Independent Study Project (ISP) Collection   SIT Study Abroad

Spring 2023

Migrants sans Papiers: the Impact of Cantonal Program and Policy Discrepancies on Undocumented Migrant Healthcare Utilization in Switzerland

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Spring 2023

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Abstract

While Switzerland houses what is generally considered one of the best healthcare systems globally, regional policy discrepancies leave undocumented migrants (UDM) in precarious conditions that threaten the nation's claim to universal health coverage. Critical analyses of existing UDM-catering structures in different cantons, the Swiss Confederation member states, reveal that local discrepancies in healthcare utilization are functional gradients of cantonal support and public endorsement. Relationships with these authorities are instrumental in steering health outcomes not only with program funding and outreach but also management of studies to better understand UDM health determinants and inform future preventative measures.

UDM services and initiatives operate throughout the nation albeit with urbanity variations. However, while French-speaking cantons, notably Geneva and Vaud, are generally more receptive to migrant populations and transparent with services, German-speaking cantons, including Zürich and Bern, lack public cantonal support which may create underlying currents of distrust among UDM, many of whom hear about services through word-of-mouth. Findings reveal that in place of public hospitals that assume responsibility for UDM in French-speaking regions are non-governmental organizations (NGOs) in German-speaking counterparts. While these NGOs typically develop greater trust with vulnerable populations and can aid individuals with navigating unfamiliar health systems and care treatment, they remain limited in scope in migrant support and outreach due to autonomy from cantonal authorities and thus, finite resources and funding. These results demonstrate the interplay between the different layers of organizational structures within the cantons and pave the way for investigation in how to equilibrate such differences.

Acknowledgements

Sincere thanks and gratitude goes out to the staff and team at SIT: Global Health and Development Policy, particularly Academic Director Dr. Alexambre Lambert who provided support and guidance through the independent research period. Additional thanks to Dr. Anne Golaz, Dr. Elisabeth Meur, and Françoise Florens who oversaw the program and provided a professional environment to seek advice and counseling.

Many thanks are also extended to all interviewees and informants, namely Badia El Koutit, Dr. Heikki Mattila, and Lorenzo Piccoli, without which this study would not have been possible.

Lastly, I would be remiss in not mentioning my host family in Switzerland who has provided me joy in daily interactions and support in fostering a welcoming environment, in which I was able to conduct research. The same extends to members of this study abroad cohort as well as my network of family and friends back in New York and New Haven who have provided me with emotional support and daily laughs to uphold my motivation in this process.

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Introduction

A country historically defined by its influx of migrants, Switzerland makes up 29.9% of the global population share, the third highest amongst Organisation for Economic Cooperation and Development countries in 2021. The same year, the Federal Statistical Office reported that 40% of the nation's population hails from migration backgrounds, defined by the United Nation Migration Agency (2019) as the movement "across an international border or within a State away from [ones] habitual place of residence" (p. 132). While citizens of the European Union and European Free Trade Association may, without restriction, immigrate to Switzerland and obtain residence permits by means of the 1999 Freedom of Movement Act, quota restrictions for refugees generate an inflow of undocumented (UDM) or "migrants sans papiers", individuals who enter and reside in a region without proper authority. This holds true especially for seasonal workers initially permitted entry under Switzerland's 1991 "three-circle" policy but are now unable to return to their homelands due to political turmoil or upheaval. Without the coveted "refugee" status, defined by the United Nations High Commissioner for Refugees (2010) as those forced to emigrate due to "a well-founded fear of being prosecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (p. 3), UDM, many of which come from precarious circumstances have difficulty accessing humanitarian aid and resources including food, shelter, legal counseling, and healthcare services.

In the aftermath of the Covid-19 pandemic and periods of social turbulence, Switzerland's State Secretariat for Migration received 24,511 asylum applications in 2022, excluding Ukrainians who receive special protection. Of these applications, 17,599 were processed and 4,816 were approved for asylum (Restelica, 2023), representing a 27.4% approval rate but nearly 7,000 individuals who were unable to plead their case. In 2022, Switzerland witnessed a

corresponding triple fold increase of illegal immigration of over 50,000 cases according to the Federal Office of Customs and Border Protection. UDM, many of which already carry high burdens of diseases due to global health issues ranging from the spread of infectious diseases to gender-based inequalities, traditionally cluster around urban centers and work low-wage jobs in hazardous conditions that are further conducive to poor health outcomes. Healthcare access in Switzerland, a country with a globally renowned healthcare system that practices universal but also private healthcare thus becomes of particular interest. While federal policies grant UDM the ability to purchase private health insurance, the associated costs act as systematic hindrances. Moreover, regulated by its twenty-six cantons, healthcare in Switzerland is highly decentralized and dependent on local policy implementation; there may therefore be discrepancies in healthcare access on the basis of geography and local attitudes toward immigration and social welfare. In addition with the sociocultural barriers associated with acclimating to a new language and environment, this translates into low UDM health coverage.

While there has been research based on the "availability, accessibility, acceptability and quality" framework for asylum seekers and refugee populations, there remains a knowledge gap in healthcare access for UDM, partly due to the difficulty of accessing the associated networks and data sources while balancing ethical considerations with these vulnerable populations. Thus arises the research question, "How do cantonal healthcare policies and implementations affect healthcare utilization for undocumented migrants across Switzerland?". With a focus on the role of non-governmental organizations (NGOs), local programs, and cantonal discrepancies, such a study will provide insight into the "migrant experience" and serve as a launching pad to develop targeted policies or interventions to ensure the right to health for all.

Research Methodology

To investigate the intersection between local healthcare programs and UDM healthcare utilization, this study is framed as a comparative analysis of different cantonal approaches. Data collection proceeded through both primary source interviews and secondary source literature analysis. This analysis was mainly qualitative but incorporated quantitative elements with cantonal healthcare utilization, though statistical analyses were not performed due to a lack of controls and standardized data collection. Identification of peer-reviewed literature began with the use of key terms in both English and French, for example "undocumented migrants" and "migrants san papiers", to gain access to the full scope of research. Of particular interest was Opération Papyrus, a one year regularization scheme that aimed to legalize UDM in Geneva and the subsequent study Papyrus that assessed the impact of such regularization. Many of these studies served as a useful base to gain general background information on irregular migration within Switzerland. The rest of secondary source research was identified through revised combinations of key words or references to the bibliographies of relevant literature.

