Health Vulnerabilities of Undocumented Central and Eastern European Migrants in Switzerland

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Abstract

Destitute undocumented Central and Eastern European migrants, who include homeless people, beggars, and sex workers, are in a highly vulnerable position in Switzerland. In the absence of residence permits, their access to health services and insurance is severely limited, and they suffer from severe institutional discrimination in Swiss medical facilities. The aim of this study is to examine the health vulnerabilities of destitute mobile Eastern European citizens in Geneva and Zürich. To do this, we carried out narrative-biographical interviews with destitute migrants (n = 38) and conducted a survey (n = 126) on their level of access to medical facilities. The results show that our respondents often carried health vulnerabilities originally developed and diagnosed in their home countries to Switzerland. This tendency can be observed particularly in the case of psychiatric disorders and substance abuse. Destitute migrants mostly receive therapies and medicines in their countries of origin but survive untreated in Switzerland subsequent to arrival. Without Swiss health insurance, they turn to medical services only in cases of emergency, and even then, they are either rejected or discharged after very brief treatments. This dangerous combination of individual and systemic health vulnerabilities highly exacerbates the disadvantages of destitute Eastern Europeans and hampers their integration into Swiss society.

Keywords: migration, destitution, Central and Eastern Europe, vulnerability, homelessness

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1. Introduction

Destitute undocumented Central and Eastern European (CEE) migrants, who include beggars, street sex workers, and street musicians, belong to the most vulnerable social groups in Switzerland. Approximately 30,000 undocumented CEE migrants currently live in Switzerland, and their number is steadily growing [1]. According to the first Swiss homeless count, nearly a quarter of all homeless people living in Swiss cities originate from Central and Eastern Europe [2], and the proportion of CEE migrants among sex workers and beggars is between 70% and 80% [3,4]. Estimating the exact number of destitute CEE migrants is very difficult, as they are often not counted in the official migration statistics, since most of them live in Switzerland without a residence permit and are thus invisible to Swiss authorities. As EU citizens, destitute CEE migrants are generally permitted to stay in Switzerland for 90 days, after which they become undocumented if they cannot present work and rental contracts at Swiss immigration offices to legalise their status [5].

Destitute CEE migrants often live in mass accommodation, in self-made temporary camps, or on the street, suffering from hunger and cold [6,7]. In the absence of residence permits, they are not eligible for Swiss health and social services (apart from a few emergency solutions) and are not supported by the system of social assistance [5,8,9]. Destitute undocumented migrants are also not eligible for forms of support and services dedicated to refugees and asylum seekers, as they are treated as EU tourists whose medical insurance must be covered in their home countries.

According to previous studies, the reasons for the migration of destitute CEE citizens are mostly economic. In Switzerland, temporary jobs or atypical activities (such as begging or playing street music) can provide enough money in a few months for destitute CEE migrants to sustain themselves and their families for the rest of the year, which they spend in their home countries [6,10]. As their income is very low (at least by Swiss standards), invisible, or both, destitute CEE migrants are generally not subject to taxation in Switzerland. However, like all other temporary or permanent Swiss residents, they are obligated to pay mandatory health insurance in order to receive health services. According to various data collection projects in Basel, Geneva, and Zürich [8,9,11], destitute undocumented migrants are unable to pay expensive Swiss insurance fees: beggars earn 300–400 CHF a month, street musicians earn 800–1,000 CHF, and temporary cleaners earn 1,200–1,400 CHF. Paying even the minimum Swiss insurance fees (which vary between 300 and 400 CHF per month) is almost impossible at such low incomes. Additionally, as most destitute migrants spend months or even years in Switzerland, their social insurance in their countries of origin expires, making them ineligible for health services in their home countries too [8, 12]. As a result, highly vulnerable and impoverished migrants remain uninsured in both their home countries and Switzerland. In the absence of Swiss medical services, they sometimes use the health services of neighbouring countries such as Germany, Austria, Italy, or France, as previous studies by Temesvary [8] in Basel and by Roduit [12] in Geneva have described. These neighbouring countries sustain social security–based health systems and provide more accessible services for impoverished “EU tourists” than Switzerland does. Furthermore, destitute CEE migrants can travel home to receive treatment in some non-urgent cases if they still have health insurance in their countries of origin.

Our paper focuses on the health vulnerabilities of destitute undocumented Central and Eastern European citizens living in Switzerland through an analysis of various dimensions. We first examine systemic (macro) vulnerabilities such as the availability and accessibility of (1) Swiss health services and (2) insurance for destitute migrants. We subsequently explore (3) individual experiences with Swiss medical facilities and (4) the usage of medical systems abroad. Finally, we focus on individual (micro) health vulnerabilities in the areas of (5) physical diseases and injuries, (6) psychiatric diseases, and (7) substance abuse.

