Old age vulnerabilities in Swiss born and immigrant individuals addressing the subject with two different methodological approaches

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Master thesis

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1. Overall introduction

With the ageing of western societies that can also be observed in Switzerland, scientific research on different topics surrounding old age is increasing. Whereas the proportion of elderly in the Swiss population is growing, there is another aspect that can be observed. A related category of individuals is growing in size and scientific importance, which is the category of elderly migrants. While plenty of research is done on ageing societies and on the subject of migration, the intersection of the two subject is treated less often.

The idea of this master thesis emerged at the intercept of my thematic interests in demographic change, migration and health as well as the possibility of using qualitative and quantitative data. The structure of this master thesis is slightly different than usual. Given the fact that I work with different data types and different methods, it is divided into two separate scientific papers.

The first paper, *Economic vulnerability and health status among the retired in Switzerland: A comparison of Swiss natives and immigrants*, contains a quantitative analysis based on data of the VLV survey ("Vivre-Leben-Vivere") conducted by the Center for the Interdisciplinary Study of Gerontology and Vulnerability (CIGEV) at the University of Geneva. The paper is first interested in the factors that lead to old-age financial vulnerability in Swiss born versus migrant individuals. Then, the health status of the two population groups is compared to explore the so-called "healthy migrant effect" as well as the "exhausted migrant effect". The data was analysed using the statistical program R.

The second paper, *Financial and health-related difficulties of pensioners in Switzerland: A qualitative analysis of Swiss natives and German immigrants*, focuses on 20 interviews led with individuals over 65 years of age in the research project of Mrs. Oana Ciobanu. Ten interviews with Swiss born individuals were led by myself, the ten interviews with German born individuals were led a few years earlier by another master student, Mrs. Julia Sauter. The paper is interested in the way individuals mention and evaluate their situation in terms of their finances, their health and their future. The interviews were analysed using the program Atlas.ti.

An overall conclusion will close on the results as well as the experience of doing this two-fold analysis.

2. Economic vulnerability and health status among the retired in Switzerland: A comparison of Swiss natives and immigrants[1]

Abstract

The aim of this paper is to investigate the differences in economic vulnerability and health status of elderly natives and immigrants living in Switzerland. Analyses are performed to determine the factors leading to economic vulnerability for the two populations, as well as to control if a leftover of the so-called "healthy migrant effect" can be observed after the age of retirement. Our results suggest that the main factors leading to old-age economic vulnerability are the level of education and the diversity of income sources after retirement, for both the native and the immigrant population. Also, immigrants generally reported a worse health status, even if controlled for certain variables such as age, education level and having done physical labour or not. Therefore, our results rather support the theory of the "exhausted migrant effect".

Introduction

This paper focuses on economic vulnerability and the health status of pensioners in Switzerland, while comparing the Swiss natives with immigrants. With the ageing of the population that can be observed in Switzerland (similar to other European countries), not only the percentage of Swiss citizens over 65 years is growing, but also the proportion of elderly immigrants living in Switzerland. For a long time seen as "birds of passage" (Piore 1979), as workers that will eventually return to their country of origin for their retirement, research has shown that many of them decide to stay (Bolzman, Fibbi & Vial 2006).

In 2018, 8.0% of all foreigners living permanently in Switzerland were aged 65 years and older, compared to 22.0% of the Swiss nationals (BFS, online[2]).[3] While there is still an important gap

[1] The data was collected within the framework of the National Competence Center in Research LIVES and the SINERGIA Project CRSII1-129922, financed by the Swiss National Science Foundation. The authors are grateful to the Swiss National Science Foundation for its financial assistance. The financial sponsor played no role in the design, execution, analysis, interpretation of data, or writing of the study.

All participants gave their written informed consent for inclusion before they participated in the study. The present study was conducted in accordance with the Declaration of Helsinki, and the protocol had been approved by the ethics commission of the Faculty of Psychology and Social Sciences of the University of Geneva (project identification codes: CE_FPSE_14.10.2010 and CE_FPSE_05.04.2017).

[2] BFS Bundesamt für Statistik, Altersmasszahlen der ständigen Wohnbevölkerung nach Staatsangehörigkeitskategorie und Geschlecht 1999-2018, https://www.bfs.admin.ch/bfs/de/home/statistiken/bevoelkerung/stand-entwicklung/alter-zivilstand-staatsangehoerigkeit.assetdetail.9466622.html, visited on 11.03.2020

[3] In these figures, immigrants that have been naturalised are counted as "Swiss", which may therefore bias these numbers.

between the two populations, the growing share of elderly immigrants and the specific challenges that they may face render this topic an important subject of research.

One question regarding elderly immigrants is the one concerning their economic situation. While Switzerland is one of the richest countries in the world, still 16.4% of the elderly have an income below the poverty line (BFS 2014). The elderly immigrants are even more often subject to economic difficulties, as has been shown in recent research (Bolzman & Vagni 2018; Kaeser 2015; OFS 2012). Another subject of interest that concerns elderly natives and immigrants and which may be linked to their economic situation is their health status. A large literature on social determinants of health discusses the influence of socio-economic position and other factors on the health level (Gwatkin 2000), and the health of immigrants in general has received special attention by two dominant theories on the "healthy migrant effect" (Razum 2006; Abraido-Lanza et al. 1999) or, on contrary, the "exhausted migrant effect" (Bollini & Siem 1995).

This paper aims to discuss two main questions. First, what differences in terms of economic vulnerability exist between the retired who are Swiss native born (natives) and the retired population who has a migration background (migrants), and what are the factors that explain these differences? Second, is the health status of immigrants better or worse compared to the Swiss born when controlling for certain work-life conditions?

The paper is structured in four parts. First, the theoretical and empirical context will be presented and the hypotheses that this paper claims to answer will be illustrated. Next, the research methodology will be explained. The following part will present the data analysis, and the last part constitutes a discussion of the results as well as a short conclusion.

Concepts and background

The concept of vulnerability has received growing attention in social sciences over the last years (Oris 2017). Initially a concept used to describe the agency of societies to cope with natural disasters (Wisner & Luce 1993), it has been applied to other contexts in the following decades. Schröder-Butterfill & Marianti (2006) developed the basic framework for analysing individual vulnerability in old age by arguing that a combination of exposure, threat and coping capacities leads to a bad outcome. Two types of vulnerability can be distinguished: latent vulnerability, which relates to a person being in the situation of a potential threat and risk factors, versus manifest vulnerability, describing the situation where the bad outcome has already been

produced. This framework can be applied to many different types of vulnerability, as shown by Schröder-Butterfill & Marianti (2006), who analysed homeless individuals (manifest vulnerability) and people in risk of lack of care (latent vulnerability).

The definition of economic vulnerability used in this paper will be based on the definition proposed by Gabriel (2015) and Henke (2016). For this paper, the decision was made to analyse only manifest economic vulnerability, as the dataset did not allow to create a variable for latent economic vulnerability. The main variable used in the analyses is therefore the one measuring income per month, seen as an objective measure of vulnerability.

As the Swiss pension system is for an important part based on years of contribution[4], immigrants are automatically put in a less favourable situation. Based on the theory of accumulation of disadvantages (Dannefer 2003; DiPrete & Eirich 2006), one could assume that immigrants, specifically those with low education level, will accumulate different disadvantages over time and end up in particularly vulnerable situations at the age of retirement, not only economically, but also socially, in terms of health etc. While attention has been given to the economic vulnerability of the elderly in Switzerland before (Henke 2016), the vulnerability of older immigrants as a sub-population has not received specific interest in those papers. Meanwhile, the general economic situation of the migrant population is not an untreated subject, as will be presented in the following chapter.

Another type of vulnerability that can be found in elderly natives as well as migrants concerns their health situation. A large literature investigating the social determinants of health (inter alia Gwatkin 2000; Marmot 2005) points to the link between poverty and poor health on a global level. While different papers on the health status of (elderly) migrants in Switzerland have been published (Bischoff & Wanner 2008; Guggisberg et al. 2011), the question of the link between health status and migration should be investigated in more detail.

Migrants in Switzerland

In 2017, migrants represented around 24% of the Swiss population (SEM 2017). To understand their situation and diversity better, the first important waves of migration towards Switzerland that have taken place in the second half of the 20th century will be shortly presented. After the Second World War, Switzerland's economy grew rapidly which created a need for a larger

[4] The Swiss pension system will be rapidly explained in one of the following subchapters.

work force. Recruitment agreements were developed with Italy in 1948 and with Spain in 1961, creating an inflow of low-skilled migrants from those countries (Piguet 2009). This type of migration, later expanded to Portugal in the 1980's, was seen as temporary. The general thought was that those people would come to Switzerland to work, but then return to their home country once they had earned "enough" money or reached the age of retirement. Therefore, no measures to facilitate the integration of those migrants existed, because integration did not seem necessary (Bolzman et al. 2004). In the 1960's, family reunification was facilitated for immigrants that had gained access to a permanent residence permit (Piguet 2009), and still today, family reunifications represent an important share of the annual immigrant numbers. These migrants were mainly unskilled workers employed in the construction or industrial sector (Ibid.).

