Summary Report for Work Package 4

This project has been funded with support from the European Commission. This publication reflects the views only of the author, and the Commission cannot be held responsible for any use which may be made of the information contained therein.

**Lifelong Learning Programme**

MedInt: Development of a Curriculum for medical Interpreters

WP4 - Summary Report on State-of-the-art: health care for migrants

ZEBRA

Report for Work Package (WP) 4 drafted on the basis of the reports provided by the following project partners: University of Graz (Partner 1), University Mainz/Germersheim (Partner 3), University of Ljubljana (Partner 4), University of Tampere (Partner 5), KAGes (Partner 6) and ZEBRA (Partner 7).

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Work Package 4

State-of-the-art: health care for migrants

I. Work Package Outline

Work package 4 deals with health care for asylum seekers/refugees and migrants in the partner countries. The project partners provided information on the situation in their home countries. The data was gathered in different ways: expert interviews and meetings, newspaper articles, publications as well as internet research formed the basis of what will follow. This work package aims at delivering an insight into the actual situation concerning asylum seekers/refugees and migrants and their possibility to use the health care systems in the new host countries as well as all the problems this clientele may face.

The following MedInt partners contributed to WP 4:

- University of Graz (Partner 1),
- University Mainz/Germersheim (Partner 3),
- University of Ljubljana (Partner 4)
- University of Tampere (Partner 5),
- KAGes (Styrian Hospital Corporation) (Partner 6) and
- ZEBRA (Partner 7).

The project partners were asked to provide information on the following topics:

- Short overview of the partner countries’ health care system
- Overview of the main countries of origin regarding asylum seekers/refugees and migrants
- Specific medical problems asylum seekers/refugees and migrants may face
- Access to medical services for asylum seekers/refugees and migrants (legal situation (insurance) and quality of access)
- Culturally specific concepts of health/illness
- Culturally specific taboos in medical settings

The first matter to be stated is that the reports of the different partner countries vary a lot. Regarding the partners’ contributions, hardly any information was given on the last topic (culturally specific taboos). The fact that no information is available on certain topics or at least it was very difficult and time-consuming to obtain may be taken as an interesting result in itself for this report. Instead of the last topic, we added a brief report on the conditions and effects torture victims face. The fact that there are victims of war, torture and other forms of political violence, who are traumatized in our society, is very often neglected.
II. Summary of Results

In what follows, the results of the project partners from Finland, Germany, Slovenia and Austria will be summarised.

The structure of the report has been changed slightly because of the kind of information provided by the project partners:

- Overview of the main countries of origin regarding asylum seekers/refugees and migrants
- Overview of the partner countries’ health care systems including insurance benefits for asylum seekers/refugees and migrants
- Access to medical services for asylum seekers/refugees and migrants
- Specific medical problems asylum seekers/refugees and migrants may face
- Culturally specific concepts of health/illness
- Specific treatment of traumatised people

Even though the scope of this work package only allowed us to include information on the project partners’ countries, the report may give an overview of the situation of asylum seekers/refugees and migrants concerning health care. It shows that in many areas the reasons for the target groups’ deficient access to health care services are similar in the project partners’ countries. Lack of information on the part of asylum seekers/refugees and migrants as well as on the part of health care providers is one of the major problems. Needless to say that the provision of interpreting services plays a crucial role in the context of asylum seekers, refugees, and migrants’ access to medical services as well.

II. 1. Overview of the main countries of origin regarding asylum seekers/refugees and migrants

This first subsection of the report will provide a short overview of the main countries of origin regarding asylum seekers/refugees and migrants living in Austria, Finland, Germany and Slovenia. It can be stated that the population groups of people, who do not have citizenship in the country in which they are living, are very similar in Austria and Germany, while they are somewhat different in Finland and especially so in Slovenia.

Austria

Taking a closer look at the situation in Austria, it can be stated that out of the 8.3 million people living in Austria about 90% have Austrian citizenship whereas the remaining 826,000, i.e. 10% of the population, do not. Taking a closer look at the latter, it turns out that about 455,000 of them are migrants from third countries. Focusing on the question of origin, it can be seen that people migrating to Austria are predominantly from the following five different countries: Serbia (26.78%), Turkey (21.09%), Bosnia-Herzegovina (20.32%), Croatia (12.39%), and Macedonia (3.52%).

