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Equality of opportunity

2–3 **Combating inequality of opportunity in health-care**

Our health-care system is based on the principle of openness and solidarity: all sectors of the population should have equal access to opportunities to improve, maintain and, where necessary, restore their health. This means that particular efforts are often required in order to reach disadvantaged groups. After completion of the National Programme on Migration and Health (2002–2017), the FOPH will continue its efforts to promote equality of opportunity. Because health disparities exist particularly between persons from different socio-economic backgrounds, the future focus will not only be on migrants but on socially disadvantaged individuals as a whole.

3 **Understanding and being understood**

The service provided by intercultural interpreters is often underestimated in the health-care system – and it is not funded. Yet failure to take communication problems seriously can have dire consequences. There is a considerable risk of wrong diagnoses being made and the wrong treatment being given. Interpreters translate in both directions, in full and accurately. They also help to explain and understand metaphors, images and idioms. This facilitates access to our health system for people who speak another language. spectra reports on what Carola Smolenski, the therapeutic head of the Swiss Red Cross (SRC) outpatient service for victims of torture and war, has to say.

4 **Diversity management in hospitals**

Patrick Bodenmann is the incumbent of Switzerland’s first Chair of Medicine for Vulnerable Populations at the University of Lausanne and head of the Center for Vulnerable Populations at the University Medical Outpatient Clinic, Lausanne (PMU). spectra interviewed Professor Bodenmann on topics ranging from the complexity of providing primary medical care for disadvantaged population groups to Switzerland’s role as a "diversity laboratory" and the management of problems whose solutions need to be addressed wherever an opportunity presents itself.

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Social disadvantage leads to unequal health opportunities

Health equity. Our health system is based on the fundamental principle of openness and solidarity: it must do justice to the needs of all groups in the population, irrespective of their language, origin, social status and level of education. This means that often a special effort must be made to ensure that the disadvantaged are also provided with basic health-care as well as health promotion and prevention resources.

Promoting the equality of health opportunities and equal access to health-care ("health equity") are guiding principles of Swiss health policy. The aim is for everyone to have the same opportunities to develop, maintain and – where necessary – restore their health. The Federal Council's Health 2020 strategy is intended to counter illness and associated suffering through effective prevention, early detection and long-term care. Other goals of the strategy are to boost the population's health-related skills, avoid unnecessary treatments and complications, and improve the efficiency of the health system.
This can only be achieved if we involve all parts of the population and pay special attention to the disadvantaged. The Swiss population is heterogeneous and there are various groups that do not have easy access to our health system or to important health information. Statutory health insurance ensures that everyone has access to the health system. Yet vulnerable groups in the population often fail to make adequate or appropriate use of health-care. We are facing the challenge of improving health opportunities by creating easy access for everyone to health promotion, prevention activities and to health-care, and by narrowing the gap between the privileged and the disadvantaged.

Unequal resources, complex effects

But who are the disadvantaged, and what steps can be taken to improve their situation specifically? A closer look at health-equity issues inevitably takes us beyond the scope of health-care in the narrower sense. We need to consider the fundamental question of the distribution of resources, opportunities in life and available courses of action in our society: social inequality – or in other words the unequal distribution of material and immaterial resources – has a major impact on health. In the academic literature, access to resources is generally described in terms of differences in socio-economic status (i.e. differences in education, professional status and income). Social disadvantage leads to unequal health opportunities. Poorer living conditions and riskier health behaviours mean that the socially disadvantaged are often exposed to greater stresses on their health from birth.
Other factors that determine social inequality include gender identity, age, a migratory background, disability or region of residence. One or several of these factors may affect a person's health situation and result in unequal health opportunities. However, they rarely have a direct impact on health. A higher income, for example, doesn't automatically mean better health. Rather, these factors have a complex effect on our behaviour and lifestyle and thus on our health too.

Health risks and the disadvantaged

Not everyone in Switzerland is able to enjoy the best possible health. People with little education, a low professional status or a low income have a substantially lower life expectancy. In addition, they suffer more frequently from health problems. Socio-economically disadvantaged migrants are also particularly affected by unequal health opportunities.

> The measures defined in the National Migration and Health Programme (2002–2017) mainly targeted migrants with a low social status, a low level of health skills and the corresponding health problems.

Studies show that their physical and mental health is often not as good as that of the native population. They are exposed to greater health risks, for example as a result of physically strenuous work or a migration history that places a psychological burden on them, and find it harder to access our health system. Their knowledge about health-promoting behaviour is often inadequate and they have difficulty in communicating with health-care providers. From the standpoint of health and integration policy, health inequity must be considered problematic when health risks affect entire groups within the population and a better state of health cannot be achieved solely by the individual taking responsibility for a healthy lifestyle. It is against this background that the Federal Office of Public Health has been involved in migration and health since the early 1990s. The measures defined in the National Migration and Health Programme (2002–2017) mainly targeted migrants with a low social status, a low level of health skills and the corresponding health problems. But the programme was also designed to improve the skills of health-care professionals in caring for migrants and provided them with appropriate tools. In addition, research was carried out to fill gaps in knowledge and to facilitate the implementation of specific measures.

