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Health Care Provision to Refugees from the Balkans in Private and Hospital Practice in Switzerland

Switzerland is a small country in the heart of Europe. It is a Federation of 25 Cantons. Each Canton is a state, with its capital, its government, its administration, police, education and health system, etc.

Refugees who arrive to Switzerland and claim for asylum are first given shelter in one of the four registration centres, that are located along the border and placed under the responsibility of the Federal State. If their request is estimated legitimate and if they meet the legal conditions, they are granted the status of asylum seekers. The fact that they crossed the border illegally is not relevant. The refugees have a first medical examination including, in particular, a search for tuberculosis and vaccinations. This check does not focus on individual health problems, its aim being public health. Later, according to a system of quotas, the refugees are handed over from the registration centres to the Cantons, which have to assume further responsibility on the social and administrative levels. Only a small percentage (9 out of 10) of all asylum seekers registered in Switzerland will eventually have their claim for asylum accepted and be recognised refugees.

Since the first of January 1996 all the asylum seekers accommodated on Swiss territory are health insured on a mandatory basis. The Federal Office for Refugees pays the contributions. According to the Swiss law, asylum seekers are thus in principle granted the same access to health care as the resident population, although there may be some actual differences. Some Cantons have set up special health networks for refugees, in order to avoid an expensive and inefficient “medical tourism”. The free choice of the doctor is thus limited for asylum seekers, as they have to consult primary care physicians working in the networks. On the other hand these physicians are trained to address the specific health needs of migrant populations, like e.g. post-traumatic stress disorder and medical problems resulting from war, organized violence or torture.

Since the beginning of the war in Yugoslavia in the early nineties, Switzerland has accommodated nearly one hundred thousand refugees. Between 1992 and 1996 many of them come from Bosnia and Herzegovina. In the late nineties, with growing internal tensions in Kosovo and later with war, a large influx of new refugees arrived from this province, reaching a peak of 25'000 in 1999. Currently a significant number of migrants still arrive from Bosnia and Herzegovina, because of the ongoing social and economic crisis, and the absence of future for the young Bosnian generation.

Most refugees reaching Switzerland are young people, mostly men. Such a population should in principle be a healthy one, had they not previously been exposed to war, organised violence and other forms of ill treatment or torture. Some had no access to health care. Not surprisingly, refugees once in Switzerland, more frequently resort to medical services than the resident population. They over-consume health care services. Health insurance companies

estimate that the additional expenses for medical care to the refugees exceed that of the resident population by 40%.

I work in Lausanne as a general practitioner and in Geneva at the Department for Community medicine of the University Hospital as a consultant. More than two thirds of my patients are refugees and asylum seekers, most of them coming from the Balkans, especially from Bosnia-Herzegovina and from Kosovo.

There has been little research on the health of refugees in Switzerland as well as in other European countries. Some studies have been conducted about the access to health care services.

My purpose is not to be scientific. I intend to report my observations and my experience as a practitioner working for years with a migrant population.

According to the circumstances of their arrival in Switzerland I can divide the patients from former Yugoslavia into three main groups.

1. Refugees from Bosnia Herzegovina who arrived in Switzerland from the beginning of the war until 1995/96. Many were women, widows with children who had survived the massacres of Srebreniza and whose husbands had disappeared. They showed severe symptoms of distress and had many somatic complaints. Pain was the most frequently reported symptom: headache, low back pain or generalized pain syndromes, for which no medical explanation could be found. Other patients had personally experienced ill treatments. Their pains were late consequences of physical traumas and were not merely psychosomatic processes. Anaemia due to iron deficiency was, - and still is -, a common disease among young Bosnian women. Some of them need long lasting iron substitution therapy. Although dental condition was often disastrous, protein malnutrition was not reported.