To better gauge a migrant health perspective, the literature search was followed by a group interview with Badia El Koutit, the founder L'Association pour la Promotion des Droits Humains (APDH), a Geneva-based NGO dedicated to promoting human rights, particularly for Middle Eastern and North African migrants. In her role directing and overseeing different programs including the womens' table, Badia holds expertise in cross-cultural mediation and the lived experiences of migrants. After speaking with her in early February, a few members of the School of International Training (SIT) Global Health cohort arranged group interviews for their irrespective research projects. Although the interview was conducted in English, the nature of the group interview helped in overcoming language barriers as a few individuals were better-versed

in French than others. The following interview with Dr. Heikki Mattila, an academic advisor for

SIT International Relations who previously worked with the United Nation Migration Agency,

similarly provided background information and further points of contacts. More insight into

health access programs in different cantons and the impacts for UDM health came through the

third interview with Lorenzo Piccoli, a research fellow for the Migration Policy Centre at the

European University Institute. As author and co-author of several studies identified in the

literature search that explored regional healthcare discrepancies, Piccoli is an expert in

comparative politics and migration studies. He thus provides useful insight into patterns of

healthcare utilization across Switzerland. Professor Yves Jackson, the head of Opération Papyrus,

was available only the first week of May, past the Independent Study Project period.

In terms of ethical considerations, consent for identity and affiliation disclosure, the use

of quotes, and audio recordings were requested prior to interviews. In instances when recordings

could not be granted as with Professor Mattila as per the SIT program policies, data collection

proceeded with note-taking. As this study involves UDM, a particularly vulnerable population,

extra precautions were taken to maintain confidentiality. Migrants from ADPH introduced by

Badia are classified as "migrant X" and given minimal background such as country of origin.

Examples drawn from Jossen's (2018) interviews are described in a similar manner. Migrants are

given pseudonyms and the NGO, based in a non-UDM policy-inclusive canton, is anonymous.

Due to the clandestine nature of UDM networks, outreach was difficult but was resolved partly

due to the "snowball" or word-of-mouth approach. Given the rather niche nature of this topic,

there was also no literature that directly addressed the interplay between cantonal variations and

UDM health. However, the mixed research methodology allowed for data collection from

different perspectives which worked in tandem for a more comprehensive analysis.

Literature Review

In Switzerland, current estimates place the UDM population at 58,000 to 105,000, two-thirds of which enter the country without authority or overstay their visa and the other one-third of which fail to seek asylum or lose their legal statuses (Jossen, 2018). According to the 1996 Swiss Federal Law on Compulsory Health Care (LAMal) known as "Loi fédérale sur l'assurance-maladie" in French and "Krankenversicherung" in Swiss-German, all Swiss residents of three months or longer, regardless of legal status, must be enrolled in healthcare within an insurance scheme. In 2002, the Federal Social Insurance Office accordingly threatened legal sanctions against private companies that denied insurance coverage to UDM (Jossen, 2018), as an attempt toward universal healthcare. This, in reality, posed a paradox to migrants legally obliged to seek insurance in Switzerland, a country consistently ranked among the highest per-capita healthcare spending, lagging only behind the US. In addition to the CHF 300 to 2,500 annual excess and additional retention fee, payment of 10% of remaining costs up to CHF 700, residents must pay monthly premiums which on average, flux between CHF 300 to 400. Recent reports from Swissinfo (2022) reveal 3.9% to 9.5% increases in monthly premiums across the cantons averaging at CHF 335 and resulting in an average bill of CHF 397, which according to Jossen (2018) constitutes about 26% to 49% of a UDM's average income. As such, this translates to a 80% to 90% proportion of UDM who are uninsured across Switzerland (Jossen, 2018).

For UDM and other uninsured populations, Sprang et al. (2010) report CHF 50 to 100 for a GP consultation, CHF 500 for hospitalization, and CHF 4,000 to 20,000 for birth events. Because individuals within these populations, many of which come from precarious economic backgrounds and face post-migration barriers due to a lack of labor protection, typically cannot afford such care, health services are only sought when absolutely necessary, resulting in overall

diminished quality of life and health outcomes. Alternatively, when UDM do seek care, there is a prolonged gap between the onset of symptoms and first consultation when compared to residents as observed in Meditrina, a Zürich-based medical center (Bilger et al., 2011). Invariably, previous studies reveal that compared to the general Swiss population, UDM are more likely to suffer from sexually transmitted infections, tuberculosis, and parasitic infections including Chagas disease (Yves et al., 2018). In regards to reproductive health and pregnancy care, UDM are less likely to utilize available technologies; compared to 2% of their documented counterparts, 18% of undocumented women did not conduct cervical smear tests (Wolff & Epiney, 2008, as cited in Jossen, 2018). Furthermore, undocumented women sought antenatal care four weeks later than Swiss nationals, representing a delay to care when health systems hinder accessibility.

While economic subsidies in the form of premium reductions exist, they are largely variable based on the cantons which steer healthcare access on the basis of a) financial qualifications for reductions, b) ownership of public entities, c) subsidies of private counterparts, and d) alternative access channels in the absence of health insurance (Piccoli & Wanner, 2022). Of the twenty-six cantons, only the ones of Vaud and Geneva have "implemented primary care services within the public healthcare system for this population" while other cantons "delegate this task to nongovernmental organizations or offer no service at all, apart from access to the emergency department of public hospitals" (Yves et al., 2018, p. 2). Starting in 1957, the canton of Vaud began targeting interventions and funneling public funding toward vulnerable populations including the young, elderly, and those with irregular incomes. According to an interview conducted by Piccoli (2018) with a doctor from Lausanne, not only are patients granted complete confidentiality but healthcare services are also extended at "preferential rates

or even free of charge depending on the financial possibilities of the patient" made possible by a well-invested safety-net infrastructure enables the distribution of substantial health care subsidies. Since the early 2000s, these tasks and programs have been delegated to the "Unité des Populations Vulnérables" (UPV) and "Centre de Santé Infirmier" (CSI) departments at the University of Lausanne.