2. Methods and material

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2.1. Data collection and processing

During data collection, we applied a mixed methodology in the form of (1) semi-structured expert interviews, (2) qualitative narrative-biographical interviews (with destitute CEE migrants), and (3) a vulnerability survey on subjective social and health conditions. Although data collection was completed using a quantitative survey, we view our research study as a qualitative project for which quantitative data provided important supplementary information to fill the research gaps that we could not explain through the qualitative data. These gaps are mostly related to the systemic factors of health and social vulnerabilities that respondents faced (access to services and insurance). It is important to mention that the research project as a whole examined not only health vulnerabilities but also social-relational, housing, and employment-related factors.

In the first wave of data collection, we carried out 16 expert interviews with frontline workers for social and medical service providers (such as social workers, counsellors, mental health experts, service managers, and other professionals) working directly with destitute CEE migrants. These expert interviews helped us to understand the systemic context of health vulnerabilities from the viewpoint of social and medical services.

In the second wave, researchers carried out 38 narrative-biographical interviews with destitute undocumented CEE citizens in Zürich and Geneva, the two largest cities in Switzerland. During the narrative interviews, respondents were free to discuss their life conditions, and interviewers only marginally directed them, if necessary, towards the main research topic of health (and other) vulnerabilities [6,13,14]. By conducting these interviews, we were able to collect enough information about the respondents' medical conditions, diseases, and experiences with Swiss health services.

Finally, we executed a vulnerability survey (developed by the research team) with the involvement of 126 participants in two cities. The survey was about the subjective perception of social and health vulnerabilities, and it also reflected on the basic sociodemographic characteristics of the participants. During the quantitative data collection, we asked about the level of access of destitute migrants to various services, such as general/ambulatory care, special medical care (hospitals), psychiatric care, and dental care. Respondents could answer the questions (asking whether they had access to a given service) with "yes", "no", or "not relevant". Then, if they said no, we asked them to estimate how serious a problem the non-take-up of the given service was for them, on a scale from 1 (low) to 5 (high). From the results, we created a cumulative health vulnerability index which covered all five medical dimensions represented above.

The data collection started in April 2021 and was completed in November 2022. The survey and most interviews were carried out at social institutions such as soup kitchens, day-care services, counselling stations, and night shelters in Zürich and Geneva. Some interviews were conducted in public places such as parks and railway stations or on the street. The interviews were conducted and processed by research fellows at the FHNW and by external colleagues. We conducted the interviews in German, English, French, Romanian and Hungarian, hiring students or external colleagues with special language skills where necessary.

2.2. Sampling

The interviewees were recruited via a snowball method. We explicitly required respondents to answer our questions and then introduce us to other potential participants for further interviews. The generous support of social workers was very important in our selection of destitute CEE migrants. For the interviews, we selected people arriving from CEE countries that were EU member states because of the varying eligibilities of EU and non-EU citizens in Switzerland. Our selection criteria were as follows: (1) CEE citizenship, (2) a history of undocumented status in Switzerland, and (3) homelessness (based on the ETHOS categorisation). The ETHOS (European Typology of Homelessness and Housing Exclusion) typology on homelessness was developed by FEANTSA, an international homelessness research organisation [15]. This categorisation considers people homeless if they are roofless, lack housing, or their accommodation is insecure or inadequate.

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3. Theory and calculations

The comprehensive concept of resources (reserves) and vulnerabilities focuses on the dynamics and status of the well-being of individuals and communities [16]. Psychological, health, and social resources consist of material and nonmaterial goods, skills, conditions, networks, and privileges that contribute to a steady state which provides protection from various stressors and diseases that endanger general well-being [17]. Health reserves and vulnerabilities are affected by genetic and biological conditions, family and work circumstances, and general social factors such as the living environment [18]. These internal and external determinants intersect and can reinforce reserves or exacerbate vulnerabilities, based on the cumulative advantage and disadvantage (CAD) model of Dannefer [19]. Social inequalities (for example in housing and working conditions) contribute strongly to the exacerbation of health vulnerabilities. Health policies and institutions should diminish these vulnerabilities and secure the access of highly vulnerable groups to general medical services and facilities.

Health vulnerabilities are not always related to objective systemic conditions (such as the availability of services) and other objective indicators. The subjective perception of health vulnerabilities is at least as important as the objective dimensions in understanding the sophisticated intersection of health (and other) vulnerabilities. The subjective perception of health is highly affected by cultural dimensions that are deeply rooted in families and communities [20]. Besides the impact of family and community, the individual perceptions of health regarding a person's medical history, experiences, attitudes, and other factors (e.g., how they tolerate pain or the lack of hygiene) are also important elements of subjective health vulnerabilities [12, 21].

The neoliberal health systems of wealthy Western countries such as Switzerland and the United States often fail to alleviate the health disadvantages of highly vulnerable people [21], such that entire social groups with serious medical needs can remain without proper care [22]. In Switzerland, many undocumented migrants were excluded from social and medical support during the first wave of the COVID-19 pandemic [13]. The Swiss system was not ready to vaccinate and treat undocumented people, mostly for administrative reasons. Even when free vaccines were available to all, undocumented migrants often did not know how to obtain them without proper information. In addition, they regularly avoided taking advantage of free medical services, as they were afraid to be registered and deported after revealing their undocumented status [5, 21].