An important proportion of the elderly immigrants of Switzerland today have come to Switzerland in this very specific migration framework and therefore share some characteristics such as country of origin, level of education, low-paid employments, etc. However, a diversification of the elderly migrants in Switzerland can be observed in recent years.

The Swiss pension system

Another important aspect to consider when talking about elderly people in Switzerland is the structure of the pension system. The Swiss pension system is based on three pillars: the first pillar, called OASI (old age and survivors insurance), is based on annual contributions paid by all Swiss residents, regardless of their employment status or nationality. The amount of the OASI-pension is maximum 2'350 Swiss francs per month for a single person and 3'525 Swiss Francs for a married couple (BSV 2018), which is meant to finance the basic needs of the elderly. Independently of the income level, the OASI only pays up to this maximum amount. Therefore, the system includes a redistribution of wealth, as individuals with a high income contribute a higher amount, but do not get a higher rent payment in return. One characteristic of the system is that this maximum amount can only be attended if the person has been contributing during 44 years, and for each year between age 21 and 65 that the individual did not contribute, the final amount of the pension is reduced by 2.3% (Ibid.).

The second pillar, the occupational pension, is meant to complete the OASI pension to allow pensioners to keep more or less the same living standard as prior to retirement. All individuals which are employed and gain more than 21'500 francs per year contribute to the second pillar (Armingeon 2018), which excludes those that work in atypical positions, mainly part-time

workers in low-skilled jobs. The amount of the occupational pension depends the accumulated amount of contributions at the age of retirement, and there is no system of redistribution of wealth as there is in the first pillar.

The third pillar finally consists of private provisions, which are voluntary. There are specific bank accounts with higher interest rates that can be used for this pillar, or simply any other form of wealth accumulation.

This system of three pillars is completed by supplementary benefits. Individuals who, after combining the income of the three pillars and an eventual fortune, have a lower income per month than the poverty line, can apply for supplementary benefits. As they must be demanded, many people that might be entitled to get those funds may not actually get them for lack of information or other problems linked to the application process. Also, individuals need to live in Switzerland for a minimum of ten consecutive years to be entitled for supplementary benefits.

The situation of elderly migrants in Switzerland

When analysing the existing literature focusing on the situation of elderly migrants in Switzerland, certain results seem to recur. Different studies have come to the result that elderly migrants more often face economic difficulties than Swiss citizens (Bolzman, Poncioni-Derigo, Vial & Fibbi 2004; Bolzman 2012; Hungerbühler 2012; BFS 2014). Especially immigrant women are in difficult situations, as they often did not contribute to the second pillar because of their unpaid household work or part-time jobs that stayed under the limit of contribution (Bolzman et al. 2004; BFS 2014). A paper looking at the situation of immigrant women from Italy and Spain showed that women are more often worried about their financial situation then men (Fibbi, Bolzman & Vial 1999). Elderly immigrants also more often seem to have a very low fortune or no fortune at all than Swiss citizens (BFS 2014; Kaeser 2015), and their difficulties to access the supplementary benefits, mostly due to lack of information or language barriers, have been highlighted (Hungerbühler 2012; OFS 2012).

In regard to the mortality of migrants, Bollini & Siem (1995) showed that migrants in different countries have more accidents and are more often in a situation of disability than natives, which they explain through lower entitlements. An analysis based on Latino immigrants in the United States (Abraido-Lanza et al. 1999) showed a paradox, as those migrants lived in lower socioeconomic standards than the locals but still seemed to have lower mortality levels. Abraido-Lanza et al. tested the hypothesis of the “healthy migrant effect”, which suggests that

immigrants pass a certain selection for good health as they leave their country of origin and therefore have lower mortality levels, as well as the "salmon-bias" theory, which tries to explain the paradox by the return-migration of elderly migrants, which would bias the mortality data of immigrants. In their data, both theories were not able to fully explain the paradox. In the Swiss context, it has been shown that migrants do have a lower mortality level then natives (Zufferey 2014), explained through a certain selection effect at the entry and the exit of the county (leading ill individuals to migrate back to their home country), but also the so-called "culture of migration", which describes psychosocial factors often found in immigrants such as motivation and will to succeed which may positively influence the health status of individuals.

Not only mortality, but also the health status of migrants in Switzerland has received some scientific attention. While some papers did conclude that immigrants in general have a lower health status than Swiss citizens (Guggisberg et al. 2011), others find that this is only true for specific nationalities (Bischoff & Wanner 2008; Volken & Rüesch 2014). Grossmann et al. (2010) found that immigrants in Switzerland have a higher risk for cardiovascular risk factors such as overweight and physical inactivity, even though this analysis did not specifically concentrate on elderly migrants but included migrants of all age categories. Further analyses found that the prevalence of overweight and obesity was higher for migrants from Italy, Spain, Portugal and the former Republic of Yugoslavia, but not for migrants from Germany or France (Marques-Vidal, Vollenweider, Waeber & Paccaud 2011). While the healthy migrant effect is generally thought to be effective shortly after the immigration, the question we will address in this paper is if we can see some left-over of this health advantage in elderly immigrants if controlled for their working-live conditions, or if their health status is lower than that of their Swiss counterparts which would be more in line with the recent research on health status.

Hypotheses

Based on the literature review, this paper aims to test the following hypotheses:

1. The factors that influence the risk of being in a situation of economic vulnerability are different for Swiss natives and immigrants.
2. Immigrants that have arrived earlier in Switzerland have a lower risk of economic vulnerability than immigrants that have arrived more recently.
3. When controlled for the working conditions of the individuals, migrants declare to have a worse health status than Swiss natives.

Methodology

This paper is based on the VLV survey ("Vivre-Leben-Vivere") conducted by the Center for the Interdisciplinary Study of Gerontology and Vulnerability (CIGEV), University of Geneva[5]. Data was collected in 2012 in five Swiss cantons (Geneva, Ticino, Basel, Bern, Wallis). The survey focuses on the living standards and health situation of people aged 65 and over in Switzerland. The study covered 3'600 individuals, randomly selected and stratified by sex and age (Ludwig, Cavalli & Oris 2014).

Participants first received an auto-administered questionnaire and later an interviewer did a computer-assisted personal interview. The questionnaire was developed in French and translated to German, Italian, Spanish and Portuguese. Bilingual interviewers were recruited to ensure maximum understanding of the questions.

The final sample for this paper features 2361 individuals, including 1076 women and 1285 men. For this sample, individuals who did not respond to some of the central variables were excluded[6]. For the Body Mass Index (BMI) variable which was calculated based on the weight and the height variables, people who did not respond to either of the two base variables were recoded in their own category, as the non-response may not be random but influenced by the actual weight.

As there are two subjects of interest in this paper, two main dependent variables have been used. The first one is manifest and subjective economic vulnerability, based on the income per month which is a categorical variable[7]. Based on the poverty line which is around 2247 Swiss francs for a single individual (BFS, online[8]), individuals with an income below 2'400 CHF were coded as vulnerable, resulting in a binary variable. As the variable of income per month is relating to the household income, the income category was related to the number of individuals living with the interviewed individual. Any supplementary individual was given the weight of 0.5 based on the new OECD scale[9].

[5] For more information on the VLV dataset, see Ludwig, Cavalli & Oris 2014
[6] This was the case for the following variables: origin, education level, health status, monthly income, place of living, alcohol & tobacco consumption, physical work, still working after 65.
[7] The categories are: 0-1'200, 1'200-2'400, 2'400-3'600, 3'600-4'800, 4'800-6'000, 6'000-7'200, 7'200-10'000, 10'000-15'000, and "more than 15'000" Swiss Francs.
[8] BFS Bundesamt für Statistik, Armut, https://www.bfs.admin.ch/bfs/de/home/statistiken/wirtschaftliche-soziale-situation-bevoelkerung/soziale-situation-wohlbefinden-und-armut/armut-und-materielle-entbehrungen/armut.html, visited on 12.01.2020
[9] For more information on the OECD equivalence scale, see online: http://www.oecd.org/els/soc/OECD-Note-EquivalenceScales.pdf, visited on 02.04.2020

The second dependent variable used was the subjective health status. Based on a variable that allows individuals to rate their current health status between “bad”, “rather bad”, “satisfying”, “good” and “very good”, a new variable was created, grouping the first three categories into “bad” and the last two into the category “good”.

To find answers to some of the hypotheses of this paper, the sample was divided into one database containing the natives, and one containing the migrants. Individuals were classed as “natives” if they either answered to have Swiss origins or if they were born in Switzerland (which is a question only asked to those without Swiss origins). This definition was used as being born in Switzerland seems more relevant to the years of contribution to the pension system than the nationality of the individual or of its parents. The distinction is therefore made between individuals born in Switzerland and born abroad, independently of their nationality. First, some descriptive analyses were run. In the next step, classification trees were run with a large variety of variables to find the most relevant variables. Then, based on the recoded binary variables, logistic regression models were first run with economic vulnerability and then with the health status as dependent variable. The regressions models were developed once for the native population, and once for the immigrant population. Depending on the population, different variables have shown to create significant results, leading to different models for the two populations.