Regarding Austrian inhabitants who are citizens of an EU country, the main groups are people from Germany followed by Poland, Romania, Hungary, Slovakia and Italy.

Regarding asylum seekers, the situation is as follows: The number of applications has declined over the last few years (from 20,129 in 1999 to 11,921 in 2007, reaching its peak at 39,354 applications in 2002).
There were 34,634 requests for asylum pending by the end of 2007. 11,301 applications had still been pending for more than three years (see www.bmi.gv.at). Another interesting fact is that the main countries of origin of asylum seekers in Austria have changed slightly since 2007: Whereas in 2007, most applicants were from Serbia, Russia, and Moldova, the situation has changed a little since then. In May 2008, the majority of asylum seekers were from Russia, followed by Afghanistan and Serbia. (Statistics of the Federal Ministry of the Interior, BMI)

**Germany**

There were about 82 million inhabitants in Germany in 2007. Among the 6.7 million registered inhabitants without German citizenship, which is about 8 % of the total population, almost 1/3 come from European Union countries and 2/3 come from third countries. Among those inhabitants coming from third countries, about 1.7 million have Turkish citizenship, followed by Serbia\(^1\) (468,000), Croatia (225,000), the Russian Federation (188,000) and Bosnia and Herzegovina (160,000).

Among the 2.3 million who come from the European Union, most are Italian followed by people from Poland, Greece, Austria and the Netherlands. (Statistics of the Federal Ministry of the Interior, the Federal Office of Statistics (Statistisches Bundesamt) and the Registration Office for Foreigners (Ausländerzentralregister))

**Finland**

In Finland, the number of migrants and people speaking languages other than the official ones of Finland has been growing steadily over the last decades and will continue to grow. Out of the 5.3 million people residing in Finland, approx. 173,000 people speak languages other than Finnish, Swedish or Sami as their mother tongue. 133,000, or some 2.5 %, are foreign nationals, and the four biggest nationalities are Russian (26,000), Estonian (20,000), Swedish (8,400), and Somali (4,800).

China, Thailand, Germany, Turkey, Great Britain and Iraq all are represented by over three thousand people. (Statistics Finland; Finnish Migration Service)

In 2008, as in the previous year, Finland is going to accept 750 quota refugees. The biggest groups will come from Iraq, Burma, and Congo. In 2007, a total of 1,793 refugees, asylum seekers who were granted asylum or a residence permit, and family members were received in Finnish municipalities (1,142 in the year before). In last few years, the main countries of origin of asylum seekers have been Iraq, Serbia, Russia and Somalia, followed by Afghanistan, Iran, Nigeria, Turkey, and Belarus. (Finnish Migration Service)

In 2007, over 10,000 people (non-EU citizens) applied for a residence permit in Finland to study or work. These statistics are once again topped by Russians, with more than one-third of the applications, followed by Chinese, Ukrainians, and Turkish people. More than 90 % of the applicants were granted a residence permit. The numbers are growing very fast: the number of applications for a work permit rose by no less than 59 % compared with 2006. (Finnish Migration Service) As the Finnish government openly seeks to enhance the recruitment of foreign workers to make up for the demographic challenge, this group of migrants is bound to grow accordingly in the coming years and decades.

**Slovenia**

In 2001 (more up-to-date statistical data is not available), 45,273 people out of the 2 million inhabitants of Slovenia didn't have Slovenian citizenship, which is about 2.3 %.

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\(^1\) Serbia includes persons coming from “Serbia and Montenegro” and “Yugoslavia” as they are still registered under the “old” names.
We face a special situation in Slovenia: Due to the war in Croatia and Bosnia, more than 70,000 refugees from Croatia and Bosnia fled to Slovenia in April 2002. The demographic structure of refugees is nearly the same today as this initial situation. The majority come from the states of the former Socialist Republic of Yugoslavia, in particular, the Roma from Kosovo.

In addition, some immigrants come from states that formally belong to the Soviet Union and some from Turkey.