The Swiss system of healthcare is based on cooperation between private insurers and private or semi-private medical services such as hospitals, clinics, and general practitioners. Central government and cantons merely preside over the regulation of medical services and the occasional support of people who are unable to pay the market price for private insurance programmes. Swiss residents are obligated to have compulsory medical insurance, which they can supplement with various elective options (such as dental care or higher-level services such as a private room in hospitals). The price of basic insurance is a flat rate, which means that different income groups must pay the same price regardless of financial status. The price of insurance varies based on the given insurance company, the canton of residency, and the franchise (self-participation) of insured people. Only the poorest people, such as refugees or people receiving a social allowance or minimum pension, are eligible for state compensation to cover insurance fees.

4. Results

4.1. Sociodemographic characteristics

Our target group were young compared to the average age in Switzerland (42.2 years). More than half (52.4%) of respondents were less than 31 years old, while a third of them (36.5%) belonged to the 32–45 age group. Regarding their nationalities, two-thirds (65%) of respondents were from Romania, followed by Poland (10.5%) and Bulgaria (10%). The majority

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(65%) of our interviewees belonged to the Roma ethnic minority. The Roma were highly overrepresented among the participants and their share among destitute CEE migrants was significantly higher than their share of the population in their countries of origin (which ranged from 8% to 12%) [23]. However, despite their very vulnerable situation, we did not find higher health vulnerabilities among the Roma compared to the non-Roma, and therefore we did not apply ethnicity as an explanatory factor of health vulnerabilities in this paper. Regarding housing conditions, 84.5% of respondents lived as homeless in Switzerland based on the ETHOS typologies. Furthermore, 78.57% of respondents identified themselves as poor or very poor (86.25% among the Roma), and the subjective perception of poverty was higher (85%) among people staying for less than a year in Switzerland.

4.2. Overview of health status, disease, and injuries

Substance abuse was a leading issue among respondents in Zürich, where 40% of interviewees were active users of illicit drugs and/or alcohol. In Geneva, the prevalence of substance abuse was substantially lower (17% of interviewees). The prevalence of diagnosed psychiatric cases was considerably higher than the Swiss average (6%) [25] in both cities (25% in Zürich and 17% in Geneva). Furthermore, 10% of respondents in Zürich and 28% in Geneva suffered from other chronic diseases.

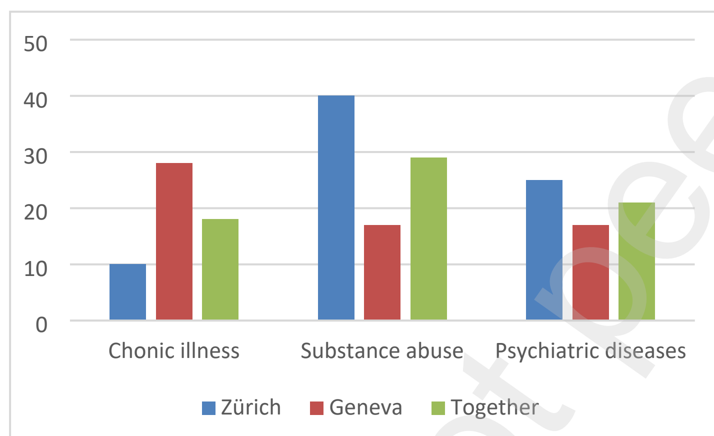

Figure 2. Types of diseases (%, n = 38)

Based on the narrative interviews, 76% of the destitute CEE migrants perceived their general health condition as being good or satisfactory. Good health condition was mostly described in the interviews as a lack of acute and/or painful diseases. This positive subjective individual health assessment was probably due to the young age of the interviewees.

Our results confirmed that destitute CEE migrants turn to Swiss medical services when they lack any other possibilities and cannot go without treatment. These cases often include serious injuries where treatment is necessary and cannot be postponed. Injuries regularly happen at work, as destitute migrants are often employed illegally under dangerous conditions as construction workers, kitchen aids, or harvest workers. Illegal employment and a lack of medical insurance makes them extremely vulnerable.

> *In 2018, I suffered a serious hand injury. I was working on a scaffold when I fell, right on my hand. It was broken twice […]. I was taken to the hospital by my colleagues, where I received first aid. (man, Romania, 33)*

In the case of dental services, one-fifth (18.1%) of respondents received dental care in Switzerland. Most of these cases were urgent dental cases, and the services were provided by emergency public dental stations. Where dental interventions were less urgent, they were often either postponed until the migrants were able to travel home for affordable solutions or not treated at all. To relieve the pain resulting from injuries and dental problems, the migrants

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occasionally used alcohol or other "home practices", as they did not have access to prescribed painkillers.