Support for health-care professionals

Within the context of the National Migration and Health Programme, the FOPH worked with partner organisations to develop and promote a large number of activities to improve the health of particularly vulnerable groups within the population and to support health-care personnel in caring for migrants. Today the following are available, for example:

- interpreters working in more than 50 languages (who are either present during consultations or provide telephone interpreting);
- health information in various languages (available on the migesplus.ch platform) and a platform for multilingual media cooperation (migesMedia);
- online training for health-care professionals on the topic of communicating with migrants ("Interaction and quality" e-learning course);
- expertise of the Swiss Hospitals for Equity Network (centres of excellence in providing health-care to migrants)
- a network for the prevention of female genital mutilation;
- research findings such as the health monitoring of the migrant population in Switzerland, which has been carried out twice (2004 and 2010), and studies of mother-and-child health and the health situation of undocumented migrants.

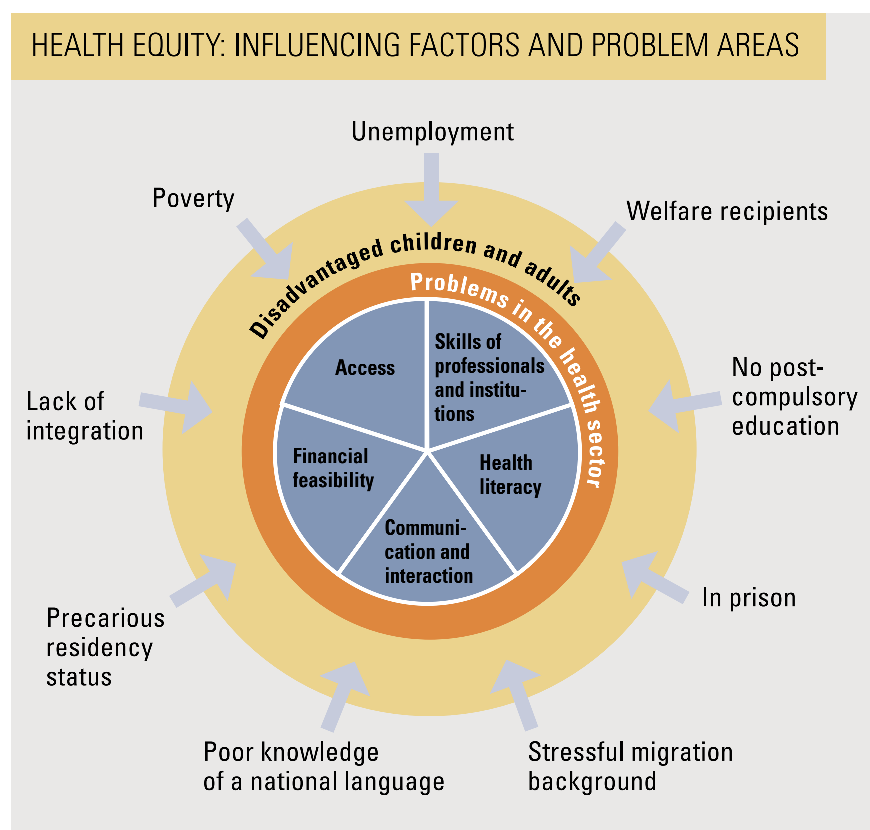
Experience from some of these projects is described in this issue of spectra.

New target groups in the FOPH's sights

The National Migration and Health Programme was concluded at the end of 2017. The main activities from this programme will be integrated into the Federal Government's strategies and ongoing tasks. The major activities in the areas of health skills and health information will be continued. The same applies to strengthening the skills of health-care professionals in interacting with migrants and promoting of intercultural interpreting (see page 3). In this way, the FOPH will continue to contribute to the country's integration policy.
Since there are differences in health not only between native Swiss and migrants but also, and more particularly, between people with different socio-economic backgrounds, disadvantaged native Swiss will also be included in future activities. The FOPH has defined the target groups that will be the focus of efforts in the coming years. In particular, these are: people affected by poverty, asylum seekers and prison inmates. They were chosen on the basis of factors that, either singly or in combination, result in disadvantages in terms of health (see figure).

> The FOPH has defined the target groups that will be the focus of efforts in the coming years. In particular, these are: people affected by poverty, asylum seekers and prison inmates.