Presentation of relevant variables

The variables that are represented in the final models will now be presented. First, there is education, which was recoded in four categories (primary & secondary education, apprenticeship, higher secondary education & other, tertiary education). The next included variable is called “OASI”, which is a recoded binary variable that is “yes” if individuals receive only an OASI pension or social aid, and “no” if they have an income from the second and/or third pillar and/or other incomes as for example from their fortune. Another variable is asking for the moment of retirement, which can be “at the official age of retirement”, “precipitate retirement”, “belated retirement”, “still working” or “No Answer”. The moment of retirement can either be related to financial problems (which would lead individuals to work longer), financial well-being (only wealthy individuals can afford an early retirement) or health problems which may force an individual to retire early. One variable concerns the place of living, which was recoded into the categories “at home (owned)”, “at home (rented)” and

"other" which includes living with family members, friends or in a nursing home. The next variable refers to the question if the individual has done physical work in the past or not, and one variable is asking if the individual is smoking or not. Finally, in the models run on the population of migrants, the recoded variable "original nationality" is used. This variable has the following categories: "Only Swiss", "German & French", "Spanish & Italian", and "Others". The categories have been coded this way to allow for more individuals in each category, while trying to distinguish between migrants from western vs. southern Europe. The category of "Only Swiss" contains those immigrants that have achieved Swiss nationality and not declared a second nationality, which makes it impossible to classify them into one of the other categories. Another variable used ("Pension") is "Yes" when the individual receives an income from the second pillar, and "No" if it doesn't.

Data analysis

First, the final sample and some of its characteristics are going to be presented, before turning to the regression models.

When interested in the economic vulnerability, 10.7% of the immigrants in the sample are categorised as vulnerable compared to 5.7% of the Swiss born, based on the threshold of 2400 Swiss Francs per person explained earlier. The immigrants in the sample are therefore more often in a situation of economic vulnerability, which is consistent with the existing literature. The situation is similar in terms of the health status, where 42.22% of the Swiss declare to have a bad health status, compared to 47.33% of the immigrants. This result is as well not surprising, based on the existing health analyses of migrants in Switzerland. It is interesting to mention that the migrant population is slightly younger than the native population, with a mean age of 76.37 versus 77.93 years. In contrast to the reviewed literature, the percentual differences between the two populations in risk behaviours (such as smoking, alcohol consumption and overweight) are negligibly small or even inexistent.

To test the first hypothesis, which assumes that the risk factors influencing the likelihood of economic vulnerability are different for the Swiss born and the immigrants, regressions models on the separated data sets were run. Table 1 shows the regression models for the Swiss born sub-population with the factors that significantly influence the risk of being in a situation of economic vulnerability. Model 1 only includes education and shows that there is a correlation

between having a higher secondary or tertiary education and being less often in a situation of economical vulnerability.

In model 2, which includes the variable OASI that is "Yes" if the individual receives only an OASI pension or social aid, this second variable is significant as well, meaning that those individuals are at a higher risk of being vulnerable, while reducing the significance of the education variable. This mediation effect is not surprising, as individuals with a higher education are logically more likely to have a pension fund or to have been able to contribute to the voluntary third pillar.

Table 1: Binomial logit models on vulnerability of swiss born retirees; Exp. (β)

	M1	M2	M3	M4	M5
Education (REF: Primary & Secondary)					
Apprenticeship	0.686	0.977	1.026	1.046	1.034
Superior Secondary & Other	0.197***	0.291***	0.307***	0.313***	0.312***
Tertiary	0.298***	0.512**	0.524**	0.517**	0.495**
OASI Yes (REF: No)		4.377***	4.321***	4.228***	4.151***
Moment of retirement (REF: Age 65 / 64)					
Anticipated			0.430***	0.440***	0.417***
Belated			0.553	0.597	0.59
Still working			0.704	0.723	0.651
NA			0.589	0.602	0.598
Place of living (REF: Rented space)					
Owned Space				1.227	1.23
Other				2.524***	2.591***
Smoker Yes (REF: No)					1.977**
Constant	0.111***	0.054***	0.071***	0.058***	0.055***
Observations	1,987	1,987	1,987	1,987	1,987
Log Likelihood	-418.943	-396.329	-390.126	-387.045	-384.452
Akaike Inf. Crit.	845.887	802.657	798.251	796.089	792.904
Note:					*p<0.1; **p<0.05; ***p<0.01

The third model then includes the moment of retirement, and only the individuals with an anticipated retirement show significant differences to the reference category, which are the individuals who retired at the official moment of retirement[10]. Those with an anticipated retirement are 2.325 times less likely to experience economic vulnerability, which can be interpreted as a sign that only individuals with a stable, non-vulnerable economic situation can afford to retire early. On the other hand, individuals which retire late have no significant difference to individuals retiring at 65 years, which may be because this category includes two types of individuals, those that retire late out of economic need and those that retire late because of a fulfilling job.

In model 4, the living situation was added, showing that individuals which are not living at their owned or rented place, but in other circumstances (elderly's home, friends, family) are 2.524 times more likely to be economically vulnerable. Most probably, this is rather a sign that economically vulnerable individuals cannot afford to live at their own, than for living in such circumstances influencing the probability of economic vulnerability.

The final model (M5) adds the variable "Smoker", which also has a significant coefficient, pointing out an association between smoking and being economically vulnerable, without strongly influencing the coefficients of the other variables. Again, the direction of this association is most probably that vulnerable individuals smoke more often, and not that individuals are economically vulnerable because they smoke.

Table 2 shows the equivalent analysis for the immigrant population. As this population is considerably smaller than the population of the Swiss born, it is not surprising that there were less variables that were significant. Therefore, only three models were retained for this analysis, based on AIC and BIC.

The first model only includes the education level, exactly as the first model for the Swiss born. For the migrants, only those with a tertiary education have a significantly lower risk of being in a vulnerable situation after retirement than the reference category, but in general the effect of the education level on economic vulnerability seems comparable to the Swiss born.

[10] The official age of retirement in Switzerland is 65 years for men and 64 years for women.

The second model adds the variable of original nationality. Because the category of "Only Swiss" is not homogeneous, as the individuals in this category may come from different countries of origin but have either given up or simply not mentioned their other nationality, the category of individuals with German or French nationality was chosen as reference category, thought to have similar levels of economic vulnerability to the Swiss born based on existing literature. The results show that only the coefficient of the category of "Others" is (weakly) significant, indicating that individuals which have declared another nationality than the four listed countries, have a 3.201 times higher risk of being economically vulnerable than individuals from Germany and France. What is the most interesting here is that the category "Italian and Spanish" does not show significant differences to the base category, which would have been expected.

Table 2: Binomial logit models on vulnerability of immigrant retirees; Exp. (β)

	M1	M2	M3
Education (REF: Primary & Secondary)			
Apprenticeship	0.561	0.636	0.698
Superior Secondary &Other	0.882	0.964	1.098
Tertiary	0.182***	0.178***	0.221**
Nationality (REF: German & French)			
Italian & Spanish		2.198	1.938
Only Swiss		1.897	1.767
Other		3.201*	2.709
Pension Yes (REF: No)			0.406**
Constant	0.210***	0.101***	0.149***
Observations	374	374	374
Log Likelihood	-119.946	-118.246	-115.158
Akaike Inf. Crit.	247.892	250.493	246.316
Note:			*p<0.1; **p<0.05; ***p<0.01

The last model includes the variable “Pension”, and not surprisingly immigrants that do receive a pension are 2.463 times less likely to be in a vulnerable position than those who don’t. Adding this variable also slightly lowers the effect of education, indicating a mediation effect between these variables. The effect of the country of origin measured through nationality disappears completely in model 3, indicating another important mediation effect, especially for the category of individuals with an “Other” nationality.

These two sets of analyses allow to see that while education is a factor that influences the likelihood of being economically vulnerable for both sub-samples, the other variables with significant effects differ to a certain extent. A part of this difference is probably due to the smaller sample of migrants, leading to lower significance levels. Also, the variable “OASI” in the Swiss born model and the variable “Pension” in the immigrant model measure two sides of the same situation, namely the income sources. Hypothesis 1 can therefore only be confirmed to a certain extent.

The second hypothesis, stating that the number of years of presence influence the risk of being in a situation of economic vulnerability for immigrants could not be confirmed with the regression models run (not shown). This may be due to a high number of missing values, as there is no variable asking specifically for the date of arrival, but the year of arrival had to be found through a set of variables which ask for important moments of change in the life of the individual. Therefore, 219 out of 374 immigrants could not be attributed a year of arrival as they didn’t mention their immigration to Switzerland as one of the four most transforming moments in their life. As a result, the regressions did not show significant coefficients, neither on their own nor in combination with other variables.

We will now turn to the analysis in terms of health status. Table 3 shows the results of the logit model, which is this time calculated upon the total sample, Swiss born and immigrants together. The goal of this analysis is to see if elderly immigrants have a better or worse health status than Swiss born individuals, when controlled for certain variables linked to their working life.

The first model only contains the variable which distinguishes individuals with Swiss origin from individuals with a migratory background that are born abroad, and from individuals with a migratory background but born in Switzerland. The results show that individuals without

Swiss origins have generally a worse health status, with the coefficient of those born in Switzerland being more accentuated than the coefficient for those born abroad.

The following models incorporate different variables that could influence the health status, to find out if the effect of migratory background and birth country stays significant. As age is added in model 2, the coefficients of the first model change a little and partly become less significant.