4.3. Access to health services

The quantitative survey showed that only 12.6% of our respondents used general medical services (such as general practitioners or ambulatory services) in Switzerland, and one-third of them mentioned that they needed a general medical service but could not receive it for several reasons (mostly because of the missing health insurance). Our data showed that one-fifth (20.5%) of respondents used special medical services (such as hospital care or gynaecological or dermatological clinics) in Switzerland, a much higher percentage than those who used general services (12.6%). This confirms that destitute CEE migrants use medical services in Switzerland only if they have urgent needs, especially painful diseases or injuries. Only 1.6% of respondents received psychiatric care in Zürich or Geneva, while a mere 7.9% travelled home or to other countries to receive medical support.

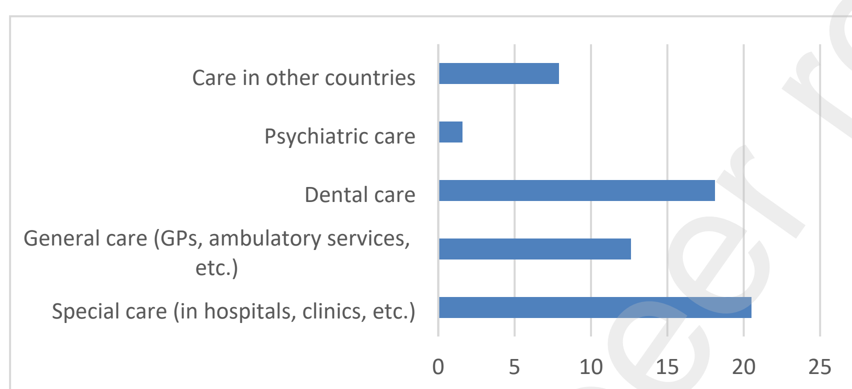

Figure 1. Types of health services used by destitute CEE migrants in Switzerland (in %, n = 126)

Most destitute CEE citizens faced a serious shortage of medical care and treatment in Zürich and Geneva. Free health services are generally not available for poorer people in Switzerland, apart from a few ad hoc forms of support organised by local NGOs. Services such as CAMSCO in Geneva and Ambulatorium in Zürich offer services for destitute undocumented migrants for free or at a reduced price. These services are limited to counselling and short-term therapies. The costs of such treatments are mostly paid by social organisations or public hospital funds.

> *If you have insurance, you don't need help. If you don't have insurance, you must go to CAMSCO, and they give you vouchers and you can have your teeth removed. (woman, Romania, 31)*

Swiss hospitals and clinics reject destitute undocumented CEE migrants unless the treatment is for emergency or epidemic reasons. Pandemic-related admissions often occurred during the recent COVID-19 crisis. Hospitals and clinics treating uninsured people regularly send the medical bills directly to the people or social organisations with whom they were staying before their hospitalisation, such as homeless shelters or day-care services. Social organisations attempt to help their clients through private donations and cantonal support, but their financial capabilities are very limited. Accumulating medical bills often push destitute people into a debt spiral as they must pay unsettled debts immediately after finding a job. A social counselling station in Zürich has the ability to effectively support its clients with a combination of private donations and state support.

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A lot of destitute Central and Eastern Europeans are sent to us by hospitals. They receive care but cannot pay the bills without insurance. So they are sent to us by hospitals or by the insurers, where they have serious debts because of unpaid bills. (manager at a counselling station for sans-papiers)

Understanding the Swiss healthcare system, with its multiple insurers and numerous services, is extremely complicated for newcomers. Even if they are allowed health insurance, destitute CEE migrants often do not understand the Swiss system of private services and insurance, which is markedly different from the social security systems in CEE countries. In the absence of adequate language skills, and in light of the difficulty of adapting to their new sociocultural environment in Switzerland, many destitute CEE migrants do not trust the Swiss healthcare system. They are also often afraid of the costs they must pay after leaving hospitals.

There is mistrust among destitute Eastern European migrants towards the Swiss medical services. A Roma woman, for example, left the emergency station a day after she had been admitted despite her serious heart problems. (social worker at a daycare service)

According to our expert interviews carried out with service managers at the City Social Departments of Zürich and Geneva, medical care for destitute CEE "tourists" is not the responsibility of the city, and the Social Department cannot take over the expensive costs of therapies for every uninsured foreigner. The administrative managers stated that if destitute undocumented people do not need urgent help, they must return to their home countries where they are insured. As the number of unpaid medical treatments is very high, political debates about the responsibility of the cantons have become very intense in the past few years. The situation was further exacerbated during the recent COVID-19 pandemic, during which a lot of uninsured CEE migrants were treated in Switzerland.