There had been a lot of refugees from different Muslim countries up to 2001. The reason for that was that Bosnia and Herzegovina cancelled all visas for inhabitants of countries that helped them during the war. A lot of migrants came to Sarajevo (the capital of Bosnia and Herzegovina) and then continued north by car. At that time, more than 100 people a day came to Slovenia.

Therefore, the majority of refugees and migrants in Slovenia come from the former Yugoslav republics, the former Soviet Union, the Middle East and the Far East.

We also have to bear in mind that there are not only asylum seekers/refugees and migrants from the countries mentioned above who need interpreting services. There are also many people who came to live in the host countries from abroad and who already have been granted citizenship, but might still need interpreting services in highly specialised situations like health care.

II. 2. Overview of the Partner Countries’ Health Care Systems

This subsection will give short overviews of the health care systems in the partner countries followed by information about the insurance benefits for asylum seekers/refugees and migrants.

It turned out that health care benefits for asylum seekers are restricted in Germany, Finland and Slovenia; they only have access to the most essential services. In Austria, asylum seekers can theoretically make use of the benefits of the statutory health insurance, although there are different obstacles. For example, living in rural areas - where reception centres for asylum seekers are located in many cases – can be a problem, as they often cannot afford the travel expenses to a doctor, hospital etc.

II. 2. a. Austria’s Health Care System

As a public welfare system, the Austrian social security system aims at ensuring a basic standard of living and at providing health care in case of illness, invalidity, maternity, unemployment or old age. Among accident and pension insurance, health insurance is one of the main branches of the Austrian social insurance system.

Regarding the question of who is insured and who can consequently make use of the benefits, the following extract taken from a publication by the Federal Ministry of Health and Women on Public Health in Austria (2005) gives a good insight into the topic:

“The coverage provided by statutory health insurance extends not only to the insured himself, but to members of his family such as children and spouses or partners, provided they do not pay health insurance contributions in their own names. About two-thirds of those pay health insurance contributions, while the remainder receive free coverage.

2 Most of the following information is based on this publication (http://www.bmgf.gv.at/cms/site/attachments/8/6/6/CH0713/CMS1051011595227/public_health_in_austria_2005_internet.pdf [June 30th, 2008])
as family members (e.g. children) and/or are co-insured by an additional contribution in cases regulated by law (in effect since 2001). As a result, 98 percent of the population is covered by statutory health insurance.

Statutory health insurance is organised according to vocational groups and regional aspects, with some very wide variations in arrangements.

As previously mentioned, an insured person is entitled to make use of several benefits as are members of his/her family. These range from medical aid, medications, hospital care, home nursing services, psychotherapy, clinical/psychological diagnosis to preventive medical check-ups. Some of the above-mentioned will be discussed in more detail at this point:

• **Medical Aid**: In the extensive network of doctors and hospitals provided, insured people are allowed to visit any contracting doctor (depending on their insurance) in case of illness. They may consult a doctor without a contract as well, but in this case, they will have to pay a deductible amount. Farmers’, civil service employees’ as well as self-employed people’s health insurance scheme differs from the afore-mentioned: a co-payment is usually required.

• **Hospital care**: Any insured person has the right to immediate hospital treatment in case it is required. In Austrian hospitals, a distinction is made between two different classes of fees – a general and a special one. Depending on the class as well as the insurance carrier, any insured person has to pay a deductible amount ranging from 8 to 15 € per day. Only in special cases, such as childbirth, are the expenses fully covered.

• **Medications**: Medications are prescribed by doctors and can be obtained in any pharmacy. The patient is asked to pay a deductible amount of €4.80 per packet of medication.

• **Psychotherapy**: Psychotherapy as well as clinical-psychological diagnosis have been obligatory benefits since 1992, but insured people normally are asked to pay the major part of the costs.

• **Mother-Child Medical Card Examinations**: Since 1974, examinations of pregnant women as well as children up to the age of 62 months are offered free of charge.

• **Travel and Transport Costs**: Transport to and from hospitals as well as the nearest contracting doctor are fully covered in case public transport is considered inadvisable.

Insured people are provided with numerous other benefits by the Austrian health care system, such as preventive medical check-ups, sickness benefits as well as maternity benefits.