HEALTH EQUITY: INFLUENCING FACTORS AND PROBLEM AREAS



This figure does not show all the factors that can lead to disadvantage and to the associated health-related problems. Rather it should be understood as underlining the main focus areas of the FOPH in the coming years. Gender and age, two aspects not shown here, should also be taken into account with respect to the selected target groups. Promotion of equal opportunities is a task currently shared by various departments within the FOPH. Examples include health insurance (social compensation through reduced premiums), HIV/STI prevention

and prevention of non-communicable diseases (NCD strategy), and mental health (see separate articles in this issue of spectra).
Equality of opportunities is an aspect that must always be borne in mind so that the implementation of health promotion and prevention activities can be targeted – and in order to ensure good health-care for all. Target groups who are particularly affected by health inequity must be identified and the question of whether they can be reached with existing services and activities must be reviewed. If not, they must be approached with easily accessible offers (in specific settings). Ultimately, this strategy can also reduce the over- and underprovision of care and the provision of the wrong type of care.

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Forum

Understanding and being understood – traumatized refugees and working with intercultural interpreters

It is estimated that currently between 40 and 50 per cent of all asylum seekers and refugees from war zones and crisis regions are suffering from trauma-related illnesses. Many of them have repeatedly experienced traumatic situations as a result of war, torture and life-threatening escapes. Once in Switzerland they are confronted with a new culture and aspects of residency and social law that will have a fundamental impact on their lives for years to come. Continual uncertainty about their entitlement to stay in Switzerland, a long asylum process associated with cramped living conditions and enduring poverty substantially increase the risk of their developing a mental disorder or of a health problem persisting. Moreover, access to medical care is made more difficult by various barriers. As a result, asylum seekers frequently have medical conditions that go undiagnosed and receive inadequate treatment. This ultimately leads to greater costs for the health system.
Language is the most crucial barrier to access for people who have fled their home countries. Thus "working in trialogue" is the standard procedure at the outpatient service for victims of torture and war operated by the SRC. Examinations, counselling and therapy would be impossible without intercultural interpreters. In many cases they act as mediators of both language and culture. They help to explain and understand socioculturally derived metaphors, images and idioms. The feeling of being understood, and being able to understand oneself, is a vital basis for good, professional psychotherapy as well as for appropriate basic medical care.
An example from everyday practice illustrates the relevance of the work done by intercultural interpreters. According to the referring doctor, a 19-year-old man from Syria had already undertaken an odyssey through the Swiss health system. He had already been seen in the emergency department twice with fainting fits and panic attacks. After an attack followed by confusion and aggressive behaviour, he was admitted to the acute psychiatric service for an inpatient stay lasting several days. Subsequent in-depth neurological workup, including an MRI scan of his head, produced no findings; the clinical symptoms could not be clarified. According to the patient, the examinations we carried out were the first done with the aid of an interpreter. Our specialised psychiatric and psychometric investigations showed that he was suffering from post-traumatic stress disorder and associated pronounced dissociation. The patient gained evident relief from talking about what he had experienced in his home country and while fleeing. He was gradually able to verbalise his deep distress at the violent death of his parents and the continuing uncertainty as to the fate of his siblings, and to process these experiences in a therapeutic setting. He did not subsequently present himself at the emergency department.
It is clear to us that adequate health-care can often only be provided to traumatised refugees with the aid of professional translation. Early identification of asylum seekers' mental problems and a rapid, adequate response not only relieves great individual suffering; it also facilitates their social and occupational integration in Switzerland and avoids considerable costs further down the line.
In the health service, successful communication is an integral and indispensable part of any treatment. For this reason, interpretation and translation services must be funded by the health-insurance providers and welfare authorities.

Dr Carola Smolenski, therapeutic head of the outpatient service for victims of torture and war, Swiss Red Cross

At first hand

The Swiss population has a long life expectancy and generally enjoys good health. The strengths of our health system include the high quality of care and the wide range of benefits covered by the statutory health insurance in this country. Yet there are some distinct differences in the health of various groups within the population – differences that we can influence and therefore do not want to accept as a matter of course. Our strategies should make a contribution to mitigating these differences so that we reach out even to the weakest members of society.

In this context I would particularly like to emphasise the following points: the benefits offered by our health system must also be accessible to and affordable by people who speak other languages, have a low standard of education or are affected by poverty. Our health-care professionals need the skills and tools to enable them to communicate with people from a wide variety of backgrounds. Our health information should be communicated in such a way that everyone understands it and can improve their health skills accordingly.

While carrying out the National Migration and Health Programme, we looked for ways of achieving these goals. We implemented numerous projects that are still proving their worth today and are still as important as ever against a background of growing scepticism about immigrants and the vulnerable. Most of these projects were conceived and launched by the FOPH in conjunction with external partners (particularly the State Secretariat for Migration, the cantons and many umbrella organisations and NGOs). I would like to extend my sincere thanks to our partners for their keen participation, and hope that they will continue to offer their experience and knowledge to help us achieve our goals in the future.