Medical care is not the responsibility of the city – if they need constant help, they must return to their home countries. (manager of the city's social services, Zürich)

Zürich has introduced a new pilot project called City Card which aims to alleviate the negative effects of COVID-19 for undocumented people by temporarily legalising their status. City Card functions as a quasi–residence permit that enables undocumented people to use some basic welfare services and to justify themselves to the authorities. Behind City Card stands a broader welfare program called Basic Economic Support (BES), a project to the value of 2 million CHF that is transferred directly to social services. This support programme allows service providers to pay the hospital bills of destitute CEE migrants and other uninsured people in need. The COVID-19 pandemic led to new and more precarious living conditions for destitute CEE migrants in both Switzerland and their countries of origin. Their living circumstances became even harder in their home countries, motivating them to travel abroad to find better opportunities. However, job possibilities became very limited in Switzerland, too. Sex work, for instance, was prohibited in most Swiss cantons for reasons of hygiene, while begging and street music were also no longer viable as people disappeared from public places during the lockdown. Positions traditionally occupied by women in gastronomy and home care were also limited as a result of the pandemic [13].

COVID functioned as a booster in the migration of destitute CEE people as life became more unbearable in their home countries. (social worker at a daycare service)

Destitute people living in Switzerland without documentation are at risk of unemployment, homelessness, and extreme poverty. Fortunately, local charity programmes and private donations from the Swiss Solidarity Fund can support some field institutions in diminishing the social exclusion of highly vulnerable groups. Geneva lacks an equivalent

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programme to BES in Zürich. Frontline social work organisations, such as soup kitchens, day-care services, night shelters, and counselling stations, are mostly sustained by NGOs, and their survival depends on private and public donations. These NGOs are often poorly financed, and they work with many volunteers, as they cannot admit qualified social workers.

> *A lot of sans-papiers have lost their jobs during COVID. They need urgent social assistance. We received a lot of support from private persons, e.g., in the form of food tickets, or they took over the health insurance fees. (manager at a counselling station for sans-papiers)*

4.4. Health insurance

Without residence permits, it is almost impossible to apply for health insurance, and consequently, only 8 of the 38 interviewees (21%) in Switzerland had health insurance. Additionally, flat-rate insurance fees disproportionally burden poor people, as they must turn a large share of their income towards insurance fees. Moreover, the most vulnerable people avoid care for financial reasons, because of the high out-of-pocket expenses incurred by the patient [31]. In rare cases, destitute migrants intentionally choose illegal employment to avoid taxation and high health insurance burdens. For instance, a former sex worker, working now as a part-time cleaner, gave up her temporary residence permit and continued working illegally, as she could not pay taxes and contributions out of her low income.

> *If you have papers without a job, you still need to pay taxes and health insurance. For what? I do not have 300 francs for a health insurance that I do not even use. It is a luxury that I cannot afford. (woman, Hungary, 51)*

Most respondents were surprised and/or upset that dental care was not included in basic Swiss insurance. In most CEE countries, basic dental care is covered by statutory health insurance, but in Switzerland, destitute migrants need supplementary insurance or they must pay for dental services directly to private providers.

> *It is terrible, I pay the health insurance, but it is not valid for my teeth, I should pay it separately. (woman, Romania, 31)*

If destitute CEE migrants lack Swiss health insurance, they are forced to rely on the support of NGOs that can pay their hospital bills. There are no permanent state or cantonal programmes to cover these debts; however, there are some initiatives, such as the previously introduced City Card project in Zürich, that provide support for uninsured people.

> *I was in hospital for 3 weeks. A social organisation paid for that, but I do not know its name. I was in the psychiatric clinic when someone visited me from social services, collected my data and paid the bills. (man, Hungary, 41)*

Social workers in frontline services mentioned that some CEE citizens forgot to cancel their Swiss health insurance when they returned to their home countries, and the debts from the unpaid insurance fees accumulated in Switzerland. As a result, when they returned to Switzerland, they faced serious debts, the payment of which caused a lot of difficulties for social organisations. People without insurance can be viewed by medical facilities as being risky and expensive patients, and therefore hospitals often only provide them with emergency services and discharge them as soon as the urgent treatment ends [24]. Receiving rehabilitation is practically unattainable for destitute CEE migrants without health insurance, and vulnerable people are discharged very early without follow-up examinations.

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Even if they are in psychosis and are hospitalised, they are discharged in 24 hours without medical insurance. This affects not only Eastern Europeans but other uninsured EU migrants, too. (social worker at a daycare service)

4.5. Experience of Swiss health services

Eastern European migrants often face rejection when they turn to hospitals. Destitute CEE citizens (like all other foreigners without insurance) are generally denied care by Swiss medical facilities in the absence of health insurance.

Once I tried to go to a clinic that was free for all. It was called Ambulatorium, but I was sent away, and they told me to go back to my Slovakian doctors, as they treat only injuries and illnesses that require immediate intervention. (man, Slovakia, 40)

In the quantitative survey, 20.5% of the interviewees were treated in Swiss hospitals for various conditions including psychiatric treatments, gynaecological problems, and injuries. Moreover, it is clear from the biographical interviews that most patients were discharged after a short course of medical treatment, they did not receive any rehabilitation, and they were not cared for after leaving the hospital.

