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Original research article

Immigrants from Mongolia – their health and experience with healthcare in the Czech Republic

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ABSTRACT

At present, foreigners form over four percent of the Czech population. According to the Czech Statistical Office, nearly six thousand of them are immigrants from Mongolia. The reason for this migration is usually the possibility of getting a job and therefore improving their economic situation. The aim of the research, which is part of the project entitled ''Social Determinants of Health in Selected Target Groups'', was to analyze the relationship between a set of selected social characteristics and characteristics of health. The paper refers to immigrants from Mongolia who are living in South Bohemia. The qualitative survey was performed by interviewing nineteen respondents. After the interviews and analysis of the data, major semantic categories and subcategories were identified. This paper focuses on the current health status of immigrants, the type of health insurance, experience with doctors, and their level of satisfaction with receiving healthcare. The results helped to reveal numerous problems concerning the health of immigrants, and the use of healthcare in our country. Respondents reported health problems such as chronic backache, headaches, fatigue and hearing impairments. These problems were all associated with an unsuitable work environment. While receiving healthcare, the respondents met with a negative attitude from medical staff. According to the respondents, the most common causes of this were language barriers, and doctors and nurses prejudice towards foreigners.

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Introduction

Migration and the integration of immigrants into the majority population is currently one of humanity's most sensitive global problems. Like the rest of the world, Europe is experiencing an increase in the flow of migration that has never been seen before. This is because of increase in transport infrastructure, the internet, social networking and the globalization movement. On one hand, its positive economic

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and demographic aspects are valuable, but it is also responsible for creating social tension between immigrants and the majority population. For future coexistence it is crucial to develop the ability of intercultural acceptance, and mutual coexistence of different people, ethnic groups and minorities [1].

At the turn of the 20th and 21st centuries, following a period when there was a great influx of asylum seekers and foreigners, the Czech Republic became not only a transit country but also a target country for different nationalities. The situation and flow of migration in the Czech Republic are of interest to many organizations, institutions, companies, scientists and the general public. It is clear that the issue of coexistence and the integration of foreigners into society is an important issue across Europe. The multicultural composition of particular countries significantly influences migration flow, social behaviour, and interaction among groups and individuals. These are reflected by different levels and contexts of life of the inhabitants of those countries.

According to the CSO, in the Czech Republic on December 31st, 2012, there were over 438,000 foreigners on a permanent or long-term stay, and there were 5599 immigrants from Mongolia [2]. The most common reason for migrating to the Czech Republic is the possibility of getting a job and improving their economic situation. However, if they are able to overcome the various obstacles and get to the Czech Republic, they then have unskilled jobs and are poorly paid. Frequent problems are the language barrier, the closed nature of the community, and also illegal status in the Czech Republic [3]. According to Vacková and Brabcová [4], the Mongolians in the Czech Republic work mostly in industry. It is possible to assume that it is a managed migration, based on Czech companies' demands for Mongolian workers.

Issues such as the differences in migrant healthcare or working conditions are not unknown, but they are often underestimated or even ignored. It is important that all European countries adopt specific measures in the area of health policy for immigrants [5]. According to the Marmot Review research report [6], there are large differences in health between countries and locations which have a social rather than biological cause for their problems. For example, the life expectancy of women in Botswana is 43, while the average life expectancy of women in Japan is 86 (the WHO statistics). The differences are not only in so geographically remote locations. The difference in life expectancy in different districts of Glasgow (distance only 12 km) is 25 years [6].

Health can no longer be seen as a dichotomy of ''health vs. disease'' (by dividing the word disease, Carp and Müller [7] point out the social consequences of illnesses and come closer to a broader definition of health). Health is no longer complete physical, mental, social and spiritual well-being, as there is also a so-called ''health potential'' – the ability of an individual to live a full life. In history, the development of the definition of health has moved from a clear distinction between illness and health (which proved to be insufficient due to the multifactorial causation of disease), to broader definitions and so-called ''bliss'' (bio-psycho-socio-spiritual). Gradually this terminological trend makes it impossible to comprehensively examine the health of an individual, because ''health'' encompasses many aspects which are not possible to cover in the survey. For this reason, the WHO accepted a narrower definition – health as health potential, i.e. the ability to live a full life.

The concept of the ten social determinants of health, published by Wilkinson and Marmot [8] in Copenhagen, is one of the efforts that have been made to more comprehensively analyze the health status of individuals. It focuses on the following determinants of health: social gradient, stress, childhood, social exclusion, unemployment, social support, nutrition, addiction and transportation. The significance of the concept was also confirmed by the WHO founding committee that focus on the social determinants of health (in English: Commission on Social Determinants of Health). The necessity of the issue was confirmed in the ''Political Declaration on Social Determinants of Health'', which was adopted in Rio de Janeiro in October, 2011 (Rio Political Declaration on Social Determinants of Health) [9].

Social determinants of health serve to provide an interface for many scientific disciplines that study causes of diseases, but also serve to consider the prevention, early detection of causes, and solutions and consequences for different professions. In this context, we can talk about the emergence of a global movement that is concerned with reducing health inequalities, and has prompted the creation of international portals, for example: www.health-inequalities.eu (the international project, DETERMINE, National Health Institute), www.mighealthnet.org (the international project, MIGHEALTHNET), the European network of organizations to promote health, the EuroHealthNet, or the International Union for the Promotion of Health and Education (from eng. orig. International Union for the promotion of Health and Education [IUHPE] http://www.iuhpe.org/).

Materials and methods

The paper is based on a research project entitled ''Social determinants of health in selected target groups'', it was supported by funds from the Faculty of Health and Social Studies, University of South Bohemia in České Budějovice, for the development of science and research (number: SDZ2012_002). The aim of the research was to analyze the relationship between selected social characteristics and selected characteristics of health.

The research was conducted using a qualitative research method, which uses a small set of respondents without statistical representation. Data collection was carried out using interviews. This method was chosen because it allowed for the possibility of creating additional questions, making a maximum yield of the interviews, and in-depth development of the established objectives and research questions (as Miovský claims [10]).

The semi-structured interview was divided into several parts. In this article, we focus on the subjective perception of individual respondents' health, and their experience with the use of healthcare in the Czech Republic.

The data collected from each respondent was first recorded on audio and then analyzed. The audio was transcribed into text. The transcription was literal, and the text was converted into standard language. In the next phase, sentences that bore no essential or important information to the research were left

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