Within the Geneva University Hospitals (HUG), health authorities began diverting efforts and allocating funds into guaranteeing quality healthcare following LAMal and currently operate under the "Unité mobile de soins communautaires" (UMSCO) and "Programme Santé Migrations" (PSM) departments (Piccoli, 2018). One HUG-based study with 732 participants examined primary healthcare outcomes for UDM throughout 2014 and identified a mean of 2.9 health conditions, which in 18.4% of cases, affected the endocrine, metabolic, and nutritional body systems (Yves et al., 2018). A majority of 71.8% participants had at least one chronic condition while 20% had three or more. Within this sample population, hypertension, obesity or overweightness, and gastric disorders, all of which are common comorbidities, were also highly prevalent, reflective of general conditions across Europe where diabetes runs common among migrants who have double the cardiovascular mortality rate compared to non-migrants (Yves et al., 2018). Such a pattern further highlights the chronic disease burden and risk of hospitalization for preventable complications in migrants, particularly UDM.

In conversation with preceding studies, the reported 2.9 mean health conditions among the UDM sample represent a significantly higher number of health conditions compared to other migrant groups, namely asylum seekers; one study of 3,170 participants identified a mean of 0.58 health issues (Pfortmueller at al., 2013, as cited in Yves et al., 2018), while another showed a median of 0 conditions (Bischoff et al., 2009, as cited in Yves et al., 2018). This trend of health

disparities between migrant groups is also documented by Tzogiou et al. (2021) who used the Oaxaca-Blinder approach using linked health survey data and determined that in comparison to non-migrants, certain immigrant groups tend to suffer from higher mortality and morbidity rates. In accordance, one Swiss comparative analysis of mortality patterns reveals mean death ages of 54 for UDM, 71 for documented migrants, and 80 for Swiss citizens (Piccoli & Wanner, 2022). This gradient demonstrates the importance of considering different migrant subpopulations and shared characteristics, for instance legal status, when studying health outcomes. In consideration of cultural relativity, Tzogiou et al. (2021) reveal that immigrants more closely similar with native populations, for example, second versus first generation and culturally similar versus dissimilar immigrants were less likely to experience impaired quality of life attributed to health issues.

Beyond Geneva and Vaud, networks among UDM remain covert. In these cases, a lack of cantonal support hinders the distribution of quality care in a timely manner. In one anonymous non-governmental organization (NGO) based in a canton with no specialized services for UDM, the range of equipment and therefore service is severely limited; in the words of David, a volunteering general practitioner (GP), "there are many things we can't offer… We now have an ECG [electrocardiogram]. But we have no spirometer, we can't fully examine people's hearing and so on. We don't have our own lab. We're only open three half days a week" (Jossen, 2018, p. 26). Similarly, the canton of Zürich provides no alternative healthcare access channels for its estimated 10,000 UDM population. Rather, private associations such as the Protestant Church, NGOs, and informal networks such as "Meditrina" intercede as third party provider systems but remain independent of cantonal authorities (Piccoli, 2018).

While research on cantonal comparisons are relatively limited, Piccoli & Wanner (2022) reveal that while death from circulatory system diseases was on average twice as frequent in UDM compared to their documented counterparts and Swiss nationals, the effect was less noticeable in the "inclusive policies" cantons, defined as programs promoting the "inclusion of undocumented immigrants in the mainstream system", namely Geneva and Vaud. The "no policy" group on the other spectrum was defined as cantons with "no public policy in place". Interestingly, the greatest statistical significant difference occurred in health outcomes of UDM who resided in the aforementioned "inclusive policies" cantons and in the "fragmented policies" cantons, seven regions with "no structured policy, but coordination with NGOs and public funding" (Piccoli & Wanner, 2022), emphasizing the importance of fully integrating all populations into healthcare programs and policy to promote global health. Such results suggest promising policy-informing implications for proper access to health across all twenty-six cantons. This ensuing study thus aims to investigate the knowledge gap of cantonal variations in healthcare utilization among UDM, a severely neglected population in current literature, and roles different organizational entities including local actors and NGOs as well as governances play in shaping healthcare seeking paths.

Analysis

Migration in the Context of Healthcare Decentralization in Switzerland

Setting the larger scene of international migration, Professor Heikka Mattila describes how the majority of migrants who transcend across borders have working papers in order. Certain populations, including migrants across the US-Mexican border and those from the Mediterranean, Mattila continues, contain a larger proportion of irregular migrants (personal communication, April 14, 2023). Domestic and international law often focus more on those

coming through authorized channels including refugees and asylum seekers rather than UDM due to the notion that they drain public coffers of social welfare and medical care.

From a legal stance, Article 12 of the Federal Constitution of the Swiss Confederation states all individuals are entitled to assistance and resources to lead a dignified life which the Federal Office of Public Health has interpreted as medical care beyond emergency aid. However such a framework remains subjective and dependent on local authorities. According to Bilger et al. (2011), some cantons have implemented the "right to basic medical care" in their constitutions but remain ambiguous in what and for who this entails. Other cantons have worked more rigorously to ensure the right to health. In December, 2011, for example, the HUG Advisory Board of Medical Ethics recommended that irrespective of insurance status, UDM should be entitled to the same healthcare as the general Swiss population which Piccoli describes as "access not only to emergency services but also 'essential and continual' services including treatment to diseases like HIV or cancer and biomedical consultations with physicians" (personal communication, April 27). Such a provision has allowed for the creation of mainstream UDM-targeted programs publicly funded by government authorities in Geneva that are absent in other cantons.

Another case in point is the process of regularization, in which individuals obtain a resident permit for where they previously lived illegally. In 2001, Swiss law granted cantons the ability to apply a regularization provision in cases of "acute individual hardship", which in 2018 was extended to cover rejected asylum seekers as well. Ambiguity of such a framework, similar to the previous example of Article 12, led to high variations in regularization applications; from 2001 to 2004, "90% of all applications were forwarded by Geneva, Vaud, Fribourg and Neuchâtel, and Bern while other cantons have not applied this provision at all" (Federal Office

for Migration, 2004, as cited in Bilger et al., 2011, p. 18). This, in part, can be attributed to the tendency of certain cantons to be more liberal versus conservative in attitudes toward social welfare and immigration. Responsible for setting service provider licensing requirements, health insurance premium costs, funding toward public and private facilities, and more generally local treatment toward UDM, cantons hold great jurisdiction over healthcare access. Studying these discrepancies can then inform efforts in providing uniform healthcare across Switzerland.