Table 3: Binomial logit models on health status; Exp. (β)

	M1	M2	M3	M4	M5	M6
Origin (REF: Swiss origins)						
Born abroad	0.795**	0.724***	0.733***	0.734***	0.754**	0.783**
Not Swiss but born in CH	0.449***	0.520**	0.525**	0.532**	0.542**	0.551**
Age		0.948***	0.949***	0.950***	0.953***	0.954***
Education (REF: Primary & Secondary)						
Apprenticeship			1.559***	1.510***	1.497***	1.428***
Superior Secondary & Other			1.940***	1.781***	1.754***	1.661***
Tertiary			2.213***	2.073***	2.013***	1.871***
Physical Work Yes (REF: No)				0.736***	0.738***	0.747***
Place of living (REF: Rented space)						
Owned space					1.189*	1.186*
Other					0.554***	0.557***
OASI Yes (REF: No)						0.763**
Constant	1.400***	90.674***	48.947***	55.748***	40.806***	41.527***
Observations	2,361	2,361	2,361	2,361	2,361	2,361
Log Likelihood	-1,607.503	-1,554.414	-1,533.501	-1,528.159	-1,520.011	-1,517.332
Akaike Inf. Crit.	3,221.005	3,116.829	3,081.003	3,072.319	3,060.022	3,056.665
Note:						*p<0.1; **p<0.05; ***p<0.01

Adding the level of education in model 3 (with all categories having a better health status compared to those with the reference level, the lowest education level possible) has less impact on the coefficients of the first model, and the same is the case for the variable of having done physical work which is added in model 4. Individuals which have done physical work have a coefficient of 0.736, indicating that they are 1.35 times less likely to mention a good health status after the age of retirement.

In model 5, the variable of the place of living is added, and individuals which live in "Other" circumstances are less likely to report being in good health, which seems logical as individuals with a specifically bad health status are more in need of care, which is often delivered at elderly's homes. Individuals living in a space that they own in contrary, are more likely to be in better health compared to the reference group, which are individuals living in a rented space.

The last variable which is added is the OASI-variable, and it shows that individuals which only receive an OASI pension and/or social aid, are less likely to report being in good health than those individuals who additionally have other income sources. While the addition of these last two variables have changed the coefficients of the birth-place variable, there remain significant differences between the Swiss origin-individuals and those without Swiss origins, born in Switzerland or born abroad. Those born in Switzerland still have a lower coefficient, meaning that their health status difference to the individuals of Swiss origin is more marked than that of those born abroad.

Based on our data, we therefore cannot confirm a sort of "persistent" healthy migrant effect, which would mean that migrants declared a better health status if controlled for their working conditions, done here through multiple proxy variables. It might still be that the health of migrants was better at their moment of arrival, but then deteriorated briskly over time without its explanation being captured by the variables used above. Still, the individuals born outside of Switzerland have a smaller health status difference to the Swiss-origin-individuals, than those with migratory background but that have been born in Switzerland. This may be due to a certain selection effect, whereby actual immigrants are somehow subjected to health selection, compared to individuals with a migratory background that have been born in Switzerland. Also, this is consistent with the analysis of Tarnutzer & Bopp (2012) which found that only first-generation immigrants had a mortality advantage compared to Swiss natives, but not second-generation immigrants. In general, individuals with a migratory background seem to have a lower health status than the Swiss born, which was confirmed by a supplementary regression that distinguishes only between Swiss born (natives) of either origin and actual immigrants

(regression table not shown in this paper). The third hypothesis can therefore be considered as confirmed.

Conclusion

In this paper we were interested in the differences in terms of economic vulnerability that exist between Swiss natives and immigrants over 65 years of age, as well as in the factors that explain these differences. The second subject of the paper was linked to the so called "healthy migrant effect", as we were interested in the health status of elderly immigrants compared to their Swiss counterparts if controlled for certain work-life related variables.

The first hypothesis stated that the risk factors for being in a situation of economic vulnerability after the age of retirement are different for Swiss born individuals and immigrants. As we have seen in the previous chapter, the analyses show that this is only partly true. For both populations, education has a significant effect, even though it is unclear if there is actual causality or rather correlation, where individuals coming from a lower-class family background achieve a lower education. The sources of income play an important role for both categories as well, in the sense that individuals which mainly receive an OASI pension and / or social aid have a significantly higher likelihood of being economically vulnerable than those that receive an occupational pension. Finally, some variables showed significant results for the natives but not for the immigrants such as being a smoker, but this is probably rather a case of correlation than of causality.

The second hypothesis was interested in the effect of the years of presence of immigrants on their risk of being in a vulnerable situation. As there was no official variable that could be used, and the recoded variable based on individuals' most important changes in their life had a very high percentage of missing values, it is not surprising that the regressions with this information did not show any significant results. It would be important for further data collection on immigrants to systematically ask for their year of arrival or years of presence, as this might be an interesting information to investigate.

The third and last hypothesis was based on the two principles of the "healthy migrant effect" and the "exhausted migrant effect" and stated that migrants would declare a worse health status than natives if controlled for the working conditions of the individuals. The results of this paper support this hypothesis, as the immigrants declare a lower respectively worse health status than natives. While there are other factors significantly influencing the likelihood to be in worse

health, such as age, education or having done some sort of physically demanding work, the fact of being an immigrant stays significant and is only to a certain extent mediated by these factors. The difference between migrants of first and second generation, respectively between the migrants of second generation and individuals of swiss origin should be further investigated.

In general, there seem to be only limited differences in the factors that lead to vulnerability in elderly individuals between those that have been born in Switzerland and those born abroad. This can be seen as positive on one hand, indicating that the Swiss pension system is not discriminating based on origin, but on the other hand we still see that at least in our data there are more vulnerable immigrants than natives, as there are also more immigrants with a lower education level. As the income sources of individuals seem to be strongly influencing the risk of economic vulnerability, the difference between the two groups is indicating that immigrants receive less often a pension from the second pillar than natives, respectively that they more often depend mostly on the first pillar, OASI. While this makes sense for some parts of the immigrant population, such as women which may more often have done unpaid household work, men should be receiving a pension from the second pillar, even if they have been working in low-skilled jobs. Of course, the second pillar became mandatory only in 1985, but even the oldest individuals in the sample should have benefited from at least some years of contribution to the occupational pension.

Concerning the health of migrants, the results of this paper have rather supported the paradigm of the "exhausted migrant", as the elderly immigrants have declared a worse health status than their Swiss native counterparts. The results are therefore in line with recent research which also found that migrants have a worse health status (Guggisberg et al. 2011), and while some of the difference was explained by the education level, a significant gap remained. The "healthy migrant effect", while maybe active in the first years after arrival, has not shown to have a long-term influence on the health status of immigrants.

Any social policy trying to diminish the poverty of elderly immigrants should therefore take into account that if education plays such an important role, poverty of elderly immigrants will only start to shrink if the average education level of immigrants is approximating the average of the Swiss native population. While this is already the case for immigrants from countries such as Germany and France, no such development can be expected from other countries of origin in the next few years. Also, lowering the minimum income needed to be able to contribute

to the second pillar might be worth discussing as it could lower the percentage of individuals relying only on OASI after retirement. Finally, more data is needed on pensions that individuals may receive from other countries, as no questions on such income were asked. Therefore, individuals may or may not have included such types of income in their numbers, blurring the results. In general, while the VLV dataset was not specifically created for analyses on elderly migrants, more detailed information on this portion of the Swiss population would be needed.

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3. Financial and health-related difficulties of pensioners in Switzerland: A qualitative analysis of Swiss natives and German immigrants[11]

Abstract

The aim of this paper is to analyse how pensioners in Switzerland evaluate their situation and approach their difficulties in terms of health and finances, as well as how they plan their future. For this purpose, 20 semi-structured interviews were analysed with Atlas.ti using thematical coding. The results show that the interviewed individuals seem in overall good health and in financially stable situations. All individuals declare that their health status is better compared to other individuals their age, even if they evaluate their own health status as bad. Most individuals did mention health problems during the course of the interview that they had not mentioned when asked directly about their health status or episodes of bad health. Concerning their future, many expressed positions such as "having to wait and see", while some took the first necessary steps such as producing a will or getting a membership at a nursing home. The German born individuals more often declared a clear aversion to nursing homes than the Swiss born individuals.

Introduction

This paper presents a qualitative study among Swiss born individuals and German immigrants living in Switzerland at the age of retirement in regard to their financial and health-related difficulties. As societies are growing older in most parts of Europe, elderly people are getting more and more scientific attention. In 2018, the elderly (defined as individuals over 65 years of age) represented 18.5% of the population in Switzerland (BFS, online[12]), and this percentage is expected to grow over the next decades.

As the elderly represent a growing part of society, different, more detailed age-related subjects gain more scientific interest. One of these subjects is vulnerability in old age, which can be provoked by two main factors: the financial situation and health issues. These two subjects will be the core themes of this paper. Even though Switzerland is one of the richest countries in the

[11] The interviews with older Germans were conducted part of the research project 'Ageing Migrants' Well-being: The Structuring of Local Welfare Provisions at the Intersection of Public, Private, Third Sector and the Family' coordinated by Ruxandra Oana Ciobanu and funded by the People Programme (Marie Curie Actions) of the European Union's Seventh Framework Programme (FP7/2007-2013) under REA Grant agreement no 328518. The interviews with older natives were conducted part of the research project 'Vulnerability in old age: A comparative approach' coordinated by Ruxandra Oana Ciobanu and funded by the Swiss National Science Foundation, Grant number PMPDP1_171274/1.