In addition, there is the possibility of obtaining private health insurance by paying premiums. About one-third of the Austrian population does so as it grants them privileged treatment in hospitals (single bedrooms, for example) and other benefits, such as the possibility to consult doctors of their choice - whether they are contracting doctors or not does not matter in this case.

To sum up, health insurance contributions are obligatory for anyone living and working in Austria. Besides accident and pension insurance, health insurance is part of the social security insurance system. The afore-mentioned benefits are granted to you as an insured person.
Insurance benefits for asylum seekers/refugees and migrants
The Austrian legal foundation plays a crucial role in the question of whether someone is granted access to the Austrian health care system or not. Taking a closer look at asylum seekers, the situation is as follows: During the asylum procedure, asylum seekers are granted ‘Grundversorgung’ (primary care). Primary care means that their basic needs will be fulfilled during the request for asylum. The primary care system includes provision of accommodation, food/money as well as access to the social insurance system via the ‘Gebietskrankenkasse’ (or GKK), the general statutory health insurance fund. Consequently, he/she is enabled to make use of any health care benefits provided by the GKK as the insurance coverage is provided as long as he/she is a recipient of primary care.

In some cases, however, asylum seekers may cease to be insured or even lose their claim to primary health care as a whole. The latter is the case if an asylum seeker, for example, leaves the reception camp for more than three days, since it is their obligation to report there on a regular basis. There is still the possibility of revision though and, in some cases, primary care is even granted retroactively. In the event that the asylum procedure ends in a negative decision, the person only has the right to reapply for primary care if deportation is considered inappropriate.

Another problem that arises is that living in rural areas - where reception camps for asylum seekers are often located – can be disadvantageous, for example, as asylum seekers are very often provided insurance coverage, but cannot make use of it as they simply cannot afford the travel expenses to a doctor, hospital etc.

Having the right to social benefits, it often happens in the case of approved refugees that they are not aware of the fact that it is up to them to co-insure their family. Consequently, it is not unusual that family members are uninsured.

Shifting the focus to migrants at this point, it is important to state that employment is a decisive factor with regard to them as it grants them insurance. In case a family member is insured, co-insurance is possible as well. One of the main problems that approved refugees face as well is being on supplementary benefits seeing as all people in Austria who are dependent on it are not insured. Their access to the health care system is via special health insurance certificates which only grant medical aid to a certain extent. Obviously, being on supplementary benefit means stigmatization: Not only is it very time-consuming to get the afore-mentioned health insurance certificates, but limited benefits are problematic as well and can actually be considered as substantial unequal treatment.

II. 2. b. Germany’s Health Care System

The rise of Germany’s modern health care system dates back to 1883, when the parliament passed a law that made health insurance mandatory nationwide for certain employees. This statutory health insurance was to be based on the solidarity and pay-as-you-go principles and it was built upon existing voluntary or mandatory local schemes of social insurance. Cash and in-kind benefits were to be financed by proportional contributions from mandatory as well as voluntary members and their employers.

Every person living and working in Germany is normally covered by a health insurance scheme. In 2003, approx. 88% of the population were covered by statutory health insurance (SHI), nearly 78% mandatorily and 10% voluntarily. Independent of the status, the amount of contribution paid or the duration of insurance, members and their dependents are entitled to the same benefits.

3 Most of the following information is based on the report published by Busse in 2005 as part of a survey done by the WHO on the health care systems.
The following types of benefits are currently included in the benefits package:

- **Treatment of disease** (ambulatory medical care and normal dental care):
  Patients have free choice of physicians, psychotherapists (since 1999), dentists, pharmacists, and nursing care providers. They may also choose other health professionals, however, access to reimbursed care is only available upon referral by a physician. Family practitioners (about half of ambulatory physicians) are not gatekeepers in Germany, although their coordinating competencies have been strengthened in recent years.

- **Inpatient/Hospital care**: German hospitals have traditionally focused on inpatient care; there are strict sector borders to ambulatory care. While acute hospitals in the hospital plan provide outpatient emergency care, only university hospitals have formal outpatient facilities. Day surgery and ambulatory pre- and post-hospital care have become additional fields of increasing activity. Since 2004, hospitals have been granted additional competencies to provide care to outpatients that require highly specialized care on a regular basis. Furthermore, ambulatory care for patients with certain rare diseases and special forms of disease progression as well as highly specialized services have been declared areas of hospital activity by the SHI Modernization Act.

