaginations about the Other than before. To avoid a static view on a dynamic reality like ethnicity, a new perspective is necessary.

Conclusion

The discussion has been developed by making use of the analytical concept of doing. I have argued that ethnicity is made meaningful within elderly care through the ways in which identities in general are imagined. Ethnic relations are therefore essentialised interactions that are primarily substantiated through institutional structures. From this perspective, ethnicity becomes much more than individual expression and expectation. Ethnicity is consequently not an attribute, but an activity performed by the individual in accordance with a socially produced discourse, a “doing” of discursively controlled activities that constitutes the interaction between individuals. In the doing of ethnicity, class and gender feature as prominent factors. This intersectionality has repercussions for the way in which ethnic identities are both imagined and performed. Doing ethnicity thus presupposes social actions within social contexts that are discursively produced and reproduced. The meaning of ethnicity is thereby made possible – and also limited by the way in which we imagine and perform identity.

CONCLUSIONS: TOWARDS DIFFERENCE SENSITIVITY IN ORGANISATIONS THROUGH REFLEXIVITY

Carin Björngren Cuadra in collaboration with Sandro Cattacin

Organisations are both the problem and the solution: that is what this volume tells us. All the texts in this book urge a specific approach to Migration and Health, though, within an organisational perspective and from different theoretical and practical viewpoints. They highlight urgent issues fuelling the agenda on Migration and Health. The outermost frame consists of the challenges confronting the healthcare sector by the social and demographic changes of migration, together with the recognition of diversity in terms of, for example, ethnicity, 'race', gender or disability (advocated by social movements).

Challenges come to the fore through a new awareness of mainstream systems being exclusionary in relation to difference. Basically, these challenges can also be seen as coming from within the healthcare system as leading principles, such as equity in the provision of health-care, gain foothold. Equity in terms of access and equal care might be understood as a matter of quality (Bischoff 2006). Arguments to confront this challenge can thus be anchored in a need to develop a substantial equality with regard to access to care of equal quality, although as Renschler and Cattacin make clear, it might also be motivated in arguments aiming at efficiency and a productive use of resources.

As a whole, the articles included in this volume highlight the implications for healthcare systems. They put organisational change and development in perspective when critical actions are taken towards an accessible healthcare. This volume advocates an organisational perspective based on the authors' assumption that this is where 'the action is': 'action' both understood as innovative actions and in terms of existing barriers to care, enacted power relations, an imbalance in the distribution of resources, ongoing exclusion of presumptive patients, a neglect of needs, suffering,

‘othering’ and discrimination. An overarching concept might be exclusion. A deeper understanding of the organisational level can contribute to our investigation of the ways in which the healthcare system reacts to the needs of our pluralistic society and the diversity of its patients.

Organisation Excludes

The authors in this volume provide rich, empirically-based understandings of the ongoing processes and measures taken to deal with the challenges facing the health system. They reveal that in order to modify a system it is necessary to transform political consciousness, adapt institutional practices and increase individual awareness. Barriers to healthcare and an under-utilisation of services by migrants have been observed in the literature, but the picture is neither unambiguous nor elaborative. In general, it is fair to say that migrants have a reduced access to healthcare when compared with the majority population. This can be due to the patients’ language-proficiency and the staff’s attitudes and sensitivity to second-language speakers, as well as different concepts of health and disease. Likewise, the presence of racism and xenophobia forge selective barriers to healthcare (Maggi 2003) and structures the environment of the health system. The ‘political’ work of creating a society open to differences is called for. But as Nazroo shows, not only is under-treatment due to cultural differences a commented problem, but also that over-diagnosis and over-estimation of illness (i.e. mental illness) in some groups might occur as a result of patterns of “racialisation” by the experts (Nazroo 2001:140). In fact, it would seem that healthcare organisations don’t really know how to deal with differences.

From an organisational perspective, there is a risk of perpetuating the reproduction of exclusory practices and discourses. Healthcare systems are supposed to follow a universal approach, or ‘indiscriminate all-round distribution’, but the weakness of this approach is that it does not correspond to everybody’s needs and life circumstances. A universalistic healthcare system with no orientation towards *difference* actually excludes needs and thus does not represent normality. Hitherto, the healthcare system is not able to work with difference but rather approaches it as an anomaly, an exception or out of the mainstream.