By far the greatest health problems reported among Bosnian refugees of that period were due to intense psychological stress that stemmed directly from the war. The psychological consequences of extreme violence are currently well known and have been described and classified among psychiatric diseases as Post Traumatic Stress Disorder (PTSD). PTSD is scarcely any thing else than a normal reaction of a normal person to abnormal events. It can be regretted that PTSD has been classified in DSM IV and in ICD 10 as a psychiatric disease. Mental suffering in war torn countries can be very severe and often needs psychological support. PTSD had a very high prevalence among refugees from Bosnia-Herzegovina and its effects are long lasting. They are characterised by sleep disturbances, nightmares, flashbacks and behavioural changes. Yet it should be remembered that human distress is not a psychiatric disorder per se, although real psychiatric diseases may develop after severe psychological trauma. Major depression, panic attacks and psychotic diseases have been frequently observed and the patients sometimes needed to be referred to psychiatric structures. Experiencing extreme violence can bring out of balance a formerly existing but compensated psychiatric disorder.

Somatization is the bodily expression of psychological and social suffering. It exists in any population and in any part of the world but is of course extremely frequent among migrants in situation of social distress. It poorly responds to most initiated treatments, may become chronic and lead to disability. The therapeutic possibilities are limited. The chronic somatoforme illnesses may even become a substitute of an identity among patients whose

personal and social life has been completely destroyed. The likelihood that medical treatment improves their health is thus meagre.

2. The second group is constituted of refugees who arrived from Kosovo during the war in 1999. Their number was around 25'000. They were granted temporary admission to Switzerland. They were informed their stay would be limited in time. The health problems were similar to those displayed by the refugees from Bosnia a few years earlier, although the mass traumas the refugees from Kosovo had experience did not reach the intensity of the massacres of Srebreniza or the Serbian detention camps. A large number of expatriate ethnic Albanians from Kosovo have settled since years in Switzerland. They were able to support socially and financially the newly arrived compatriots. Hence the latter had less recourse to health services than had other refugees. For an unknown reason headache is a particularly common form of somatization among ethnic Albanians from Kosovo. Many of them are reluctant to accept that their symptoms have a psychosomatic or socio-somatic origin. They request CT scan or other specialized investigations that prove useless. If they do not obtain satisfaction, they tend to believe that because of their status of migrants they only deserve a second-class medicine.

3. The third group of patients are migrants currently leaving Bosnia mainly for economic and social reasons, (unemployment, restitution of the houses to the former owner etc.). This does not mean that these persons had not previously during the war been exposed to traumas, but these events are already ancient. Some show chronic after-effects, but others were able to cope with their traumas. Their legal chances to be granted asylum in Switzerland are virtually non-existent. Some of them consider Switzerland as a springboard for further migration to a third country. But the resettlement to a third country needs time and Switzerland expels them rapidly, with only one exception: the persons who are seriously ill and need a specific treatment, which cannot be provided in the home country. Thus, the patient may amplify the slightest symptoms. The physician then faces a difficult problem, not only a medical one, but an ethical one: he has to make the difference between what is real medical suffering, possibly a symptom of a serious disease, and what is obviously amplified by the patient in order to obtain a medical certificate that would make him eligible for a humanitarian admission.

Practicing medicine with asylum seekers is a difficult and sometimes frustrating job. The patients have numerous complaints and requests, which we do not always understand, and the initiated treatments do not bring the expected results. The uncertainty about the length of their stay in Switzerland makes it difficult to set up therapeutic projects. Cultural and linguistic barriers complicate the difficult patient-doctor relation and misunderstandings can impede the therapeutic results. Professional interpreters, supposed to be also cultural mediators, are often required.

Refugees who obtain asylum in Switzerland do not necessarily show long-lasting improvement. After a short period of "honeymoon" following the grant of asylum the previous complaints and symptoms may reappear unchanged. Among them, those who were able to cope with their past, who have learned the local language and started a job usually disappear from the medical circuits.

Acknowledging the human rights violations the refugees were exposed to, is an important task for the doctor, but it is by far not sufficient. We must help our patients leave their status of victims and become survivors, in other words persons who are able to live with a past history

that does not permanently invade the present. But I confess that, because of the political and social uncertainty in which these persons live, this goal is difficult to achieve.

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