I was taken to the hospital. I spent three weeks there. I said that I was hearing voices and had anxiety. After three weeks I was simply discharged onto the street. (man, Hungary, 41)

Very early discharges are not medically underscored, and they often lead to a “swing door effect”, as people soon return to medical facilities because their diseases are not cured; rather, their symptoms are temporarily alleviated [24]. This practice imposes further costs on medical facilities that would be avoidable with adequate treatment.

4.6. Travelling abroad to receive healthcare

Despite the absence of available healthcare services in Switzerland, only 7.9% of respondents in our quantitative survey travelled to other countries for medical care. Most respondents no longer had insurance in Eastern European countries, or they could not afford the high costs of travel. The few such journeys that did occur were for dental and gynaecological treatments, which could be planned for.

So, I finally returned to Romania for the care. It took two weeks as I had to go back more times. The health system in Romania is not the best [laughing], but they did a good job with my teeth. (woman, Romania, 36)

The other reasons for respondents using services in their home countries were language (they understood the doctors) and general trust in CEE medical personnel (and lack of trust in Swiss medical services). For example, a Hungarian–Slovakian middle-aged man was afraid that his data would be forwarded to the Swiss immigration authorities, and he would be deported after receiving care.

Apart from that, I am healthy and do not want to go to the hospital as I do not trust Swiss doctors. They forward your data to the police, and you will be deported with a short notice. (man, Slovakia, 45)

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4.7. *Psychiatric disorders*

Serious psychiatric disorders such as depression, neurosis, schizophrenia, and anxiety occur more frequently among destitute CEE migrants compared to the rest of Swiss society. More than 20% of our respondents had a diagnosed psychiatric illness, while the prevalence of psychiatric issues in the Swiss population is 6% [25]. In addition, psychiatric disorders often remain undiagnosed or untreated, particularly in the case of vulnerable social groups. Street sex workers and the homeless are particularly at risk due to their extreme living and working conditions [2,24,26]. Some of our interviewees were originally diagnosed and treated in their home countries but went untreated and stopped taking medicines after arriving in Switzerland. Psychiatric disorders deepen the vulnerability and exacerbate the social marginalisation of destitute undocumented people [27]. Homelessness and sex work often result from serious psychiatric disorders, and people land on the street because of the social implications of such disorders [28].

> *They have often serious psychiatric disorders. Those women who work while suffering from psychosis are not professional sex workers; they simply have no other choice to sustain themselves. Mentally ill sex workers often need to leave brothels, and thus the street is the only place where they can work. (social worker at a counselling station for sex workers)*

Although one-fifth of our interviewees had previously been diagnosed with psychiatric illnesses (mostly in their countries of origin), only 1.6% had received psychiatric care in Switzerland. Despite their limited access to Swiss psychiatric services, most respondents did not consider their lack of psychiatric care as a problem, and they expressed the belief that psychiatric disorders were not “real” diseases.

> - *Do you have any illnesses?*
> - *No, I am healthy. But I hear voices in my head. I have been under psychiatric treatment for 7 years and I also receive medicines. (man, Hungary, 41)*

During the narrative interviews, eight out of the 38 interviewees discussed previously receiving psychiatric treatment in their home countries. Most of those eight interviewees had been diagnosed with schizophrenia and/or chronic depression. They had usually received proper psychiatric care in their countries of origin but could not continue their treatment in Switzerland.

> *I was about 25 when I was diagnosed with schizophrenia. I had symptoms and my mother recognised it, and also my colleagues noticed it and said that something was wrong in my head. (man, Romania, 27)*

> *I suffered so much that I fell into depression. At first, it was just a bad mood, but later, suicidal thoughts came too. I spent a few weeks in hospital because of burn-out and other problems. (man, Hungary, 24)*

Most respondents had a longer history of psychiatric disorders, and they received care in various countries during their repeated migration. Going without psychotherapy and medication contributed to the exacerbation of their psychiatric illnesses and increased their risk of psychosis.

> *I have no insurance, so I do not have medicines now. I do not know how to get my pills here, but they will hopefully help me with it. Depression is a terrible thing; if I cannot have my medicines, I collapse mentally like an old house. (man, Romania, 27)*

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The seriousness of a lack of medication is shown by the fact that a few respondents had to be transported to psychiatric clinics for forced treatment when they experienced psychosis and endangered other people in public spaces. A Hungarian man with schizophrenia, for instance, spent weeks in custody before he was transported to a psychiatric clinic, because he attacked a passenger in a tram while in a state of psychosis. In the absence of adequate mental health services, some of the interviewees tried to sustain their consultations with their Eastern European doctors or solicited family members to send them medicines by post. A man suffering from schizophrenia originally organised his medication through his mother, who regularly posted pills to him from Romania, but this was not viable in the long term.