The Undocumented Migrant-NGO Relationship

Case Study #1: ADPH, a Geneva-based NGO

For UDM who may not have access to social welfare benefits that asylum seekers or refugees possess, NGOs serve as a critical channel in seeking social and logistical support. Badia El Koutit, founder and executive director of ADPH, briefly describes the idea of cultural psychiatry and describes health consultation as a cross-cultural interaction where different beliefs, attitudes, and knowledge from both the patient and doctor may influence medical treatment and health outcomes. Because many organizations like APDH are staffed by migrant women themselves, there is often an innate level of trust built between migrant newcomers and support staff. Badia herself, for example, is a Moroccan migrant who went through the process of assimilating into a new country and navigating the health and social welfare system. She serves as what Bilger et al. (2011) refer to as a "key mediator", someone of a similar background who can truly reach through to "newcomers" and mediate between UDM and institutions of the host country because of his/her own experiences. Additional programs such as roundtables aimed to aid migrants with resettlement not only establish migrant-NGO trust but also empower them with a solidified sense of self; in these spaces, women who hail from Middle Eastern and Northern African countries with patriarchal hierarchies can detach from their identities of "mother" and

"wife" and instead exist as and claim their individual identity. Itineraries and meetings planned based on conversations and counseling rather than inferences allows ADPH to effectively serve migrant populations in Geneva.

While ADPH does not specialize in deliverance of healthcare services directly, it serves as an intermediary to connect individuals to specialists, for example, migrants seeking mental health services. Rather than quality, accessibility remains the primary barrier for healthcare; from her personal experience and discussions with other migrants, Badia recounts how expectations of high-quality Swiss healthcare typically matched up with the realities. However, cultural and translational barriers can sometimes interfere with healthcare deliverance. In the case of Switzerland where there are many homeopathic medicine practitioners, certain alternative medicine beliefs including treatment based on the self-healing nature of the body may not necessarily match up a patient's understanding of medicine and bodily systems. Badia identifies language as the primary barrier in healthcare settings and details one encounter in which a patient unknowingly consented to a procedure he did not want and another where a woman seeking gynecological services was extremely discomforted because the specialist she was taken to was male which she was unaccustomed to but unable to express (personal communication, April 4, 2023). When there are no translational services available, male figures may step in but are unable to accurately relay communications due to gender-based roles which are especially prevalent in families from migrant backgrounds. Other times, children, having spent a larger part of their life in the host country may take up translational roles. This however, may not only be ineffective due to a lack of familiarity with medical vocabulary but also may negatively shift family dynamics in who carries the burden of care. NGOs thus serve as a neutral party as a pathway to healthcare access.

Another role of NGOs beyond cultural acclimation include assurance of the right to health for migrants and aid with paperwork and documents. While the average healthcare premium as outlined above ranges from CHF 300 to 400 and is canton-dependent, Badia herself pays CHF 700 per month because she was not informed she was paying for the general insurance as well as for specialized physiotherapy services. Badia describes how this is shared experience among migrants; being presented with paperwork especially in foreign languages is very overwhelming and means signing or consenting to terms one does not fully comprehend. Because many migrants may not possess high legal literacy, they are unaware of the LAMal healthcare mandate and are blindsided when they are mailed monthly insurance bills they cannot afford. Similarly, though UDM are entitled to the same healthcare services as the rest of the Swiss population, many remain unaware of their right to health and avoid healthcare settings due to fear of deportation. One previously undocumented woman, migrant A, recounts the difficulty of seeking antenatal and reproductive care– while she had positive experiences with her previous two pregnancies in Tunisia, the third in Geneva was more obscured with apprehension. After her initial consultation, migrant A was highly reluctant to return in fear of the police. Following her cesarean section which she was informed was necessary due to the timing of her previous births, migrant A was also upset but did not report to medical authorities in fear of retribution (Koutit, personal communication, April 4, 2023). In such cases, members within NGOs who have built trust with the UDMs may intervene and either speak on their behalf or encourage them to voice concerns themselves.

Case Study #2: Unnamed NGO in a "No Policy" Canton

The previous example of migrant A is a narrative consistent amongst many migrants regardless of age and gender; through interviews conducted at an unnamed NGO where 90% of

patients do not have health insurance, Jossen (2018) shares the fear of UDM, 90% of which do not have health insurance. Maria, who fled political turbulence in her home country, immigrated to Switzerland in 1997 and was permitted to remain in the country because of her marriage which soon deteriorated due to marital and family abuse. When governmental authorities refused to recognize her remarriage several years later, Maria went through several bureaucratic complications appealing to the state secretary, state court, and federal court for a total of nine times which cost her husband more than CHF 20,000. She then details how immigration authorities attempted to deport her several times provoking fear to the point where "even in the night… if I should hear a car, I would get out of bed to go and see if it's the police" (Jossen, 2018, p. 55). The physical and psychological toll caused pain Maria described as "outworldly" and "even more than punishment". It was only until after her run-in with this NGO that she finally received quality gynecological support and care free of charge. Maria was diagnosed with a myriad of health conditions including a fibroid causing heavy menstruation, iron deficiency anemia, high blood pressure, and depression which she was then able to seek treatment for from healthcare professionals within the network.

Similarly, other patients Jossen (2018) interviewed, some of whom lacked healthcare access for upwards of a decade, accessed treatments for a variety of health issues including dental problems, diabetes, and cancer only by means of the NGO's network. The scope of support also extended to mental health support and other issues including food and housing insecurity. While instrumental in aiding migrants navigate an unfamiliar healthcare system, NGOs have limitations especially in cantons that do not funnel public funds and investments into such organizations. David, the volunteer GP who previously commented on the lack of medical equipment available in certain facilities, describes the balancing act between seeking medical

procedures and managing organizational capacities especially financially. He summarizes how in surgery, "I was used to being generous… everything that was a potential diagnosis was checked in the lab" whereas with UDM, clinical tests and diagnoses are inextricably linked with money (Jossen, 2018, p. 58). David chronicles a medically ambiguous situation where he was not sure whether a woman had just badly bruised or broken her finger. Though he sent her a referral for solely an x-ray, the woman was attended to by an orthopedic surgeon who operated on her which was "from a medical perspective, perfect", but posed a great challenge as it cost CHF 6,000 to 7,000, a significant financial burden (Jossen, 2018, p. 58).