- **Medications**: For medications, patients are asked to pay a co-payment from 5 € to 10 €.

- **Care provided by allied health professionals** such as physiotherapists, speech and language therapists and occupational therapists

In addition, there are numerous other benefits for insured people like medical devices, nursing care at home if this prevents or reduces hospital stays, certain areas of rehabilitative care, prevention of disease, health promotion at the workplace, screening for disease, emergency and rescue care and patient transport in certain health conditions.

In Germany there are co-payments and other out-of-pocket payments which need to be paid. They have risen substantially for SHI-insured patients since 2004. Co-payments have been increased and standardized to 10 € per inpatient day (up to a maximum of 28 days per year) and to between 5 € and 10 € for services and products in ambulatory care. Exemptions from co-payments are granted to children and adolescents up to the age of 18 (except for dentures, orthodontic treatment and transportation) and pregnant women.

When someone’s income exceeds about € 46,800 (2007) per year, a person has the possibility to contract a Private Health Insurance (PHI). The PHI has two facets in Germany: to fully cover a portion of the population and to offer supplementary and complementary insurance for SHI-insured people. Between 1975 and 2002, the number of people who have full coverage rose from 4.2 million to 7.7 million, which represents 6.9% and 9.3% of the population respectively.

**Insurance benefits for asylum seekers/refugees and migrants**

Social benefits are in accordance with the Federal Act on Benefits for Asylum Seekers: **Asylum seekers**, persons rejected and obliged to leave the country or persons whose residence is tolerated under the stipulations of international law or for political and humanitarian reasons (de-facto-refugees) are not usually entitled to statutory health insurance. Statutory health insurance may only be applied for **after three years of residence** unless asylum is granted prior to this. These persons are entitled to benefits as set out by the Act on Benefits for Asylum Seekers. Benefits are granted unconditionally in the case of acute and painful illnesses. However, there are certain restrictions to their insurance coverage in contrast to persons with regular statutory health insurance. These limitations include dental care, e.g. dentures and orthodontic treatment. Their insurance benefits only cover acute and painful illnesses.
German social welfare legislation makes no mention of covering the costs incurred when the service of an interpreter is required. As a result the statutory heath insurances are not obliged to meet such costs. Nor does the Association of Private Health Insurances make any provision for such a service.

The only mention of meeting costs incurred for providing the services of an interpreter occurs in section 37 of the Federal Law on Income Support. According to a ruling of the Superior Administrative Court in Lüneburg of 11.01.2002 – 4MA 1/02, 4B 136/01, the cost of providing interpretation has to be met by the income support provider when the health insurance has agreed to pay for psychotherapy based on depth psychology (in this case, for a patient suffering from post-traumatic stress disorder as a result of torture), which would be impossible without the assistance of an interpreter.

II. 2. c. Finland’s Health Care System

The Finnish health care system is mainly funded by public assets. All employees and employers contribute a certain percentage of their earnings/paid salaries and wages to an obligatory, general social security scheme that covers health care as well. Patients also pay a symbolic fee for the use of services, either on a yearly basis or call by call. The services are organised on a municipal basis, and several municipalities often form a community of health care services, thus aspiring to an economy of scale in the provision of the services. Major cities have central hospitals that serve a larger area with specialised health services, and university towns that educate future doctors have university hospitals and clinics.

Instructions given to patients vary slightly from one municipality to another, for example, as to where patients should turn to when in need of medical care. As an example, the guidelines of the city of Tampere are described in the following (City of Tampere, 2008).

When a person falls ill or has a minor accident, the first thing to do is to phone a nurse on-call at the guidance telephone number of health services or to go to see a nurse at the clinic of the area of residence. The nurse assesses the need of treatment and either makes an appointment with a doctor for the patient or gives instructions on self-care. If the area clinic is closed (they are only open during regular office hours) and the patient needs immediate care, the patient is advised to go to the clinic on-duty, where patients are treated in order of urgency. This means waiting times can be rather long, up to 8 hours on busy weekends with limited personnel.

