The politics and the media have discovered for some years a subject called "migration and integration", not focusing on the future oriented creation of a society of cultural variety, but rather on the limitation of the immigration and on the obligation of the immigrants to obey the "German leading culture'. Yet is Germany, in its social reality, for some time a country of immigration. The ordinary, but also many scientific interpretations of the connection of migration and health are culturally stamped therefore being problematic because social structural variables – status affiliation, employment / unemployment, living conditions, training, sex, age, migration status etc. – are extensively fading out.

Germany as an immigrant society. The politics and the media have discovered for some years a subject called "migration and integration", not focusing on the future oriented creation of a society of cultural variety, but rather on the limitation of the immigration and on the obligation of the immigrants to obey the "German leading culture'. Yet is Germany, in its social reality, for some time a country of immigration, even if many politicians and the majority of the population refuse to believe it. The immigration issue lead to racist deliverances, the Prime Minister Edmund Stoiber Vorschub even stating that the German people “are mixed by foreign immigrants”¹.

A sidelight on history shows that the immigration and emigration of people, the encounter of their cultures and bordering experience on present-day Germany were not an exception: after the downfall of the Roman Empire, the Roman soldiers and mercenaries remained in Germania, settling down in the onetime Roman cities, in Mainz as well. For many centuries, the local, religious, ethnical and national minorities were Jews, Sinti and Roma, Sorbs, Frisians and Danes.

Starting with the 16th century, the Huguenots, the Dutch and the Salzburg inhabitants made their appearance as religious refugees and development workers, and in the 14th century the Italians settled down as bankers, salesmen, artists. The first modern immigrant workers came after 1870/71, the Ruhr poles, immediately obtaining the Prussian citizenship.

As a consequence of the booming economic development, at the turn of the century, the German Empire turned from an emigration country to an immigration

one, being on the second place (the second biggest “labour force importing land” - 1914) after USA, with 1,2 Million immigrant workers. These few historical data belay that the revived ideology of the national state, whose citizens are ethnically and culturally homogeneous, was empirically incorrect, even in the past. West Germany eventually came to enjoy prolonged economic growth beginning in the early 1950s.

After the Second World War the so-called “economic miracle” of the labour force demand increased in West Germany, not being able to cover the local labour force potential.

On the 22nd December 1955 Germany and Italy closed a contract on the „Recruitment and settlement of labour forces” in Rome, after that following other contracts with more countries in the 60s such as Spain, Greece, Turkey, Portugal, Morocco, Tunisia and Yugoslavia.

The immigrants were not part of the German history, reality and workday since the recruitment contracts, but since the Middle Ages, and not the poor ones were always the immigrants, but very often qualified specialists, enriching the cultural and economic development of the country.

Some information on the “foreigners” living in Germany, who picture a drawn immigration situation, because they relate the status “Foreigner” to the nationality, but the denizen and the emigrants of German origin from East European states are considered German and their “emigration background” remains unconsidered.

According to the Demographic Federal Office², Germany has around 7,34 Million Foreigners, i.e. a percentage of 9% of the entire population. These figures have remained constant for 10 years. If we also count the immigrants with German citizenship, with 3 Million emigrants of German origin from East European states, then we reach a sum of 15 Million people with migration background living in Germany, i.e. 20% of the population. The largest groups are the Turks with 1,878 Million (25, 6%), the Italians with 601 Thsd (8, 2%), immigrants from Serbia and Montenegro with 568 Thsd (7, 7%), Greeks with 355 Thsd (4, 8%), Poles with 327 Thsd. (4, 5%), Croatians with 237 Thsd. (3, 2%) and Austrians with 190 Thsd (2, 6%). Over 30% of the foreigners come from a member country of the European Union, but the other immigrants belong also to European countries. The „Foreign Population“ is, due to its prolonged whereabouts, a stable component of the population of Germany, which explains why many migrants are socially and culturally integrated in our health system, thus they do not expect any different care.

Migration and Health. The ordinary, but also many scientific interpretations of the connection of migration and health are culturally stamped therefore being problematic because social structural variables – status affiliation, employment / unemployment, living conditions, training, gender, age, migration status etc. – are extensively fading out.

Therefore considerable health risks of migrants correlate: primarily with the over representation of workers and with unemployment and the living conditions compared to the German population, and secondarily with the cultural factors.

Before the second half of the 19th century, as a consequence of the transoceanic emigration movement in the United States of America, the syndrome “Nostalgia” was conceived by psychiatrists, explaining the predisposition of Italian immigrants for the mental illness caused by a so-called “cultural shock”.

From the sociological research carried out by the Chicago school in the 30s to the first German scientific analyses on the health consequences of the work migration in the 70s and early 80s of the 20th century, the cultural dimension as a problem-generating variable represents the centre of perception. Real or alleged specifics of the migrants regarding the genesis of health problems, the definition of clinical pictures, the development of the disease and of its treatment and the conditions of the health system performances are drawn back to cultural differences and conflicts.

Socio-cultural and demographic central particularities of migrants, who can find expression in the health system as well, can be found in the following variables:

- Age: The immigrants are clearly younger than the German population, the older age groups being considerably less occupied. Age is an important variable with regard to health and disease risks. The variable “Age” favours the migrant’s health condition.
- Gender: The rate among male migrants is comparatively higher, leading to a higher percentage of mortality in slighter morbidity in comparison with the German population.
- Work: the employer-employee relationships and the work conditions of the immigrants are often marked through slight formal work qualifications, heavy physical work and flexible working hours, thus the majority of the

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3 Generalized statements are not possible due to the fact that European societies strongly differ from one another regarding the migration history, the present situation and the composition of the migrant population. The following remarks are drawn from a German perspective, the situation in classic immigration countries such as France, Sweden, Belgium and Luxembourg may be commensurable, while the situation is presenting itself differently in countries like Poland, Hungary and Romania.
“foreigners” perform unqualified jobs, while the German employees are working on higher professional positions. Therefore, there is a greater possibility of accidents and diseases among the migrants. The social subsegment status of many migrants definitely correlates with higher accident risks and other health oriented burdens, many times leading to chronical diseases.