Another migrant at the NGO, Jonathan, left his home country following the death of his two brothers, who like him, both suffered type I and type II diabetes. Because he had already given up his assets for the journey to Switzerland, Jonathan had no means of care during the trip and was immediately hospitalized upon arrival. Because he could have been treated in his home country, according to immigration authorities, Jonathan was rejected asylum and subsequently left without a means to secure employment and shelter all while experiencing worsening health conditions. Similar to the case of Maria, it was only after Jonathan's referral to the NGO that he was able to secure diabetes care through the network and build trusting relations with health professionals, notably Caroline. Even after the NGO financially secured health insurance for Jonathan, he had to be constantly reminded of his right to seek counseling and healthcare services. With the support of Caroline and trusted doctors in organizing not only pro-bono medical treatment but also housing, Jonathan began the process of recuperating. As aforementioned however, NGO support teams are restricted in some capacities; Caroline recalls how the team was almost relieved when Jonathan experienced another medical episode as it would at least allow him access to resources including food and shelter in the hospital. Moreover,

while the insurance company that the NGO partners with attempts to make special arrangements, there are only a few trained specialists and outcomes are dependent on a case-by-case basis. Many other companies do not extend the same levels of data protection, making it difficult to provide wide scale services for UDM. Alluding to Maria, for example, though she is in her own words "freed from bondages", she still faces an ongoing battle choosing between paying for insurance premiums and efforts of legalization to obtain proper employment and ensure a life without fear. The existing roles of NGOs thus fall within the realms of social and financial support in healthcare access but remain limited in scope and reach.

The Undocumented Migrant- Canton Relationship

French Speaking Cantons

With further investigation into cantonal policies and program implementation, it becomes evident that legal entitlement to healthcare granted on the federal level does not necessarily correspond to access. Aid for migrants including Social Services are thus typically not extended to UDM especially in private healthcare settings as Badia reveals (personal communication, April 4, 2023). Contrary to traditional models of healthcare services where private healthcare entails better service at higher charges, Badia lends insight into how in the undocumented sector, public facilities are usually much more effective because they can afford to dedicate more time to a patient's needs and have more resources for vulnerable populations. In HUG, for instance, translators who offer services free of charge may be available whereas othertimes, NGOs step in to help. Other times when these groups are not present however, migrants, particularly UDM may have to pay for services out-of-pocket, which represents a supplementary cost that must be paid on top of premium insurance and deductibles. In this manner, utilization of healthcare

services is more dependent on the relationships between different organizational structures within a given region.

Though migrant A faced difficulties in accessing reproductive care, she received support from Social Services during the twenty-one days of bedrest following her cesarean section. During this period, medical bills were forwarded to social welfare programs which greatly alleviated financial burdens she may have experienced otherwise. Although migrant A spoke French rather fluently, medical personnel also offered to bring in translational services during consultation and offered food, clothes, and other childcare necessities for childbirth. It is critical to note how this instance of health service occurred in Geneva which has already established itself as an UDM inclusive canton. Here, where the distinction between various migrant populations is blurred, legality plays a minimal role in service delivery compared to other regions.

HUG, UMSCO, and PSM in Geneva. In further analysis of healthcare access in Geneva, cantonal HUG provides healthcare access to migrants, both with and without legal status as well as other vulnerable populations including the homeless and sex workers. Its UMSCO team is composed of ten full-time employees including six nurses that make up the first part of the "double gate-keeping model" who offer free drop-in services and regularly make rounds in Geneva to areas such as homeless shelters (Bilger et al., 2011). The second element of this model includes practitioners such as dentists, gynecologists, and psychotherapists in the outpatient clinic in addition to social workers who conduct socio-economic assessments of patients and assist with administrative tasks accordingly. A robust system with a committee to assess a patient's conditions based on certain medical, social, and economic criteria ensures a distribution of funds on a case-by-case basis. This system accounts for different circumstances

for a needs-based approach; for example, select patients without health insurance have the financial means to cover treatment costs while those with insurance may not. Operations funded by the Social Services Department by the city of Geneva, UMSCO coordinates with other local social services and organizations and according to Bilger et al. (2011) "is a member of the cantonal-communal *platform against exclusion* which coordinates different services for the marginalized on a local level" (p. 58). One partnership includes the one with association *Pharmacies du Cœuer* which allows patients with an UMSCO physician prescription to obtain medications for free in two city pharmacies. For Centre Santé Migrants within the PSM department which treats unsuccessful asylum seekers, another collaboration with cultural mediators trained by the Geneva Swiss Red Cross (SRC) enables the proper deliverance of healthcare.

      PMU, UPV, and CSI in Vaud. In Vaud, the only other canton with mainstream policy in place for UDM, the UPV and CSI units similarly operate under a double gate model. Healthcare facilities provide a wide range of services including preventative care and surgical services while staff are trained in transcultural interactions to effectively serve its clientele. Because the Policlinique Médicale Universitaire is a legally recognized institution, it receives considerable funding from the Canton of Vaud and additionally benefits from federal and municipal subsidies (Bilger et al., 2011). In partnership with the cantonal university hospital "Centre Hospitalier Universitaire Vaudois", Fleur de Pavé which aids female sex workers regardless of legal status, and the UDM serving association "Point d'Eau Lausanne" which is funded by the city of Lausanne, PMU possesses strong networks of physicians and UDM rights advocates that mobilize to provide quality healthcare to UDM and push for further legislation to do so. Because the divergence of identity and different social issues including economic disparity and racial bias

is prevalent among vulnerable populations, interorganizational collaboration and coordination allows for the efficient allocation of resources and discussions on future initiatives to identify and address gaps. Such collaboration also helps to avoid duplications and strengthen existing networks, for instance, creating stronger initiatives in place of multiple poorly-administered ones. With earned trust from the target community as well as support of cantonal authorities which Piccoli describes may "create broader community channels through billboards in the city and social networks for more extensive reach" (personal communication, April 27, 2023), these programs namely Geneva's HUG and Vaud's PMU reach wider audiences and achieve greater impact, a self-perpetuating cycle.