In non-urgent cases, the patient’s “personal doctor”, who works at the area clinic and is responsible for a certain population of the area, sees the patient and assesses the need of further treatment, follow-up and specialised health care services. For pregnant women and their families, there are specialized maternity and child welfare clinics that take care of all basic medical services for children under seven years of age (i.e. children that do not go to school yet) and pregnant women (regular health checks during the pregnancy and for children, vaccinations, preparation of delivery etc.) and also provide support for the whole family.

For people suffering from mental problems, the “personal doctor” of the area clinic can give a referral that opens the doors to mental health care services. The personnel of mother and child welfare clinics, occupational health care services and social services may also direct people to mental health care professionals. A large number of mental patients are treated as outpatients, but there are also inpatients.
Private doctors and clinics and private occupational health care (that employers offer to their personnel) are a complementary part of the public health care system. A certain proportion of the costs of private health care are refunded to patients from public funds, on certain grounds, as a compensation for not using the time and effort of the public sector. Especially in dental care, the number of people using private services is quite high due to the long waiting times of public services. Municipal providers of medical care may also guide their patients to private clinics if they are unable to provide them with certain treatment or in the time frame stated by the “treatment guarantee” that was introduced in Finland in 2005.

Most of the time, patients need urgent treatment, and are, of course, treated immediately whenever necessary. For non-urgent medical care, there are lead times for the provision of treatment, which aim at reducing the sometimes unreasonably long waiting times for patients and forcing municipalities to gather the necessary resources and to use them in an effective way. Non-urgent medical services have to be provided without exceeding a certain waiting time limit. This means that patients have to be able to get in touch with area clinics during their normal office hours without delay, either by phone or by stopping by. If the need of treatment cannot be assessed on the phone, patients have to be given a reception time within three days. If treatment cannot be started during the visit to the health care unit, it has to start within three months at the latest. The respective maximum waiting time for possible specialized health care services provided at the local health centre is six months. Patients need a doctor’s referral in order to be treated in a hospital. After the hospital receives the referral, the estimation of the need of treatment has to begin within three weeks, either based on the referral or by calling the patient to the hospital. If it is stated that he/she needs hospital care, treatment has to start no later than six months after the assessment of the need. (Ministry of Social Affairs and Health)

Insurance benefits for asylum seekers/refugees and migrants

All permanent residents of Finland have equal access to health care – including migrants, returnees and refugees who are treated on the same basis as anyone else. However, health care for asylum seekers with and without a temporary residence permit (“status B” permit) is restricted; they only have access to the most essential services. These usually are provided in and by accommodation centres for asylum seekers in diverse ways. In practice, children and pregnant women belonging to this group of migrants usually are provided with any medical services they may need, not just the most essential ones.

The government provides municipalities that accommodate refugees and asylum seekers with financial assistance in order to provide them with the necessary medical services.

The Finnish Act on the Status and Rights of Patients 785/1992 (Act on the Status and Rights of Patients 1992) includes a section specifically aimed at interpreting: interpreting is handled in Section 5, under “Patients’ right to be informed”. It states that a patient shall be informed about her/his state of health, treatment alternatives and their effects etc.: “Health care professionals should try to give the information in such a way that the patient can understand it. If the health care professional does not know the language used by the patient [...] interpretation should be provided if possible”. (See also WP3 report) Since health care professionals have this obligation, the costs for the interpreting services provided are carried by the institution, not by the patient.

II. 2. d. Slovenia’s Health Care System

In 1992, health care reforms were adopted to modify the health care system in place when Slovenia was part of the former communist country of Yugoslavia. Direct health care funding from the government was replaced by a mostly employer-funded system run in conjunction with a new system of compulsory public health insurance.
The Slovenian health care system provides universal and comprehensive health care access to all Slovenian citizens regardless of income. There is a system of compulsory social health insurance that has introduced complementary voluntary insurance and has privatized physician practices in primary or specialized outpatient health care. Far larger segments of the population purchased voluntary insurance than originally anticipated, thus further increasing the total resources available for health care in the early 1990s.