Even worse, exclusionary practices are also enacted in discourses. If the relevant organisational environments affirm signs of exclusion as normality – for instance through populist simplifications – finding these arguments inside the actual organisations comes as no surprise. Björngren Cuadra and Lill give us illuminating insights into this dynamic. Their interpretation is that the professionals’ understanding of difference is intertwined with images of culture, ethnicity, structural social stratification and

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subordination. Furthermore, they maintain that we can conceptualise this convergence as two dynamics of intersections between, on the one hand ethnicity and social class, and on other hand, morally grounded considerations involving an understanding of cultural difference, ethnicity and gender. This is particularly salient in reasoning regarding ‘immigrant patients’ or ‘immigrant colleagues’ (Dahinden et al. 2003).

Both Björngren Cuadra’s and Lill’s perspectives actualise a concern of professionals’ and care experts’ practice as well as for their education. The interest is thus twofold. Practices need to be critically studied so that we can develop our understanding of how ethnicity and culture and other migration related issues are dealt with in both practice and discourse by managerial and operational staff alike.

In this context, the impact that models of transcultural competence have on access to care can also be scrutinised (Maggi 2003). A critical examination of existing education is called for here; one vital focus being the way in which concepts such as ethnicity are presented and dealt with in order to avoid the confirmation of stereotypes, as highlighted by Lill.

Exclusionary practices of a more fundamental and immediate nature, such as the lack of entitlement to healthcare, are also addressed. Milena Chimienti, Christin Acherman and Ramin Baghir-Zada introduce us to some vulnerable and precarious situations faced by undocumented migrants. While undocumented migrants’ conditions are rarely acknowledged in either research or in practice, in these pages both the lack of healthcare and poor health status in comparison to migrant groups and majority populations are highlighted. Furthermore, studies undertaken at the interface between health structures and life worlds make it clear that conditioned entitlements are not always used by undocumented migrants because they are afraid of making use of this right.³⁷ These studies make salient a conflict in the intersection between international and national obligations regarding the right to health and healthcare and Human Rights stating everyone’s right to appropriate health and living conditions. In this respect, it would appear that undocumented entitlements to care are not in conformity with the Human Rights obligations (see Hunt 2006 on Sweden).

Undocumented migrants are among the most vulnerable when it comes to health. Health determinants tend to be related to one’s own personal

³⁷ In the case of Switzerland, a study on undocumented migrants’ access to healthcare shows that 74 percent of the respondents were afraid that the care provider might inform the authorities of their undocumented status (Ingleby et al. 2005). In the case of Sweden, Medicin Sans Frontière (MSF) reports that fear of approaching services and being reported to the authorities acted as a deterrent to seeking healthcare for undocumented migrants. Every fourth person (24.5%) of respondents reported this fear (MSF 2005).

resources and social networks. Lack of structural support not only leads to current problematic conditions, but might also lead to an imminent increase in health problems on a public health scale. Furthermore, a fundamental conflict between the health professionals' ethical code and the legislative codes becomes apparent. With Hunt, and bearing practitioners at public clinics in Sweden in mind, we can make the following generalised observations:

Sweden's present law and practice places health professionals in a very difficult - if not impossible - position. Does a doctor turn away a sick, pregnant, undocumented woman who cannot afford to pay for the medical treatment she - and her unborn baby - needs? If so, what has become of the doctor's professional ethical duty to provide healthcare to the sick without discrimination? (Hunt 2006).

In this conflictive correlation we also see a critical potential embodied in health professionals active in providing care challenging public policy.

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Against the backdrop of these highly problematic observations and with facets of critical potential and possible 'openings' to hand, the authors of this volume also point towards the development of inclusion. In fact, at organisational level we also find solutions and fruitful processes. They involve the development of political consciousness, institutional practices and an individual awareness of the practitioners' everyday reality. In relation to this rather complex setting, Renschler and Cattacin provide a multilayered concept, *difference sensitivity*, with which to approach the complexity.

This concept implies a broad approach and acknowledges the centrality of organisational scope as opposed to an interpretation of personal venture or quality. It also pays attention to the situational intersection of ethnicity, race, gender, class and age. The concept's most interesting deduction is that difference sensitivity has to be understood as an integral part of the organisations' actual core activity and enacted in terms of professionalism. It implies changes that go well beyond isolated events and the strivings of secluded actors. Adding a 'migration and ethnicity' perspective to the dominant mainstream system would not 'help much' in making a difference or changes. On the contrary, what is made salient by Renschler, Cattacin and also by Karl-Trummer and Krajic is that the implementation of difference sensitivity has to do with *representation* and *participation* within decisive assemblies. Moreover, a clear *distribution of responsibility* and *power* is needed to ensure continuity in measures aiming at productive responses to diversity, whether at a decisive level or in the very encounter

with patients. Systematic measures have to be incorporated into regular procedures and supported at organisational level. Furthermore, it is of vital importance that these recourses are implemented in full, rather than in part or sectorised tracks.