[12] https://www.bfs.admin.ch/bfs/de/home/statistiken/bevoelkerung/stand-entwicklung/alter-zivilstand-staatsangehoerigkeit.assetdetail.9466700.html, visited on 10.11.2019

World, 16.4% of the elderly in Switzerland have an income below the Swiss poverty line (BFS 2014a). As the financial situation of elderly depends for an important part on their pension, understanding of the complex Swiss pension system is necessary and information will be provided later in the paper.

While the financial situation of elderly is an important factor that leads to old-age vulnerability, another factor which can easily lead to vulnerability is the health status of individuals. As these two factors may also mutually influence each other, both of them will be analysed in this paper, separately, but also in interaction.

Although there is research interested in the financial situation (BFS 2014a; Pilgram & Seifert 2009) and / or the health situation of elderly (BFS 2014b), they are most often based on quantitative analyses. Although these analyses do present an important aspect of those phenomenon and allow to grasp a broader idea of them, such as the incidence of old-age-poverty or the general health situation of the elderly, they may not get information on those subjects from the perspective of the concerned individuals due to the structure of their data collection. Meanwhile, qualitative data should not be ignored when discussing the situation of elderly in Switzerland, as it can provide us with a much deeper understanding of the situation of the elderly and their everyday strategies to manage their financial or health-related situations. The need for an analysis of the financial and health situation of elderly individuals in Switzerland based on a qualitative approach is therefore evident. This paper aims to overcome the fact that ongoing research on health and financial situations is mostly quantitative. Furthermore, there is a lack of research on how individuals (and particularly elderly individuals) respond to the standard survey questions with regard to health and finances, such as for example the question on self-evaluated health. In consequence, there is a lack of research on how elderly individuals evaluate, approach and manage their health and finances.

This paper aims to analyse the following questions: How do pensioners in Switzerland approach their difficulties in terms of health and finances? How do they evaluate their own situation and how do they address possible (future) concerns? Can differences between Swiss and German born individuals be found?

The paper is structured into six parts. First, a short background on the Swiss pension system, old-age poverty and the health situation of elderly in Switzerland will be presented. The second part is dedicated to the literature review, discussing the state of knowledge on topics relevant to this paper, such as the self-evaluated-health-question, self-evaluation of one's financial

situation and how elderly individuals are planning their future. In the following part, the methodology of this paper will be explained, before presenting the analysis of the interviews. Finally, the paper ends with a discussion of results and a short conclusion.

Background

The Swiss pension system

The Swiss pension system is based on three pillars: the first pillar, called OASI (old age and survivors' insurance) is based on annual contributions paid by all Swiss residents, regardless of their employment status or nationality. The amount of the OASI-pension is maximum 2'350 Swiss francs per month for a single person and 3'525 Swiss francs for a married couple (BSV 2018), which is meant to finance the basic needs of the elderly. Independently of the income level, the OASI only pays up to this maximum amount. Therefore, the system includes a redistribution of wealth, as individuals with a high income contribute a higher amount, but do not get a higher rent payment in return. One characteristic of the system is that this maximum amount can only be attended if the person has been contributing during 44 years. For each year between age 21 and 65 that the individual did not contribute, the final amount of the pension is reduced by 2.3% (Ibid.).

The second pillar, the occupational pension, is meant to complete the OASI pension to allow pensioners to keep approximately the living standard they had prior to retirement. Everyone who is employed and gains more than 21'500 francs per year contributes to the second pillar (Armingeon 2018), which excludes those that work in atypical positions such as part-time low-skilled occupations. The amount of the occupational pension depends on the accumulated amount of contributions at the age of retirement, and there is no system of redistribution of wealth like there is in the first pillar.

The third pillar finally consists of private provisions, which are voluntary. There are specific bank accounts with higher interest rates that can be used for this pillar, or simply any other form of wealth accumulation.

This system of three pillars is completed by supplementary benefits. Individuals who, after combining the income of the three pillars and an eventual fortune, have a lower income per month than the poverty line, can apply for supplementary benefits. As they must be demanded,

many older persons who might be entitled to get those funds may not actually get them for lack of information or other difficulties linked to the application process.

As the population of elderly immigrants enlarges, the question of the structure of the pension system with regards to immigrants becomes more relevant. Immigrants having worked at least 44 years in Switzerland receive the same OASI pension as Swiss born individuals, and of course an occupational pension if they were working in a position that led to a contribution to the second pillar. While immigrants that arrive later in their lives receive a lower pension from the Swiss system, they may have already contributed to the pension system in their country of origin, leading to the question of agreements between countries regarding the payment of pensions.

Switzerland has bilateral agreements regarding the social security network with several individual countries such as the USA, Japan or Turkey, as well as bi- and multilateral agreements with the EFTA- and EU member states (AHV/IV 2019). Individuals possessing a nationality of EU member states are regulated under the Agreement of Free Movement of Persons (AFMP), which leads individuals to pay their pension contributions in the country in which they are working, independently of their nationality (Ibid.). Normally, those agreements only concern the first pillar, namely OASI in Switzerland, and not the occupational pensions. The pensions of the second pillar, as they are paid into public or privatized insurance companies, can either be kept in the different countries they were accumulated in or the funds can possibly be transferred to one country, so that there is only one occupational pension that will be paid during retirement. Unfortunately, those transfers of "wealth" from one country to another are sometimes either cost-intensive (if they are treated as fortune, and therefore taxes apply) or even impossible, if for example the legislations of the two countries are not congruent (AHV/IV 2019). Therefore, many immigrants keep their occupational pensions separated per country in which they worked.

Old-age poverty in Switzerland

The Swiss poverty line is around 2247 Swiss francs for a single individual (BFS, online), and this definition is often used in papers to be able to clearly classify individuals as either poor or not. The research led on old-age poverty (Oris et al. 2017; BFS 2014a) shows that the factors that lead most strongly to old age poverty in Switzerland are the education level and the diversity of income sources at the age of retirement (only the first pillar, two pillars or all three). Individuals with disabilities and immigrants (Gabriel 2015) as well as elderly women

(Gabadinho & Wanner 2008; Pilgram & Seifert 2009) are more often affected. When focusing specifically on elderly immigrants in Switzerland, different studies have come to the result that they more often face economic difficulties than Swiss citizens (Bolzman, Poncio-Derigo, Vial & Fibbi 2004; Bolzman 2012; Hungerbühler 2012; BFS 2014a). The situation of German immigrants more specifically is less researched, as the immigrants with a higher poverty risk are rather those from Southern or Eastern Europe, rather than the immigrants from countries like Germany or France (Bolzman & Vagni 2015).

Health of elderly in Switzerland

The current research status on health of elderly individuals will also rapidly be presented. For the elderly living in Switzerland in general (immigrants and Swiss-born), 20% of all elderly[13] living in a private household are limited in doing some heavy household work, while 3% have serious problems with personal hygiene or care (BFS 2014b). Also, 54% of those individuals have a chronic disease or health problem (Ibid.).

When it comes to the health status of elderly immigrants in Switzerland, some papers conclude that immigrants have in general a lower health status than Swiss citizens (Guggisberg et al. 2011), while others find that this is only true for specific nationalities, but not for German immigrants (Bischoff & Wanner 2008; Volken & Rüesch 2014). Further analyses found that the prevalence of overweight and obesity was higher for immigrants from Italy, Spain, Portugal and the former Republic of Yugoslavia, but not for immigrants from Germany or France (Marques-Vidal, Vollenweider, Waeber & Paccaud 2011).

Literature review

In this chapter, some of the research on self-evaluation of health and financial well-being as well as on the future planning of elderly will be presented.

Self-evaluation of health

A broad literature exists on the difficulties of the use of self-evaluated health in scientific research. While an older paper from Tissue (1972) concluded that self-evaluated health is most closely associated to other health indicators, and not with more social elements like for example

[13] Defined as individuals at age 65 or older.

self-image, newer research suggests that subjective health is also strongly correlated to personality traits (next to other health factors, such as depression) (Schneider et al. 2004). Fylkesnes & Forde (1992) found that preoccupation with health had a negative impact on self-assessed health, while a positive health-life style had a positive impact. Benyamini, Leventhal & Leventhal (2003) conducted a detailed analysis on factors which influence the self-evaluation of health and found that factors on overall functionality (being able to walk stairs, to dress oneself, etc.) influenced the self-evaluation of all individuals. Other factors had more influence on individuals in good or very good health (such as optimism, general happiness level, amount of exercise etc.) and some had more influence on individuals in poor health (such as the medication one is taking, physical symptoms like pain and aches, worsening of chronic diseases or fatigue levels). This shows that self-evaluation of health depends on factors which can be varying depending on the current health level.

While all these analyses focus on how people evaluate their health in the context of a question that asks them directly about their current health status, there is a lack of research on how people address their health in a more spontaneous way. Therefore, it is interesting to analyse if individuals talk differently about their health when directly asked versus when brought up by them spontaneously during the interviews.