> *In the beginning, when as I was in Chur, my mum sent me my medicines by post. She got my doctor to prescribe the pills and then she sent them to me every single month. Since I have been in Zürich, I have had no medication. (man, Hungary, 41)*

As the quotation above shows, these in-between solutions are temporary and cannot be a substitute for proper treatment and medication for destitute CEE migrants.

> *These are [showing the pills] from Romania, but there are only three of them left. If I take them, I feel good – or not good, but my mood is tolerable. (man, Romania, 27)*

The lack of proper medication and treatments affects not only people with psychiatric illnesses but also those suffering from other chronic diseases. For example, one HIV patient obtained some drugs from an ambulatory HIV/AIDS clinic in Zürich but not enough of them to secure his long-term treatment. This insecurity regularly leads to anxiety for many patients living without Swiss health insurance.

> *I went to the Ambulatorium after coughing for two weeks. I am HIV positive. […] My doctors said that I cannot stop taking my medicines or I will die. I have only a few medicines left, and I am in a panic. (man, Romania, 31)*

4.8. Substance abuse

One-third of the interviewees talked about having experiences with substance abuse that considerably affected their daily life. The percentage of people living with addictions among destitute CEE migrants is much higher than the Swiss average of 3% [29]. Additionally, most interviewees suffering from addiction combined alcohol with various illicit drugs. The influence of a partner or peer group was very important in the development of substance abuse.

> *My girlfriend had a lot of problems, she used drugs. Okay, we both used drugs, we did stupid things together. After that, we broke up; I stopped drugs but continued drinking. (man, Hungary, 24)*

Among destitute CEE migrants, addictions usually start in their home countries at a very young age, with cheap drugs such as “herbal” (a synthetic drug often used in Eastern Europe), painkillers, and other materials. Then, when in Switzerland, migrants occasionally switch to “Western” drugs (such as heroin or cocaine), further exacerbating their drug dependency.

> *I had no control over my life, I started to go out with friends, really bad friends I can say now. We were drinking and smoking everything. (man, Hungary, 24)*

Based on the biographical interviews, drug consumption is often rooted in unprocessed childhood trauma, including family violence, rape, and hunger. For instance, a young Romanian man who was raised in an orphanage, occasionally raped by the older boys, and forced to beg

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used drugs as a "medicine" to overcome childhood trauma. This kind of problem management only further exacerbates the precarious situation of dependent people.

> *I started using drugs not to feel this shit life around me and not to think any more about my past. I went to the UK to leave this kind of life behind. But when I dream, I see pictures from my childhood, from my past. (man, Romania, 29)*

Psychiatric disorders and drug consumption often accompany each other. In the absence of medicines, destitute people with psychiatric issues often alleviate their symptoms by drinking and using illicit drugs. Several interviewees were arrested because of drug-related issues when they either sold drugs or committed crimes under the effect of illicit drugs.

> *I had not been sleeping for three days and took a lot of drugs. I did not know what I had done. I did not even remember when and how I was arrested. (man, Hungary, 41)*

Drug-related accidents and diseases often lead to medical emergencies. The cost of these expensive emergency treatments will usually never be reimbursed by the medical facilities in Switzerland.

> *Once, I fainted on the tram and I was reanimated. Then I was transferred to the hospital, I took painkillers and drank alcohol on it. (man, Hungary, 24)*

Substance abuse not only worsens one's individual life prospects but also harms social relationships with family and friends. Besides poverty, loneliness and social isolation often trigger emigration from Central and Eastern Europe. However, addicts are unable to improve their living conditions and social relationships upon arrival in Switzerland, as substance abuse hampers their efforts to start a new life in a foreign country. Family and community networks are often eroded because of drug consumption and its accompanying problems, such as theft, deceit, and unpredictability.

> *First, I started with herbal and become quickly addicted. People become zombies on that. When I recognised that I was addicted, my relationship with my family went bad. (man, Hungary, 24)*

Alcohol and illicit drugs often help to reduce the shame and tension destitute people feel when they beg or play music in public places. Because of this vicious circle of extreme poverty and excessive substance abuse, the more they beg, the more alcohol and drugs they use.

> *I always drink when I play. I use alcohol as I feel ashamed for doing that. People watch me and think that I am a young man and I could work like the others. (man, Hungary, 24)*

5. Discussion

5.1. Main findings

Our paper was a first attempt to scrutinise the health vulnerabilities of destitute CEE migrants living in Switzerland. Although the data collected only covers the two largest Swiss cities and cannot be considered representative for the entire country, our results underscore that the general health conditions of destitute CEE migrants are highly precarious and considerably worse than the Swiss average in all analysed domains. Due to their dangerous living and working conditions as beggars, sex workers, illegal physical workers, and rough sleepers, undocumented CEE migrants are highly exposed to injuries, psychiatric disorders, and substance abuse. Besides individual health vulnerabilities, they also suffer from systemic disadvantages that are visible through their severely limited access to medical services and

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insurance schemes. These dual health vulnerabilities, at both individual and systemic levels, impact a highly disadvantaged group who also suffer from other complex vulnerabilities in housing, employment, and social networks.