One observation of these conclusions is that we can discuss healthcare organisations in terms of different rationalities, starting with the idea that an organisation can have different rationalities. The type or rationality that seems to prevail, with some exceptions, is one that is *instrumental* to a mechanical implementation of rules and norm. A form of rationality implies a relationship to the environment. Based on our observation of prevailing barriers to healthcare, inequality, a social stratification of health and the inability to adapt to new target groups, we can also ascertain that relationships seems to range from limited communication to solipsistic closure resulting in discrimination. In short, in these cases the relationship to the environment appears to be as to an entity “out there” and accordingly as to a threat.

The development urged in this volume is one of organisations open to change. Change implies a capacity for communication and embodiment with the environment. This in turn involves an organisation with *reflexive* rationality, which is non-mechanical.

Reflexivity and Quality

The interest of reflexive rationality can be further developed within a systemic model of organisations. From this perspective, an organisation is basically understood as an autonomous and self-referential system that involves a relationship with the environment. When trying to understand processes of change, an attention to factors that create patterns that encompass both the organisation and the environment is needed. This view is opposed to looking at the organisation as something totally separate from its environment and consequently relating to it as ‘out there’ (Morgan 1998). An organisational identity is instead understood as being constituted in a continuous interaction with the environment. This interaction constitutes a mirroring process of the organisation itself. Put more radically, the environment is part of the organisation (Luhmann 1982). This circular interaction process (with stable relational patterns) should not be misinterpreted and essentialised as a fortress with isolating boundaries. However, in the case of healthcare organisations, they are the logic giving rise to the observed barriers in healthcare settings.

Seen from this viewpoint, change in an organisation is by necessity a reflexive process in relation to itself and its environment; the ability to change is inversely proportionate to the organisations ‘egocentricity’.

Here a solipsistic organisation is metaphorically called egocentric (Morgan 1998). The 'egocentric' organisation clings to its more or less self assigned mission and identity, is unable to perceive itself as a part of the environment now in change and thus not able to 'read' the environment beyond its own limited identity processes. Here we might make an associative leap of analogy from egocentrism to ethnocentrism or even (ethno-) nationalism.

How, then, can healthcare organisations cope with the challenge to develop towards organisations in ongoing and reflexive development? As initially indicated, it is necessary to address modifications of the health system at different but interrelated levels. The first is the policy level. Here it is imperative to try to influence political consciousness and tackle the issues of introducing measures that are in line with current principles of international and national obligations regarding health and human rights. Based only on an enacted reflexivity, migration and ethnic difference would be acknowledged as normality in Europe. From this, appropriate measures could be taken in relation to current challenges to obtain stated equal care. As indicated, equal care can be understood in terms of quality (Bischoff 2006). Thus, fruitful incitements to create a political consciousness that encompasses groups now excluded is coupled to strivings to develop substantial equality in terms of access to care of such stated equal quality. An interconnected incitement is to be found in efficiency and utilising resources.

The model of *difference sensitivity* advocated in this volume has, at a political level, to withhold a multidimensional approach against exclusion tendencies. In this respect, one central feature is to avoid the one-sided privileging of a universalistic approach in policies, as this involves the risk of disregarding differences, migrant dynamics and communitarian acceptance of the chosen inclusion tactic. On the other hand, difference sensitivity can be said to be a relativisation of universalism. In practice, the relativisation of universalism can be achieved by introducing elements of pragmatism. In explicit terminology we might conceptualise this convergence as pragmatic difference sensitivity. An example of this could include implemented and acknowledged partial rights to care (and other essential goods like education) for the undocumented migrants (Cattacin 2006).