Self-evaluation of one's financial situation

As well as the self-evaluation of health, the evaluation of one's financial or economic situation has received some scientific interest as well. Known as the "aging paradox", research has shown that elderly individuals are more often satisfied with their financial situation than individuals in working-age: Hira & Mugenda (1998) for example found that non-retirees more often reported to be unsatisfied with their financial situation, but that they were also more optimistic about their financial future than the elderly. Hansen, Slagsvold & Moun (2008) found that an important part of the high financial satisfaction of elderly individuals is explained by higher assets and less debt than younger individuals, but that there still remains a certain paradox of elderly being more satisfied even if they have a low income and few or no assets.

Stoller & Stoller (2003) found in their paper that elderly individuals in general assess their financial resources as adequate, while individuals who evaluate their health negatively see their financial situation more critically than healthier individuals with a similar income level. These results suggest again an interaction between the financial- and the health situation which needs

to be further analysed. This is generally not surprising, as bad health often increases the expenses of individuals, and therefore the same income level does not allow for the same amount of comfortable consumption. This interaction between self-evaluated health status and financial satisfaction will be kept in mind during the analysis of the interviews.

Another field of interest that is lacking research is the question how of individuals talk about financial problems in interviews – if they tend to present their situation as more comfortable than it is, if they tend to present their situation as more dramatic than it is, or if what is said in an interview can be taken as an accurate representation of the reality. Research on this topic would be desperately needed.

Another interesting aspect in the self-evaluation of personal finances is the gendered aspect, which may have an influence on the level of financial literacy of elderly women. In their research, Wood et al. (2012) found that pensions are not really discussed in married couples and that they are rather seen as private assets than as a household subject. Therefore, women who may not have an occupational pension are prone to not really know their financial situation, as it largely depends on their husband's pension. Analysing the financial literacy of widowed women, O'Bryant & Morgan (1989) show that the longer a widow has worked in paid jobs during her marriage, the more experience she has in handling finances. Therefore, when asking elderly women about their financial situation, it should be kept in mind that they may in certain cases not be informed enough to respond in a way that corresponds to their objective situation.

Elderly planning their future

When it comes to the process of planning the future and possible upcoming problems, there is only very limited research that has analysed how elderly individuals address this process, and most of it concentrates on end-of-life decisions such as wills or funeral plans (Rosenfeld, Wenger & Kagawa-Singer 2000; Lloyd-Williams, Kennedy, Sixsmith & Sixsmith 2007). The analysis of Carrese, Mullaney, Faden & Finucane (2002) is one of the very few that focused not only on end-of-life-decisions but also the time in between. In their analysis of 20 chronically ill individuals aged 75 years and more, they found that the majority did not plan for the future and most individuals were especially reluctant to think about future health problems. Instead, individuals were talking about a "day by day" strategy and did not want to address possible problems before they really show up (Carrese, Mullaney, Faden & Finuncane 2002). We hope that this paper will bring more information on this under-developed field of research.

Methodology

This paper is based on semi-structured interviews conducted with 20 individuals living in the canton of Basel in Switzerland, ten of them being Swiss-born and ten being born in Germany. In the Swiss-born group, some individuals were found through a daytime-care-structure and asked on place if they accepted to participate in an interview. For these individuals, some guiding of employees was used to make sure only individuals with the necessary capacities to participate were selected. The interviews were led by two master students of the University of Geneva: Ms. Julia Sauter conducted the interviews with German immigrants in 2015 and I conducted the interviews with the Swiss individuals in 2018. The age range of participants was between 70 and 88 years, with a mean age of 79 years. In total, there were ten women interviewed (three Swiss-born, seven immigrants) and ten men (seven Swiss-born, three immigrants). Table 1 shows all the individuals and some of their characteristics.

Table 1: Presentation of all interviewed individuals.

Individual	Sex	Age	Born in	Education	Financial Problems	Self-evaluated Health
I1	M	76	CH	Apprenticeship	(Yes)	
I2	M	77	CH	University		
I3	F	84	CH	Secondary		
I4	M	75	CH	University		
I5	M	75	CH	Apprenticeship		
I6	M	83	CH	Apprenticeship		Bad
I7	F	86	CH	Apprenticeship		
I8	M	86	CH	University		Fair
I9	M	81	CH	University	Yes	
I10	F	82	CH	Secondary		Fair
I11	M	80	GE	University		
I12	F	75	GE	University		
I13	M	70	GE	Apprenticeship		
I14	M	73	GE	Higher Education		
I15	F	88	GE	Apprenticeship		Fair
I16	F	74	GE	High School		
I17	F	79	GE	Higher Education		
I18	F	86	GE	Apprenticeship		
I19	F	78	GE	University		
I20	F	72	GE	University		Rather Bad

As we can see, only one individual mentioned financial problems, and it is a Swiss born individual with a University degree. The last two columns were left blank if individuals declared to have no financial problems respectively evaluated their health as good or very good. We can therefore see that only two individuals mentioned to be in bad or rather bad health, three mentioned a fair health status, and all other individuals declared to be in good health. As the mean age of the sample is 79 years, this is positively surprising, even though we will detect more health problems or chronic diseases during the interviews than this directly asked question has revealed.

All interviews were being recorded and later transcribed. The interviews with the Swiss-born individuals were led in Swiss German, transcribed and then translated to English. The interviews with the German-born individuals were led in German, transcribed and translated to French. The analysis was therefore made in two different languages, and extracts from the French interviews were finally translated to English if used as citations in this paper. Most of the interviews took place at respondents' home, some in a day structure, and others in a local neighbourhood meeting point.

The method used for the analysis of the interviews was thematical coding. The interviews were first read two times while taking notes on recurrent subjects, before a first version of coding categories was created based on these notes. Then, three interviews were coded with Atlas.ti, before revisiting the initial categories and then coding all interviews with the revisited codes. A second round of coding was undertaken to make sure nothing was missed in the first round. As the interviews were transcribed in two different languages and very subtle descriptions and circumscriptions were often used by the individuals, the coding could not be done based on exact words but had to be done in a more open, thematic way.

Empirical analysis

As the purpose of this paper is to analyse the approach of pensioners to their difficulties in terms of health and finances, the answers given by the interviewed individuals will now be analysed in thematical categories.

Self-evaluation of health

First, we will address the way that individuals talked about their health situation and eventual health problems.

All individuals (18, two were not asked this question or did not answer) felt that their health status in general was above average if asked to compare themselves to the health status of other individuals in the same age.

> « I would say better. I know a lot of people my age that have health concerns. » (I13, M, 70, MIG)

> « I think that my health is better. I am really fit and in good health. » (I15, F, 88, MIG)

> « A lot better. I can walk without difficulties, I can do everything myself without any problems. » (I18, F, 86, MIG)

While it is a legitimate assumption that the individuals that agreed to be interviewed are in a specifically good health condition, it also seemed as if some took a certain pride in saying that their health is above average, even though they actually have severe chronic diseases or other kinds of illnesses:

> « It depends on what you understand as health. I would say that in my mind, I am a lot better. Maybe I am arrogant. But when I see my former colleagues, I think that I am much better in my mind than them. And on the level of the body as well. I have to say that I had multiple tumours in my breasts, that I had to operate. […] I can walk for 200 or 300 meters and then I get a strong pain in my leg, and then I can't walk anymore for a moment. » (I20, F, 72, MIG)

> « I: And how would you say is your health at the moment, rather good, average, not so good?
> X: Bad, at the moment.
> I: And if you compare with other people in your age, would you say your health is relatively good or rather bad?
> X: No, I am actually, I mean I don't feel as old as I am. » (I6, M, 83, CH)

While some of these individuals acknowledge that their health status is bad, they still think they are doing better than their peers. This may root in their picture of the elderly that they have formed in their younger years. At that time, the life expectancy and the healthy life expectancy were still lower, as one woman puts it:

> « With my age, 50 years ago, I would have been very old at 72 years. » (I20, F, 72, MIG)

Another topic that emerged from the interviews was that individuals did not always open up about their illnesses or operations when asked for them directly in the beginning of the interview, but rather said they have had no health problems, and then later in the interview mentioned some (more or less serious) health problems.

One man, after stating that he did not have any health problems, his health was good and he had no chronic diseases, started talking about his hearing problems:

> « Yes, when I think about this, I have a problem with hearing, and I already went to a doctor when I was still working, and he told me directly that my hearing problems come from the shooting-noises. I went shooting quite often for a long time, and so my ears got damaged, I didn't hear the high sounds anymore, or actually it still is like this. » (I1, M, 76, CH)

In his case, it almost seemed like he had forgotten completely about his hearing problems, and only when asked about health problems related to his job he remembered, which seemed like a sign that his hearing aid allowed him to cope pretty well.

A woman mentioned her back problems when talking about little services and help that she receives:

> « […] my husband has already done this [i.e. shopping] for me, as I said since I had the slipped disc, I had to be a bit careful, not lifting anything heavy and so on, this was a taboo. » (I3, F, 84, CH)

But contrary to what she believed in this moment, she had not mentioned her slipped disc or even back problems in general before. On the contrary, she said she did not have any physical health problems.