German Speaking Cantons

Meditrina in Zürich. In consideration of German-speaking cantons, one of particular interest is Zürich. While UDM population counts vary slightly by source and may have a larger margin of error compared to other demographics, Zürich is home to the nation's largest UDM population. According to Sans-Papiers Anlaufstelle Zürich as reported by Bilger et al. (2011), less than 1% of UDM in the canton are insured and most of those who are are pregnant women close to finalizing regularizing through marriage. For this UDM population, Piccoli asserts that the German equivalent of public authorities that provide migrant care structures in French cantons are civic society organizations that run on the goodwill of voluntary doctors and nurses (personal communication, April 27, 2023).

One such organization in Zürich is Meditrina which is subsidized by the city and makes healthcare more accessible for vulnerable populations. Founded by Médecins Sans Frontières (MsF) in January 2006, Meditrina was a direct response to the canton's UDM health crisis and aimed to serve as a point of contact between vulnerable populations and health professionals.

Four years later, after the program had accomplished its initial goals and provided more than 3,400 treatments, Meditrina was passed down to the Zürich's SRC. Through discussions with public hospitals and the cantonal university founder, Meditrina authorities were able to work with Sans-Papiers Anlaufstelle Zürich to negotiate with Public Health Department of Zürich and the cantonal social security service and lower tariffs towards care for UDM (Bilger et al., 2011). Meditrina provides a wide variety of services ranging from basic and emergency care to infectious disease control of tuberculosis and HIV. Because of its extensive network of over fifty care providers, Meditrina staff can also refer patients to specialists at free or reduced costs. In addressing cultural psychiatry and the cross-cultural nature of consultations, Meditrina is comprised of a multilingual team trained in International Health Master of Advanced Studies, a program designed to train personnel working in culturally diverse environments. Such conditions are conducive to the general success of Meditrina.

   Gesundheitsversorgung für Sans-Papiers in Bern. Its less-known analogue in Bern exists as Gesundheitsversorgung für Sans-Papiers which caters towards an exclusively UDM-clientele, unlike Meditrina. Formally established in 2005, this SRC organization inherited a network of professionals previously serving Medizinische Beratung für illegalisierte Frauen, a Bern-based non-profit organization that provided healthcare to female UDM at free or reduced charge. Organizational staff, all of whom come from migrant backgrounds, consists of a nurse who conducts a drop-in service three times a week as well as additional medical professionals. After initial assessments and counseling on disease prevention, the nurse may refer to medical staff either employed by Gesundheitsversorgung für Sans-Papiers itself or specialists in the network, including those at a SRC hospital who usually bear parts of healthcare costs. Through ties with Ambulatorium für Folter-und Kriegsopfer, a nearby center that provides ambulatory

therapies for patients traumatized by war or torture, the nurse can also send patients to an outsourced multidisciplinary team in the case that GPs and practitioners within the network itself cannot provide aid. Funded by the SRC, Gesundheitsversorgung für Sans-Papiers also manages a special fund for patients with financial hardships or difficulty obtaining health insurance. The clientele base has expanded greatly with 70 UDM patients in 2008 which doubled in the subsequent year.

Italian Speaking Cantons

AMD in Ticino. Within Ticino, Switzerland's only entirely Italian-speaking canton, its largest city Lugano is host to Antenna May Day (AMD), a non-profit service aimed at facilitating health access service to populations with legally ambiguous statuses. Founded in 2008 after MsF research declared it was impossible for UDM to access healthcare services except in emergency cases, AMD's *Salute nell'ombra* project started organizing efforts to build a network of healthcare professionals to treat UDM free of charge. Such service is made possible by volunteer services from these professionals and specialists as well as funding from cantonal social assistance called "Ufficio del Sostegno Sociale e Inserimento" that reimburses members of the *Salute nell'ombra* network including hospitals and socio-psychiatric service. AMD's additional alliances with local pharmacies allow UDM to access medications at low costs while cooperation with various migration services in Ticino allow cross-collaborative efforts instrumental to outreach. As reported by Bilger et al. (2011), the project coordinator of *Salute nell'ombra*, the service is "a member of a wide network of socio-sanitary and judicial services which have a long experience of dealing with migrants" (p. 68). Notably, AMD's partnership with local organizations active in health promotion for sex workers runs parallel to the relationship between the canton of Vaud's PMU with Fleur de Pavé. These French and

Italian-speaking canton-based organizations thus demonstrate how cross-collaborative approaches with local actors can produce synergistic relations that improve healthcare utilization among UDM.

Cantonal Variation: a Comparative Analysis

Using the framework developed by Piccoli & Wanner (2022) which divided the twenty-six cantons into three groups based on the type of UDM healthcare policies as shown in Table 1, there seems to be a trend in policy type along the basis of linguistic speaking regions; of the four French-speaking cantons, Geneva and Vaud make up group 1, the "inclusive policies" group and the other two cantons Neuchâtel and Jura belong in group 2, the "fragmented policies group". The three bilingual cantons of Bern, Fribourg, and Valais fall either into group 2 or group 3 (no policy). Further geographical and linguistic analysis reveals how in the canton of Fribourg, over two-thirds of citizens speak French making it the "most French" canton of the three. The correlation between linguistic area and policy attitudes toward UDM thus remains consistent; whereas Bern and Valais are placed in group 3, Fribourg is placed in group 2.