Since its independence, Slovenia has been increasingly moving towards becoming an industrially highly developed system. As such, it also shares some of the challenges reported by most industrialized health care systems: rising financial debt due to higher expenditures on medical equipment and pharmaceuticals; rising health care demands and diminishing health care income due to an ageing population; rising costs due to increasing expectations of the population; and regional inequalities in health status and resources. There are also some problems specific to Slovenia such as increasing volumes of care delivered by providers to reach competitive incomes, which has led to liquidity problems in public institutions as well as other consequences such as medical equipment operated by public institutions becoming largely outdated and longer waiting times for elective procedures.

A more detailed presentation of the health care system in Slovenia can be found at the following site: http://www.euro.who.int/document/E76966.pdf

**Insurance benefits for asylum seekers/refugees and migrants**

The legal situation of asylum seekers is defined by the Law on International Protection (Official Gazette of the Republic of Slovenia 111/2007).

Every asylum seeker has to be provided with food, basic hygienic facilities and has to have access to basic health care.

Regarding health care asylum seekers have the right to obtain:

- emergency medical care and emergency transportation services following the decision of a medical doctor and the right to obtain emergency dental care
- emergency medical treatment
- obstetric and gynaecological medical care, i.e. contraceptives, pregnancy termination, medical care during pregnancy and delivery

The asylum centre provides basic psychological and health care. Sometimes people need additional care. In that case, the only regularly employed interpreter (Slovene/English/French) or any of the other interpreters that have been contracted by the Ministry of Internal Affairs accompanies her/him. When the interpreter for a specific language is not immediately available, the medical examination can be postponed for an hour or more. If the situation is really urgent, relay interpreting is used or gestures or drawings are used. It often happens that medical personnel inform the interpreters at the asylum centre that their help is not needed because they found a medical worker who speaks the language of the patient. The interpreters at the asylum centre do not have any additional training for health care interpreting. (Umek 2008)

The right to interpreting services, the procedure and the conditions for selecting interpreters are defined by the rules and regulations regarding the rights of the applicants to international protection (Official Gazette of the Republic of Slovenia 67/2008). Item 17 of the Rules and Regulations says that the applicants have the right to obtain medical care provided by the public health network. In exceptional cases, psychiatric help is provided that is covered financially by the Ministry of Internal Affairs. Applicants with special needs can be provided with additional medical services as approved by a special committee.
Item 11 of the Law on International Protection defines the rights of *refugees*, which in many respects are similar to those listed above for asylum seekers. They also have the right to obtain health care. The rights of refugees as far as access to medical care is concerned are the same as those of citizens of the Republic of Slovenia. The Ministry of Health covers the expenses. Interpreting expenses are covered by the Ministry of Internal Affairs.

**II. 3. Access to medical services for asylum seekers/refugees and migrants**

This subsection of the report aims to illustrate the situation of access to health care services of asylum seekers/refugees and migrants in Austria, Germany and Finland (the information available on Slovenia has already been presented in the second part of Chapter II.2.b).

The client group is only named as “migrants” because the partner reports in general did not distinguish between asylum seekers, refugees and migrants for this section of the report and we also think this distinction is not decisive for a rough overview.

In the following, the current situations in the different partner countries are illustrated. The partners approached the problem in different ways and provided different kinds of information which reveal an interesting picture of the current situation. What can be stated for all partner countries is that the lack of information (on the part of migrants AND on the part of medical personnel) and language barriers are the main reasons for deficient access to medical services of this clientele.

**II. 3. a. Current situation in Austria**

In the following, some examples of scientific contributions as well as projects in the area of health care of migrants are summarised regarding access to health care services for migrants.

As previously mentioned, there are nearly one million foreigners living in Austria. The majority of these migrants is confronted with the Austrian health care system without really knowing anything about it - neither about its service offerings nor about the kind of health care provided. The existing language barriers are not solely to blame for the problems that arise, but numerous factors are responsible, too.

There is obviously a lack of understanding and hardly any acceptance of the need for intercultural integration. Furthermore, the lack of data and studies in this area of research impede progress. The acute shortage of interpreters is characteristic of the present situation in Austria. The situation is further exacerbated by the lack of information on the part of migrants.