Finally, another man said he had never had episodes of bad health, but then later mentioned that he had broken his spine when talking about problems with accomplishing daily activities:

> « Yes now I have that yes, because I broke two of my dorsal vertebras, and unfortunately I have an apartment with stairs inside, and I have problems with that now. » (I6, M, 83, CH)

He later mentioned that his therapy was arriving at a dead end:

> « Yes I mean now I'm in a stadium where they don't know how it's going to continue, but before I just went to therapy regularly. » (I6, M, 83, CH)

So even though his current health status was bad and quite serious, he did not feel compelled to mention it when first asked about health problems. This may come from a misunderstanding of the question (as if it only concerned past health problems), or he did not want to open up about it in the beginning of the interview. Compared to the man with hearing aid, it seems rather unlikely that he forgot about it himself, as he seemed to be in pain during the interview.

In general, many of the more serious health problems that were addressed in the interviews were mentioned by the individuals in a rather incidental way, rather than upfront when asked about their health. The illnesses mentioned upfront were things like asthma, car accidents, or joint replacements, as well as one woman that mentioned her mental health problems directly when first asked about her health.

Financial ignorance

This section will present one of the recurring subjects about money and finances, which is the ignorance of elderly of their own financial situation. Different individuals mentioned that they did not actually know their finances and their pension income that closely, for example if they contributed to the second and / or third pillar:

> « Did you contribute to the second pillar ?
>
> I think so, but that's so long ago. I think that we did it.
>
> And to the third pillar ?
>
> I don't know anymore. » (I11, M, 80, MIG)

> « Did you have the possibility to contribute to the second pillar ?
>
> I don't think so. But maybe my husband. But I don't know.
>
> And the third pillar ?

I don’t know. I think my son does this. I don’t know if I had something like that. » (I15, F, 88, MIG)

While it is in many cases true that their contribution took place quite a few years ago, their monthly income reflects their income sources. This shows that in depth knowledge of their own financial situation cannot simply be assumed of pensioners in Switzerland. Also, as the second pillar contributions only became mandatory in 1985, elderly individuals may be confused about where their money is actually coming from.

Also, two women mentioned that they actually do not really know their financial situation because their husbands took care of these things:

> « Yes yes this was the husband, I let him do everything, I wasn’t really interested in it, I always was a person who doesn’t really like numbers, but uh, he was taking care that we are well off there, and he had quite a good pension, and... no, I don’t have any sorrows when it comes to finances. » (I3, F, 84, CH)

> « I mean, I am not the one doing the financial things, my husband is doing all of that, I would have to ask my husband […] » (I10, F, 82, CH)

While this separation of financial tasks is probably due to traditional allocation of roles in a marriage and not surprising, it is interesting to see that these women in their eighties still rely completely on their husbands for all financial tasks. As women have a higher life expectancy, one would expect them to be aware that they may need to take care of their finances themselves one day. Meanwhile, these two women did not mention any thoughts in that direction, or finding their lack of knowledge and understanding problematic, it seemed more like they never thought about the possible complications that this could create.

Self-evaluation of the financial situation

Those individuals that had a more precise knowledge of their financial situation, could be divided in those completely satisfied with their financial situation (16) and those with some financial worries (2). In the first category, many mentioned that they did not only feel financially comfortable, but also accentuated their feeling of wealth by telling whom they have given financial support.

> « I have enough money. And it's rather me who gives money to my children. I don't need financial help and I don't think it will ever be the case in the future. » (I16, F, 74, MIG)

Or, if asked if paying a bill of 2500 Swiss francs would be possible:

> « Yes we could absolutely pay this. We also support the education of our grandchild, that's about 20'000 Swiss francs a year, so that would be no problem. » (I2, M, 77, CH)

In contrast, two individuals have mentioned at least some financial worries when asked for their ability to make ends meet with their pension:

> « I have to pay a lot of taxes every year, a looot of taxes, this is becoming a burden for me now in my age, I lived very economical as a young man so I could buy a house, and then we continued saving money and so on, we did a lot on this house ourselves, renovating it and so on, and now in the end I am getting punished for this, because now I have to pay a lot of taxes. » (I1, M, 76, CH)

> « X: It is very difficult. I should het a hearing aid, but it costs 6000 Swiss francs, and I, I just don't have them, and I don't get any pension from the [employer], […], and the normal one from the OASI. But also, nothing …
>
> I: Together it's not enough to be really comfortable?
>
> X: No. » (I9, M, 81, CH)

Overall, the interviewed individuals had a rather positive view of their finances, and only a few of them mentioned any difficulties or worries. While this may be due to the high education level in our sample, it may also come from the fact that talking about money is still a rather delicate subject (Alsemgeest 2016), and talking about financial problems or (perceived) poverty even more so. There was also some element of pride in the individuals saying that they receive a "good" or "generous" pension, which may have excluded the possibility of later admitting that they might still be worried about some situations. The financial aspects of future health developments or future care were not at all mentioned throughout all 20 interviews, which leads to the final part of the analysis. The one individual (I9) who mentioned financial problems

explained them through his need of medical supplies, more precisely a hearing aid, which shows to some extent the link between the two subjects. Other than this individual, it did not seem that individuals with lower self-estimated health were more often in situations of financial problems.

(Not) Thinking about the future

The last category of analysis concerns the ignorance of possible future difficulties and changes, in contrast to those individuals that are well aware of such possibilities. Several individuals have mentioned that they did not think of their future care situation yet, for example because they did not want to think about themselves needing care:

> « That's a question that I don't want to ask myself. I don't think I would feel well in a nursing home, […]. But one cannot foresee the future. » (I11, M, 80, MIG)

Another individual mentioned that it was too early for her to think about care, herself being "only" 84 years old:

> « And I just think to myself, I just let it go along as it is now, and I don't want to get started on such things, I don't do that, it is too early for that […]. » (I3, F, 84, CH)

Many individuals were hesitant to talk about a scenario where they would need full care, and gave answers like this man:

> « I: Have you ever thought about, if you would need full-time care, where you would want to live, are there any possibilities with your children or maybe an elderly's home?
>
> X: Well as long as my wife is still there, with my wife. » (I8, M, 86, CH)

In this case, he somehow bypassed the question of full care, or if his wife would be able to take full care of him, and just went on with the next question. Interestingly, only two individuals had the expectation that they would be taken care of by their spouse, and both of them were male. This may be seen as a sign that there still is a gendered character of care, as no woman expected to be taken care of by her husband, but on the other hand many of the women's husbands were already dead at the time of the interviews and therefore the answers cannot really be compared.

Many expressed a certain position of "having to wait and see", because "one cannot forsee the future" and "we will take care of that when the situation arises". Therefore, planning seemed

either not necessary or not possible for them, which allowed them to somehow ignore the problem and "deal with it later".

One man expressed this position very clearly, talking not about care, but about his health in general:

> « I don't like to go to the doctor, so I don't know if maybe I have other diseases, I don't know anything. I don't know if I have cancer, and I prefer not to know, because then the doctors would torture me with their medicaments and everything. » (I13, M, 70, MIG)

This position of not knowing and not wanting to know what may come in the future was expressed by many of the elderly interviewed. On the contrary, some individuals actually did think about their future situation and faced possible challenges, even though they did not really feel comfortable thinking about it:

> « Yes, we just did that yesterday, […] a woman came to us because of the nursing home, and that if it doesn't work out anymore, that I would agree to go to the nursing home, and I do. That's coming, that is .. but uh, as long as I can, I push it away a bit, I do. » (I10, F, 82, CH)

In another case, the couple has taken a membership in a nursing home, so that they could more or less easily get a place there, but without any specific plans about going there in the near future:

> « I: Have you ever thought about going to an elderly's home?
>
> X: No, not yet. We are members of this elderly's home [points in one direction], but we haven't thought about really going, no. » (I2, M, 77, CH)

While this man puts it as something they have not really thought about in detail, getting a membership in their local nursing home seems like a clear sign that this couple actually has thought about their future and already taken the first necessary steps, even if they still are independent enough for the moment. Still, this man talks about their plans in a rather non-final way.

Others were really well prepared, and talked about their arrangements in a very confident way:

> « Yes, I thought about it. And I have a will, and I am also member of Exit[14]. And so I would turn towards them, when everything else fails. » (I15, F, 88, MIG)

> « […], I am also preparing a paper so that they could take care of me if I am in a coma etc., I trust them a lot. » (I18, F, 86, MIG)

Finally, one woman expressed her ideas about sharing a house with other elderly individuals instead of going to an elderly's home:

> « But I also think about creating a flat-sharing community, with people that share my opinion. We all have very good pensions, and I think it would be possible to buy a house and hire a nurse and a housekeeper. That would certainly be possible from a financial point of view. » (I20, F, 72, MIG)

These individuals were much more open to talk and think about upcoming difficulties. They seemed to have accepted their age and that they would not forever stay in the good health status they currently enjoyed.

Discussion

The individuals who participated in the interviews used for this paper were overall in relatively good health and without any serious financial problems. Many of them did not want to plan their future in a definitive way, even though some had taken first steps to address subjects like future care or illness. Even if the overall situation of the interviewees was relatively good, contradictions in some of their descriptions could be found.