The second level to address in the modification of health systems is institutional practices. Here, required pragmatism might mean putting forward group and situation related projects, based on the idea that only a specific adaptation of a measure facilitates contact with a complex reality. This involves a reflexive re-negotiation of the mainstream institutional understanding of jurisdiction and responsibility. Health monitoring, in terms of access as well as of quality, is also of vital significance if conducted

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with an inclusive or specific range i.e. going beyond the majority population as one's main reference. At this level institutional discourse is in particular need of critical revision. As discourses are legitimated by the significant environment, political responsibility is also called for in this reflexive venture (ranging from criticising populist discursive exclusion to institutional practices and individual endorsement).

The third level has to do with individual awareness among health professionals regarding the challenges facing them as representatives of the (exclusionary) mainstream system and as enactors of stated equal quality care. Within this group we find a broad spectrum of receptiveness, ranging from ethnocentric practices to the critical potential inherent in the provision of care outside or at the periphery of the public system. The latter points to mainstream practices that are incongruent with the actual environment (i.e. needs). This indicates that the critical potential embraced by the professional ethics is of vital interest for ongoing and reflexive organisational change. In a reflexive development it would be fruitful to 'give voice' to these actors when implementing institutional changes at organisational level. It is interesting to reflect upon the fact that health professionals involved in providing care to undocumented migrants under the current conditions need to invoke references that are neither provided by the healthcare organisations nor the nation state.

In relation to the health experts, a normalisation of difference sensitivity in the training of healthcare providers is needed. Concepts such as 'transcultural care' or 'cultural competence' do not exclude possibilities of connecting with a historical legacy that involves ideas of racial and ethnical hierarchies and nationalism. They can still be co-opted at an institutional level and used in organising differences between ethnic categories – which involves exclusion in practice. In this context of both education and practice, Lill's research provides a fruitful perspective of images and identity formation. Such an approach could provide a useful base for reflexivity and self-critique. In relation to staff, a conscious and concrete employment and managing policy is also important.

In this volume the authors are challenging experts and policy makers in ways that - if taken seriously - require fundamental changes in the policy and organisational models that now define certain services and target groups and sidetrack others. What becomes salient is that we have outrun a uniform universalistic policy model that disregards differences. Furthermore, the authors point out that from an organisational viewpoint, learning processes geared towards an equal access to quality care based on difference sensitivity are possible; namely an enacted reflexive process involving a holistic relationship and representing a normality of difference.

This volume also indicates pragmatic ways in which a combination of multidimensional measures of change can forge a pragmatic health system that truly delivers difference sensitive care.

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THE AUTHORS

CHRISTIN ACHERMANN, Researcher at the Swiss Forum for Migration and Population Studies, University of Neuchâtel.

Email: christin.achermann@unine.ch

RAMIN BAGHIR-ZADA, Doctoral Student at the Department of Health and Society, Malmö University.

Email: ramin.baghir-zada@hs.mah.se

CARIN BJÖRNGREN CUADRA, Senior Lecturer at the Department of Health and Society and at International Migration and Ethnic Relations (IMER), Malmö University.

Email: carin.bjorngren.cuadra@imer.mah.se

SANDRO CATTACIN, Professor at the Sociological Department, University of Geneva.

Email: sandro.cattacin@unige.ch

MILENA CHIMIENTI, Researcher and Lecturer at the Department of Sociology, University of Geneva, and the Swiss Forum for Migration and Population Studies.

Email: milena.chimienti@unige.ch

BJÖRN FRYKLUND, Professor at International Migration and Ethnic Relations (IMER), Director of Malmö Institute for Studies of Migration, Diversity and Welfare (MIM), Malmö University.

Email: Bjorn.Fryklund@mah.se

URSULA KARL-TRUMMER, Managing Director at the Ludwig Boltzmann-Institute for the Sociology of Health and Medicine at the Institute for Sociology, University of Vienna.

Email: uschi.trummer@univie.ac.at

THE AUTHORS

KARL KRAJIC, Managing Director at the Ludwig Boltzmann-Institute for the Sociology of Health and Medicine at the Institute for Sociology, University of Vienna.

Email: karl.krajic@univie.ac.at

LINDA LILL, Doctoral Student at the National Institute for Working Life (Sweden).

Email: linda.lill@arbetslivsinstitutet.se

JENNY MAGGI, Researcher in Social Science, Lecturer at the Sociological Department of the University of Geneva.

Email: jenny.maggi@bluewin.ch

ISABELLE RENSCHLER, Researcher at the Sociological Department of the University of Geneva.

Email: isabelle.renschler@unige.ch

MALMÖ UNIVERSITY

SE-205 06 Malmö

Sweden

tel: +46 46 665 70 00

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