- **Unemployment**: The registered unemployment has been for centuries constantly twice as high as the average representing around 20%. The unemployment indicates a relevant health-related risk, especially regarding the psychical and psychosomatic diseases.

- **Living conditions**: Also the worse living conditions of the migrants have a great impact on their health conditions, leading especially to a higher risk of consumption/phthisis and infection diseases.

Even if, as previously mentioned, the health condition of the migrants has been extensively adjusted, there are still significant differences in some fields, such as:

- **Pregnancy, birth and children**: in this case we establish a higher rate of deaths among infants as well as still births due to indifference towards the mothers’ monthly check-ups, but we also encounter a higher death percentage among the mothers, especially the Turkish ones. The care for children with migration background is almost lacking, leading to handicaps and diseases that are not tracked down in due time. Occupational diseases and rehabilitation: occupational diseases occur more often and earlier, demanding rehabilitation measures.

- **Psychical and psychosomatic diseases**: It has not been established yet, if the immigrants have a higher predisposition for psychical illnesses, but there are indications that migrants belonging to the lower class, as well as others of similar situation, are subject to psychical and psychosomatic illnesses. Especially the Turkish women are inclined to depressions rather than other immigrant or German women, justified through traditional disease conceptions.

The role of the relatives. The potential of the family support and of other self-help oriented possibilities of the migrants in their ambivalence must be critically evaluated. Two aspects are exemplary treated: the possible role of the family within the health system and of the capacity of coping with the language problem at the interaction with the medical personnel.

On the one hand, there is the laic system – in this case the family, the relative networks, neighbours and friends - an important resource of self-help, of
emotional and material support in managing the disease and thus a necessary completion of the professional aid offer. Help may result rapidly, informal having as confidence base the joint cultural orientation.

On the other hand, the culturally-shaped familial laic theories can negatively influence the perception and the capacity of coping with the illness, as well as the adequate requests of the health system. A medical contact provided by the origin culture with illness, in particular concerning prevention behaviour and precaution investigations, can lead to false diagnoses and to the delayed professional medical help. Health problems which are not adequately treated in the relational sphere can entail more frequent hospitalizations in an acute condition. Indicators can be the higher mortality percentage of mothers and infants, the stomach diseases (especially at male migrants) as well as deficits at the early diagnosis of disabilities. The migrant rehabilitation measures are less taken into consideration as well.

The role of verbal communication. Problems of migrants in the health system result especially from the lack of communication, due to language problems, between the patients and the medical personnel or other co-workers. „Language problems“ is a diffused term, usually meaning that a person, who does not control very well or at all the language of the country he/she lives in as a communication condition as compared to the population majority, must receive assistance in an institutional context, such as the health system.

Other than in the beginning of the migration of the first generations, nowadays we deal with a different migration reality as well as with heterogeneous language conditions. A third of all immigrants live for over 20 years in Germany, the older migrants much longer; over a fourth of the migrants is represented by children, out of which more than a half are born in Germany, attending the kindergarden, the school and different training courses. Related to these three generations the stereotyped of the insufficient German knowledge is empirically not durable. Language difficulties have rather immigrants of the new „first” generations: „Thus today’s marriage migrants from Turkey in Germany find entire colonies to a large extent, allowing them to practically live exclusively in the ethnical Community. Thus the necessity of acculturation falls out especially regarding the language acquisition.“

In the medical system however average language knowledge are not sufficient, in order to manage communication problems. Communication barriers in the physician-patient-interaction are justified in the difference of layman theories of the patients founded in the everyday life knowledge and the specialist

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4 BMFSFJ 2000; Pg.189.
5 Studies show that the immigrant children and teenagers speak very often German among themselves, knoing only basic notions of their native language
6 Eckert 2004, Pg. 3.
knowledge of the professional ones. An understanding in this asymmetrical communication situation can only succeed, if the physician can reconstruct on the one hand the subjective disease theories of the patient, and the patient can on the other hand understand scientific semantics. This joint construction of meanings can succeed usually only with the aid of professional interpreters, who are able to understand and translate for both parts the common knowledge of the patient as well as the specialist knowledge. These tasks cannot be carried out by children or relatives of the patient as they do not possess the right competences regarding the history of the disease, the diagnosis and the therapy. The migrants are aware of it: in Berlin\textsuperscript{7} questioned Turkish patient from the first and second generation agree that the presence of an interpreter is indispensable in order to understand the medical diagnosis and treatment.

Structural solutions can be only optimized, if intercultural and linguistic resources are promoted and used by personnel with migration background in the health system; at present their share in health occupations is however clearly under the share of the migrants of the total population. Nevertheless, numerous intercultural continuation and further education courses are provided for years, in order to improve the conditions and the medical care within the health system.

Conclusion. Family assistance is counter productive, if it wants to replace professional medical care, without any required scientific and material presumptions. The family can take a necessary compensatory function, if the institutions of the health system do not react appropriately due to insufficient intercultural authority on specific needs and problems of migrants.

It needs to be mentioned, that the family perceived as a laic system must be charged with a function for the program „Illness Abroad“, which does not exist anymore in the communities of the migrants, and secondly, that the migrant families have acknowledged in the last 30 years a structural and functional change, which does not remain without consequences for the family resources.

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\textsuperscript{7}Vgl. Eckert 2004, Pg. 22-25.