First, let's discuss the description of health or health related problems. Many of the more serious health problems were not mentioned when first asked about their self-evaluated health status or about episodes of bad health, and the individuals mentioned them later in the interview, when health was not the main subject anymore. Two individuals mentioned their illnesses before the interview really started, both of which had had a stroke a few years earlier. Therefore, if health

[14] Exit is a Swiss company for medically assisted suicide, which is allowed under certain circumstances. For further information on the legal situation in Switzerland, see https://www.bj.admin.ch/bj/en/home/gesellschaft/gesetzgebung/archiv/sterbehilfe/formen.html

is to be analysed, the question of self-evaluated health, even combined with a question about bad episodes of health, is not sufficient to gain insight about the true and comprehensive health situation of individuals. Also, especially the older individuals in the sample often mentioned some problems in their daily activities but declared themselves to be in good or even very good health. For them, these limitations in their daily life were just part of getting older, and they were separated from "health" as a concept which seemed more related to official diagnoses and illnesses. For example, one individual (I10) explained that she had to go to a nursing home one week per year during the vacation of her husband, because she could not stay alone at home anymore as a result of her limitations in daily activities, but she still declared to be in very good health.

When asked to compare their health to the health of other individuals their age, all individuals said their health was either better or at the same level, even those who declared to be in bad health. This was a bit surprising and could be seen as a sign that individuals compare themselves to the picture of elderly that was accurate when they were still young. It could also be a certain coping mechanism – "even if my health is bad, there are others that are worse off". This comparative view of one's health would be an interesting subject to analyse more closely.

More German born individuals declared to be in very good health, compared to the Swiss who more often declared a good health, but the part of individuals mentioning a fair, rather bad or bad health status was comparable (3 Swiss-born and 2 German-born). Other differences between the two groups could not be found.

Let us now turn towards the description of finances and financial problems. 18 of 20 individuals did not mention any financial difficulties or worries, which represents 90% of the sample. While the high education level in our sample might very well have an influence on this proportion, it might also be influenced by the difficulty to talk about finances and financial problems. Many individuals took some sort of pride to say that they receive a "good" pension and even more if they could explain that they financially support their family members. No one mentioned any numbers of income or wealth, which was expected as the questions were deliberately formulated in a way that did not force individuals to talk about numbers. Most probably, individuals would not have answered a question on the income level, as many of them were already hesitant to talk openly about the very indirect questions asked.

The one individual with financial worries (I9) explained them in relation to the costs of a medical supply, which supports the assumption that health and finances are closely connected. The other individual who talked about some financial worries (I1) complained about the high taxes he has to pay on his house, but it seemed more like an inconvenience than a real problem to him. From the other perspective, the individuals who rated their health as bad did not mention any financial problems or worries.

The two individuals who mentioned some financial worries were both of Swiss origin. Other than these two, all individuals were satisfied with their financial situation, and no other differences between Swiss- and German born individuals could be detected.

If we turn to the question of planning their future, a wide variety of individuals was represented in the sample. While most mentioned strategies similar to the one's presented in Carese et al. (2002), as for example "having to wait and see" or "will we decide on that when it's time", some did actually think more precisely about their future. Three individuals mentioned plans to go to a specific nursing home or even having a membership, which is clearly a sign that they have not only thought about their future but took the first necessary steps to organize it as well. Interestingly, a higher proportion of individuals with German origin mentioned that they really do not want to live in a nursing home or that they have never thought about it (7/10), compared to the Swiss origin individuals where this proportion was clearly smaller (3/10). Also, three individuals with Swiss origins have thought more in detail about a possible nursing home (being a member, having met with an employee, knowing the names of the ones they like), compared to zero individuals with German background who had already taken this kind of further steps. As the mean age in the two groups is comparable, this discrepancy cannot be explained through differences in the variable of age. Further analysis is needed to see if these differences exists only in this sample or if they could possibly be representative, in which case there would be a need to discuss potential policy adaptations.

No specific characteristics could be found to define the individuals who do or do not want to think about their future. The individuals being part of one or the other group had diverse backgrounds, family situations and health or financial situations.

Conclusion

The aim of this article was to analyse how elderly individuals in Switzerland approach the subjects of health, finances and their future as well as how they evaluate their situation.

First, the subject of health was analysed. We found that while most individuals rated their health as good, and all rated themselves as in better or similar health as their peers, some had quite important health problems. Many of the more important health problems were not mentioned directly when asked for health problems, but later in the interviews. Self-evaluated health, even in combination with a question that asks for episodes of bad health in one's life, is therefore not sufficient to fully grasp the health situation of (elderly) individuals. Often, limitations in daily activities are not considered when evaluating one's health, it is therefore necessary to ask both subjects separately to get a better picture of the independence of elderly individuals.

Second, finances were analysed. Most individuals (90%) mentioned no financial worries at all and talked about finances in a rather generous way by mentioning whom they have given financial support. While one individual who mentioned financial problems explained them through his need of an expensive medical supply, the individuals who rated their health as bad were not the ones with financial problems.

Third, the future planning of the individuals was analysed. Most individuals did not want to think about their future and thought it was to early to start thinking for example about full care. The few individuals who did plan their future took some direct steps, like registering at a local nursing home or becoming member at an organisation for medically assisted suicide. More individuals with German origin than with Swiss origin mentioned a clear aversion against nursing homes and had no plans at all for their future.

A qualitative study like this one has clear limitations in terms of representativeness. Of course, neither the conclusions overall nor the elements concerning differences between Swiss and German born individuals can be generalized. It is a legitimate assumption that individuals who agree to participate in an interview are in relatively good health, and further studies would be needed to analyse the same subjects in individuals with an objectively bad health status. It should be kept in mind that this population would be very hard to reach, and probably not always capable to participate in interviews of about an hour length. The sample used in this paper had a relatively high education level, which may have influenced the results in all three subjects (health, finances, future planning). Nonetheless, this paper has shown that qualitative analysis on the topic of old age vulnerabilities as well as on future planning is needed to fully

understand the situation of elderly. It allows insights that a purely quantitative analysis would not have been able to grasp.

As quantitative analyses continue to be used on subjects as health and finances, the way individuals respond to the survey questions needs to be analysed further to be able to correctly interpret the answers. Do the answers really depict reality, or are they skewed? Also, the whole subject on if, how, and when elderly individuals start to plan their future needs more research, even more so as the aging of the population continues. The differences between migrants and natives should also be analysed more closely. A combination of qualitative and quantitative research methods would seem appropriate for these tasks.

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4. Overall conclusion

The goal of these two articles was to find out more about the relations between old age poverty, health and migration in Switzerland. The first, quantitative article focused on the factors that lead to old-age poverty and found similar factors for the older Swiss natives and immigrants. When it comes to health, immigrants reported a worse health status than their Swiss counterparts, even if controlled for some factors accounting for physical labour. The results rather support the theory of the "exhausted migrant effect" in old age, even if there might be a "healthy migrant effect" shortly after migration takes place.

The second, qualitative article focused on the way older individuals address and evaluate their economic or health-related difficulties. While the sample seemed to be in overall good health and financially stable situations, it was still interesting to see that all individuals declared to be in better health than other individuals their age. Most individuals mentioned health problems during the course of the interview that they had not addressed when asked directly about their health and health problems. Also, the sample could be divided into those individuals not wanting to think about their future, and those that thought about or even acted towards a self-determined future.

Using these different methodological approaches on a similar subject was very interesting. Both types of analyses have their advantages and disadvantages and working with both has led me to appreciate the different kind of information each one can create. The fact that many individuals did not mention their existing health problems when asked for them directly in the interviews is something that should be kept in mind while using the same kind of direct health question in a quantitative context. Put directly – just because an individual declares to be in good health does not mean the individual actually is, and this does not even include an objective evaluation of the health status by a third party. The person might have just forgotten to include some of their health problems, which was quite unexpected.

If I could start over the experience again, I would have liked to have the opportunity to invest more time in analysing the quantitative data before formulating the hypotheses. It would have become clear much earlier that there is no data available on the year of immigration respectively the time of presence in Switzerland. For the qualitative analysis, it would have been interesting to ask more questions about the financial situation, such as who took care of the finances in their marriage, if they owned real estate, and of course their real income. Meanwhile, even if individuals would have accepted to share their real income which would be a very sensitive question, some of them would not have been capable to give me a correct statement as their

partners are fully taking care of their finances. Still, hearing individuals talk about their finances more would have given me more content to analyse. In the same direction, talking more about their thoughts concerning their future, finding out more about the differences between those having plans and those avoiding plans would have been interesting.

Both papers have shown that there are many research opportunities in this complex field of old-age vulnerabilities. Quantitative data on migrants should include a question on their year of arrival, which would permit more differentiation among migrants and allow for very interesting research questions. Health questions need to be analysed with a certain reservation, as some (older) individuals seem to forget to mention some of their health issues. The question of elderly thinking about or planning their future is drastically lacking research. The existing literature focuses mostly on end-of-life decisions, while the decisions about organising care and living structures are excluded. It seems obvious that those thoughts and explanations could be very interesting and valuable for the planning and development of old-age care-structures, which is a subject closely linked to ageing societies. Even though there might be a difference between first intentions and concrete behaviour, increasing research on these complex subjects would be highly beneficial.