Table 1.
Cantons Categorized Based on Policy Attitudes Toward UDM

Label	Type	Cantons (with population in 2020)	Notable urban areas (with population in 2020)
Group 1: Inclusive Policies	Inclusion of undocumented immigrants in the mainstream system	Geneva (506,343), Vaud (814,762)	Geneva (203,856), Lausanne (140,202)
Group 2: Fragmented Policies	No structured policy, but coordination with NGOs with public funding	Basel-Stadt (201,156), Fribourg (325,496), Lucerne (416,347), Jura (73,709), Neuchatel (175,894), Ticino (350,986), Zürich (1,553,423)	Basel (178,120), Lucerne (82,620), Zürich (421,878), Winterthur (114,220)
Group 3: No Policy	No public policy in place	Aargau (694,072), Appenzell Innerrhoden (16,293), Appenzell Ausserrhoden (55,309), Basel-Land (292,955), Bern (1,043,132), Glarus (40,851), Grisons (200,096), Nidwalden (43,520), Obwalden (38,108), San Gallen (514,504), Schaffhausen (83,107), Schwyz (162,157), Solothurn (277,462), Thurgau (282,909), Uri (36,819), Valais (348,503), Zug (128,794)	Bern (134,794), Biel (55,206)

Note. This figure is adopted from Piccoli & Wanner (2021).

Comparing health utilization among the different programs, stark differences in the 2008 clientele base exist between Gesundheitsversorgung für Sans-Papiers's 70 patients compared to UPV/CSI's 650 and HUG's ~4,800 patients. While this may be attributed to a larger UDM population in French-speaking regions, several reports show how many German UDM "showed up at PMU (Policlinique Médicale Universitaire), in French speaking Lausanne, because they could not receive (adequate) care in their 'own' canton" (Bilger et al., 2011, p. 61). In parallel, informants within the PSM of HUG also posit that staff are only required to treat UDM residing in Geneva but frequently treat patients whose applications for asylum have been dismissed as invalid and come from other cantons where they are denied care. As seen in Table 2, cantons Geneva, Vaud, and Zürich serve larger quantities of UDM based on sheer quantity alone. Given that the number of UDM or rate at which the population has grown stayed relatively constant in the few years following, this matches reports from the State Secretariat for Migration 2015 report which estimated the UDM population at 13,000 for Geneva, 12,000 for Vaud, and 28,000 for Zürich (Bradley, 2018). In this context, healthcare utilization is seemingly higher in the French-speaking cantons; Zürich, which houses twice the number of UDM, served only a small fraction of patients that Geneva did. Discussion on Ticino's AMD and Bern's Medizinische Beratung für illegalisierte Frauen remains limited as data was collected during the early years of founding when the organizations may not have been fully established yet. While the general trend remains potent, the aforementioned ebb of migrants from other cantons to seek care and the mismatch between clientele numbers in 2008 versus UDM canton populations in 2015, direct comparison of healthcare utilization of residents of each canton is difficult.

In direct opposition to the influx of UDM into French-speaking cantons, reports indicate that despite growing UDM needs, Meditrina was almost shut down during its first two years of

operation due to the lack of patients. Since then, the clientele base has grown since then and with it, public awareness of the necessity of such initiatives yet public service providers tend not to publicly advertise their affiliation or cooperation. While such estranged relations may diminish fear of deportation for UDM, it may also undercut the legitimacy and perceived effectiveness of programs. Piccoli also describes how psychologically, treatment from "those with suits of MSF or SRC" creates a sense of isolation and disconnect from the general Swiss population who may seek care anywhere they wish (personal communication, April 27, 2023). Therefore, despite providing the same quality healthcare as cantonal hospitals and programs do, these SRC organizations may not be as effective in bolstering healthcare access because there remains a degree of separation from care for Swiss nationals that is unappealing and perhaps demeaning to UDM. Ultimately, the nature of non-cantonal endorsed programs may also delay advocacy and outreach efforts of existing programs, which upon the establishment of a solid clientele theoretically solidifies a self-promoting UDM network that operates through word of mouth.

Indeed, success of canton of Vaud's UPV/CSI and Geneva's HUG share a common denominator– UDM perception of not only autonomy from police and asylum authorities but also well-founded and trustable alliances with "different relevant stakeholders including cantonal authorities in charge of emergency aid" (Bilger et al., 2011, p. 60). One health professional from Lausanne revealed "if I ever find myself in the situation of being an undocumented migrant in need of health care in this country I would without doubt move to one of the Francophone cantons" (Piccoli, 2018, p. 161). Interestingly within group 2, there are several German speaking cantons as well as an Italian speaking canton as shown in Table 1, which suggests that linguistic region is not the sole driver of healthcare policy. Studying commonalities between organizations within Zürich, Bern, and Ticino as analyzed previously reveal they all enact partnerships with

local actors and authorities, which has shown to increase health utilization. However, these collaborations and affiliations tend to remain covert unlike in French-speaking cantons where the broadcasting of partnerships may be the make-or-break factor in creating mainstream healthcare policy and securing UDM trust.

Taking this into consideration, French-speaking regions may tend to have higher UDM healthcare utilization not only because of elaborate NGO networks but also service providers and health programs that are officially canton-approved and funded. While NGOs aimed at advocating for healthcare access for vulnerable populations exist all across the nation and are important to paving pathways for healthcare access in their own right, some may have greater capacities than others. According to Piccoli, because "German speaking canton structures run by civil society organizations are smaller, they run the risk of excluding certain populations" (personal communication, April 27, 2023). He continues how because migrant communities communicate along cultural channels, an NGO that serves primarily North African migrants may seemingly be meeting a canton's UDM health demands but is in actuality overlooking other migrant communities such as those from South America (personal communication, April 27, 2023). For other NGOs, for example, the one discussed in the second case study which is most likely to be in a German-speaking canton because of its non-inclusive policies, the aforementioned limitations, mainly economically, means there is an aid capacity threshold for healthcare and social support services. In accordance, Piccoli reveals how compared to the stability of programs such as UPV and CSI in Lausanne, many civil society organizations run only for two to three years before running out of funding or volunteers (personal communication, April 27, 2023). It is after this "threshold" or point that UDM must seek alternative healthcare channels which can typically cater a larger clientele base for extended periods if publicly-funded.

As exemplified by ADPH in Geneva, organizations in French-speaking cantons tend to receive public funding from their respective cantons (Koutit, personal communication, April 4, 2023), a possible contributing factor to better UDM health outcomes in these regions.