The FOPH will continue to work towards achieving health equity. We know that some of the major factors in achieving good health are beyond the scope of health policy in the narrower sense – belonging rather to the realms of economic, education, social and integration policy, for example. This is why health equity is a goal that we can only achieve through a concerted effort.

Pascal Strupler
Director
Federal Office of Public Health

"Diversity is an enrichment and a growing reality."

Interview with Patrick Bodenmann. Equality of opportunity in hospitals does not mean providing a "one size fits all" treatment but one tailored to a patient's individual requirements, i.e. treatment that meets the needs of the particular health problem and the particular patient. Patrick Bodenmann is familiar with this important topic, both from a theoretical and practical point of view: as university professor, as co-founder of the Swiss Hospitals for Equity, and as head of a polyclinic at the University Hospital Lausanne.

***spectra:* Professor Bodenmann, in your capacity as physician and head of the Center for Vulnerable Populations at Lausanne's University Medical Outpatient Clinic, your work focuses on disadvantaged sectors of the population. What interests you about this field?**

Patrick Bodenmann: It's a desire to combat treatment inequalities and promote equality of health-care. If we tailor patient management to the specific needs of each individual, we're being equitable, even if we don't apply absolutely the same approach to everyone.

"Some patients may certainly speak French, but their poor health literacy prevents them from understanding everything the doctor says."

Who, in your experience, are the people particularly affected by this inequality?

Such "social health inequalities" concern those who are at risk of not benefiting from high-quality health-care because they belong to specific population groups. Twenty or so years ago, those affected were mainly involuntary migrants, i.e. asylum seekers or people without documents or of no fixed residence status. Immigration grew rapidly in the 2015–2016 period and it persists – though for various reasons at a lower level. Three days ago, on the occasion of a congress in Ticino, I made a detour to Chiasso, where I saw that migratory pressures could start growing again very rapidly.

"We need to start by exploiting existing opportunities and progressing from there."

Among Swiss nationals, the problem receives less media attention, but poverty exists. In the canton of Vaud, between 7 and 8 percent of the population live below the absolute poverty line. Studies show that 10 to 15 percent of people living in the French-speaking cantons have, for financial reasons, done without health-care in the previous few months. Then there's the more subtle problem of communication. Some patients may certainly speak French, but their poor health literacy prevents them from understanding everything the doctor or nurse says. Frequent users of emergency services are also a main focus of the risks and vulnerabilities, as are prison inmates, sexual minorities, people with special needs, etc.

What sort of problems do these people have in everyday life with regard to health-care?

They have problems at three levels. The first is inherent in the patients themselves, for instance communication, which depends on their mastery of the local language, their educational level and their skills. Then there's the health system, for example hospital signage, which helps – or fails to help – each patient to find their way around. Lastly, there are the staff and the differences in their professional skills, know-how, soft skills and general understanding.

Where do we start in order to improve the situation?

We need to start by exploiting existing opportunities and progressing from there. We can sometimes act at the health-care system level itself, or at the training level for doctors and nurses. And sometimes we need to look at quality management procedures. We work on different dossiers in parallel. As soon as there's an opportunity, we take action. The deaf or hearing-impaired are a good example: the department of public health and the medical students have been mobilised, and we have been able to put a number of measures in place. This opportunity was not there three years ago.

Everything that comes under the heading of quality is essential. It may seem contradictory, but I'm a fervent defender of quality management procedures because they are of real benefit to equality of opportunity within a health-care institution.

"Quality management procedures are of real benefit to equality of opportunity within a health-care institution."

Twelve years ago, the president of H+, Peter Saladin, suggested that good management of diversity would have to become the norm in businesses. Are we anywhere near this goal today?

Management of diversity is just as important in our patients as in our health-care teams. In our outpatient clinic, diversity is a reality that is both a product of specific efforts and also a reflection of our society. If there is such a thing as a diversity laboratory anywhere in the world, then it is Switzerland, with its four national languages and three cultural regions. The fact is that management of the same health problem in a Ticino, German Swiss or French Swiss patient varies in many respects because the problem is not perceived in the same way. I don't know whether we've arrived at an ideal balance. Perhaps there's a need for more studies on the subject. In my view, diversity is an enrichment and a growing reality. The health-care system has to work with this reality and make the most of the benefits it offers, which in my experience far outweigh the difficulties.

The full version of the interview is available on www.spectra-online.ch

Our interviewee

Prof. Patrick Bodenmann is head of the Center for Vulnerable Populations. Now senior physician at Lausanne's University Department of Ambulatory Care and Community Medicine (PMU), associated professor and Chair for Medicine for Vulnerable Populations at the Faculty of Biology and Medicine of the University of Lausanne, Dr Bodenmann studied internal medicine in Lausanne and then public health in London.

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