High medical costs and the fear of being registered and deported keep most destitute CEE migrants away from Swiss medical facilities. They attend Swiss hospitals and doctors only if treatment is urgent and unavoidable. Psychiatric illnesses and extensive substance abuse are particularly relevant problems among destitute CEE migrants, and these disorders significantly hamper their chances of achieving successful social integration and labour market participation. Untreated psychiatric diseases, as well as drug and alcohol-related problems, are often exacerbated by precarious living and working conditions, and vice versa.

Most interviewees did not view psychiatric disorders and substance abuse as illnesses. Apart from some injuries and emergency cases, most health problems that we identified in Switzerland had developed and been diagnosed in the interviewees' home countries and then been "transferred" to Switzerland. Despite obvious health vulnerabilities, most participants characterised their subjective health status as good or satisfactory during the interviews. This positive self-assessment was probably due to the very young age and relatively good physical health of the interviewees.

5.2. Political implications

Swiss social policy is based on the welfare principles of subsidiarity, less eligibility, and locality [30]. Like other studies [6,14], our expert interviews underscore that decision-makers and administrative managers in cantonal social and health departments attempt to discourage "welfare tourism" by providing the least possible social rights and eligibilities for undocumented European migrants regarding their access to Swiss social and health services. As a result, thousands of undocumented CEE migrants remain without medical insurance and care in Swiss cities. As they often spend months or years in Switzerland as undocumented immigrants, they also often lose their Eastern European health insurance and cannot return to their home countries for care [4]. There is currently no federal solution for providing medical care for undocumented EU migrants in Switzerland, but some cantons, such as Zürich, Lausanne, Basel, and Geneva, attempt to provide alternative forms of local support for destitute CEE migrants, allowing limited access to their local health and social systems.

Zürich, for instance, introduced the previously complicated City Card to simplify access to emergency medical and social services during the pandemic, while Basel accepted a political decree about the support of destitute CEE migrants through basic services. These are promising local initiatives that can temporarily alleviate the vulnerabilities of undocumented migrants. However, it is very important for there to be a federal regulation on a minimum level of access to Swiss medical services for people without health insurance. Without political support for concrete social rights, destitute migrants remain powerless within the Swiss welfare system. The few NGOs supporting undocumented migrants suffer from financial problems, and their human and infrastructural conditions are deficient, as shown during the recent COVID-19 pandemic. Some NGOs organise temporary medical examinations and counselling for their clientele, but these services cannot satisfy the growing and complex needs of destitute migrants from Eastern Europe.

Our results highlight that destitute CEE citizens living in Switzerland need special attention from the Swiss healthcare system. They have extremely poor access to healthcare in their home countries and Switzerland alike, and this deprivation leads to specific and cumulative healthcare problems. Furthermore, the intersection between class (financial poverty), ethnicity (discrimination against the Roma), and gender (the vulnerability of destitute women) further exacerbates their vulnerability. Our findings show the urgent need for more equity and solidarity in the Swiss healthcare system because destitute migrants are caught between two health systems, such that they are often rejected and left without preventive and curative medical care.

5.3. Where future research is needed

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Even though the health vulnerabilities of migrants are mostly rooted in CEE countries, Swiss research projects examining the health conditions of destitute CEE migrants in Switzerland avoid analysing the development of health problems in their countries of origin. The evaluation of "original" health vulnerabilities at the micro-, meso-, and macro-levels (such as environmental impacts, institutional racism against the Roma, and the malnutrition of children living in poverty) in the migrants' home countries and their implications in Switzerland would be a huge asset in understanding the problem and supporting decision makers through the use of empirical data. As part of such an evaluation, local communities affected by migration should be examined by researchers to reveal the relationship between poor health and migration. For instance, tuberculosis (TB) occurs relatively often in destitute CEE communities such as Roma settlements and homeless camps, while this disease is almost forgotten in Switzerland. People suffering from TB become isolated, often lose their social relationships and jobs, and frequently become impoverished. We also found similar tendencies with people suffering from HIV/AIDS or psychiatric disorders. Health-based social exclusion can be a reason for migration for many people. Uncovering these comprehensive tendencies is a prerequisite for developing adequate services for people with health vulnerabilities in Swiss cities.

5.4. Conclusion

In Switzerland, there is a large and continuously growing group of destitute Central and Eastern European citizens who are not registered in the country, are mostly active in the informal labour market, and do not have health insurance. These conditions lead to multiple vulnerabilities, of which health disadvantages are particularly severe components. Migrating CEE citizens often carry their health vulnerabilities to Switzerland, where their individual disadvantages come face to face with a healthcare system that excludes and rejects them. This precarious combination of micro and macro (health) vulnerabilities contributes to the severe marginalisation of destitute people and substantially hampers their social integration in Switzerland.

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Declaration of Competing Interest

The authors have no conflict of interests to declare.

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