Comparing Zürich's Meditrina versus Bern's Gesundheitsversorgung für Sans-Papiers, the former receives cantonal support in the form of subsidies and reduced tariffs but no direct funding while the latter receives neither. Both are even marginally successful though because of funding from respective SRCs, which despite being a private funding channel is a more reliable financier because of its reputation and funds from other organizations including Swiss Solidarity, SRC Humanitarian Foundation, and other Red Cross chapters though these SRC-funded programs have much work ahead of them before attaining the success of services as far-reaching as Geneva's HUG and Vaud's UPV/CSI. Even so, it remains critical to bear in mind that despite cantonal variances in accessibility, UDM still remains a vulnerable population subject to xenophobia and discrimination. Badia illustrates several occasions where social workers requested undocumented women to put their children up for adoption and then return to their home country. Suffering both physically and mentally from not only the circumstances she fled from but also the ones she encountered in Switzerland, migrant B from Syria describes the emotional turmoil and further depression she fell into following her stillbirth when medical authorities did not grant her possession of the fetus which she requested on the basis of cultural customs. Badia recounts migrant B's crisis, "I lost my baby… and then I lost my culture" (personal communication, April 4, 2023) and her struggle with coping. Such instances serve as reminders that there remain many individuals who defy trends in UDM health and fall in the crevices of healthcare access no matter how exalted the system. It is for this reason, access patterns must be continuously analyzed to inform policy and standardize health coverage.

Table 2.

Select NGOs and Programs Targeted Toward UDM Throughout Switzerland.

Linguistic Region	Canton	Program (years since founding and 2008 data collection)	Funding Source	Collaborations	Healthcare Utilization in 2008[b]
French-speaking	Geneva	ADPH	Public, city of Geneva[a]		
		HUG: UMSCO (12), PSM (15)	Public, Canton of Geneva	UMSCO– Pharmacies du Cœuer PSM– cultural mediators trained by the Geneva SRC.	UMSCO– 3,000 UDM clients PSM– 1,000 consultations with medical staff, 800 consultations with nurses
	Vaud	PMU (51) : UPV/CSI	Public, Canton of Vaud	PMU– Centre Hospitalier Universitaire Vaudois, Fleur de Pavé, Point d'Eau Lausanne.	650 UDM
German-speaking	Zürich	Meditrina (2)	Private, Zürich SRC	Previously MsF, currently with Public Health Department of Zürich and the cantonal social security service	1,187 consultations and 248 new UDM clients
	Bern	Gesundheitsversorgung für Sans-Papiers (3)	Private, Bern SRC	Ambulatorium für Folter-und Kriegsopfer	70 UDM clients
Italian-speaking	Ticino	AMD, *Salute nell'ombra* (0)	Public, Canton of Ticino	Local pharmacies, unnamed local organizations active with migrants and other vulnerable groups	20 consultations, though it was its inaugural year

Note. The table above displays information about select programs and organizations discussed throughout this study. Data was compiled from different sources including primary interviews and secondary literature.

[a] Information on the funding source of ADPH was gleaned from correspondence with Badia following the group interview.

[b] Data was collected from Bilger et al.'s (2011) study based on interviews with key informants

Conclusion

Based on these findings, levels of organizational collaboration, funding channels, outreach efforts, and program ties with cantonal authorities all work in conjunction as determinants of UDM healthcare utilization and outcomes. While UDM networks are present all throughout Switzerland, those run by civil society organizations with no cantonal support tend to be less effective in the long run for a multitude of reasons including a) lack of public funding or volunteers, b) covert nature and referral through word-of-mouth that may not reach certain UDM communities, and c) lack of updated research to understand the migrant experience and how to best serve these demographics. Such circumstances lead to the incursion of UDM into French-speaking regions which have well-established and stable programs with histories of cooperation with cantonal authorities and local organizations that aid other vulnerable populations including sex workers and the homeless. With frequently overlapping identity markers due to structural racism and bigotry, these communities benefit from collaborations and wide networks of alliances that may be harder to form in German-speaking cantons due to more reserved and conservative attitudes.

With the rise in drop-in clinics and services for UDM, cantonal authorities and members of the general public are now beginning to realize the necessity of targeted interventions to successfully promote public health and welfare. Opération Papyrus which ran from February 20, 2017 to December 31, 2018 and legalized 2,390 long standing UDM Geneva residents was not only largely declared a huge success but also marks a critical juncture in such initiatives. Its effects seem to have reverberated across the country; in March of 2017, just at the beginning of the project's timeline, the far left in Basel called for cantonal authorities to more clearly define regularization criteria according to the Organisation of the Swiss Abroad SwissCommunity. In

the same report, Herzog (2017) describes how left-wing parties in Jura submitted a motion calling on the government to follow the Papyrus project. Such moves toward more inclusive policy demonstrate the potential to standardize UDM healthcare.

That francophone Swiss cantons may have made strides in UDM healthcare accessibility only acknowledges existing public health gaps and further highlights the needs of these populations. In examining the success factors of current systems and organizations within Geneva and Vaud, future policy may work in further refining the balance between developing relations with cantonal authorities while maintaining UDM trust. German speaking regions may instead engage with cantonal and regional advocacy to mobilize authorities to collaborate with local actors. While this study focused its analysis of French-speaking regions based on cantonal operations within Geneva and Vaud, directions for future research can focus on the other francophone cantons Neuchâtel and Jura to observe whether this trend is consistent, and if not, further investigation into a) why the previous pairing is unique and/or b) if the latter pairing shares certain characteristics with policies in German-speaking cantons. Given the wider implications of UDM healthcare, especially the lower economic strain for healthcare systems to provide preventative and primary care rather than emergency services according to Piccoli, initiatives toward truly universal healthcare not just theoretically but also in practice will generate ripple effects reaching far beyond UDM. As gains in UDM healthcare will, on a larger scale, correspond to gains in public and global health, it remains critical as ever that public authorities implement migrant-inclusive policies.

Abbreviations

ADPH– L'Association pour la Promotion des Droits Humains

CHF– Swiss Francs

CSI– Centre de Santé Infirmier

GP– General practitioner

HUG– Geneva University Hospitals

LAMal– Swiss Federal Law on Compulsory Health Care

MsF– Médecins Sans Frontières

NGO– Non-governmental organization

PSM– Programme Santé Migrations

PMU– Policlinique Médicale Universitaire

SIT– School of International Training

SRC– Swiss Red Cross

UDM– Undocumented migrant

UPV– Unité des Populations Vulnérable

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