Looking at the statistics on hospital discharges in Austria, one gets a good overview of the variety and frequency of different nationalities present in hospitals. Using this information, it is possible to estimate the number of different mother tongues spoken by patients. According to the KAGes (Styrian Hospital Corporation, which holds 90% of Styrian hospitals), 6,252 patients out of 267,231 hospital discharges in Styria were neither Austrian nor German in 2007. According to hospitals’ statistics, the ten most prominent nationalities are the following (arranged from most to least frequent): Turkey, Croatia, Rumania, Bolivia, the Russian Federation, Slovenia, Sierra Leone, Hungary, Bosnia and Herzegovina and Poland. Quite obviously, a large number of different kinds of nationalities are part of the daily routine in Austrian hospitals which, of course, makes medical treatment of foreign patients even more complicated at best. Linguistic and socio-cultural barriers can easily arise out of the afore-mentioned.
Socio-scientific research on migration and health in Austria

When trying to find out more about socio-scientific research on migration and health in Austria, the investigations of Eichbauer and Pöchhacker clearly show the problems that arise in the field of communication. An investigation carried out by Hochleitner in Tyrol focuses on the health care of Turkish female patients:

Eichbauer (cf. 2004) carried out investigations on migration and health in Austria. He tried to find out how much attention is paid to the needs and wants of the twenty-five per cent of the Viennese population with a migration background. In the course of his research, he reported about a pilot project that was launched in the Hanusch clinic, (located in the fourteenth Viennese district), called “Lived Integration in the Hospital”. It focused on Turkish female patients. The aim was to investigate how much the consequences of language barriers affect daily routines in the hospital (cf. Eichbauer 2004).

Basically, it can be stated that the doctor is reliant on further diagnostic examination, which is often costly and time-consuming, in the case of miscommunication or even a lack of communication due to language barriers. Other possible outcomes may be inaccurate or delayed diagnosis, decelerated therapy or discontinuation of the therapy (cf. ibid.).

An interesting investigation carried out by Pöchhacker (cf. 2002: 21f.) focused on communication with non-German-speaking people in the health and social sector in Vienna. Pöchhacker focused on hospitals in particular. More than five hundred employees filled in a questionnaire dealing with the present state and the target state of communication between German-speaking hospital staff and foreign language patients. In general, 95% of those surveyed had been in the situation before of having been confronted with patients who hardly knew any German. The average rate per week was ten patients who spoke a language other than German as their native language (and who had no knowledge of German). When asked what kind of languages these patients spoke, no less than twenty-seven different languages were named of which the most prominent were the following: Serbo-Croatian, Turkish, English, Polish, Arabic, Czech and Slovak (cf. ibid.: 22f.).

More than 90% of those surveyed stated that communication with these patients quite often took place via a third party who was usually a patient’s assistant. In most of these cases, the assistants were the patient’s children. Furthermore, foreign language hospital staff played a crucial role as the data revealed. Requesting external interpreters was an exception rather than the norm and, interestingly, ‘native language advisers’ were hardly ever asked to help out. (cf. ibid: 23f.). (The pilot project “Native Language Advisers for Turkish Patients” came into being in Vienna in the late 80s as part of the “Healthy Cities Project”, which had been launched by the WHO. However, these advisers had not had any professional or preparatory courses. They soon came to realize that medical interpreting not only requires knowledge of two languages, but socio-cultural competence also plays an important a role.)

With regard to contentedness with the communicative situation, the study revealed that the majority of medical students and nursing staff in particular were dissatisfied. The reasons for this were, for example, greater expenditure of time, more frequent misunderstandings as well as restrictions regarding patient information, just to mention a few. Establishing interpreting services in hospitals was mentioned as the most likely way of solving this problem (cf. ibid: 24).

Hochleitner (2004) focused on the health care of Turkish female patients in Tyrol (using cardiac pulse generator implantations as example). In the province of Tyrol, migrants make up 10% of the population living there. The majority come from the former Yugoslavia and Turkey. Even though the Austrian health care system is state-run and nearly gratuitous, according to statistics, only 2.48 female Turkish patients are granted a cardiac pulse generator implantation out of 100,000 (whereas 39.45 patients are Austrian women). Out of 1,188 implantations, not even one Turkish female was among
them. There are doubtlessly various reasons: On the one hand, the language barrier is a tremendous
problem as in the case of practice-based doctors there are no interpreters available, which often leads
to difficulties in allocation. On the other hand, it is certainly problematic for female Turkish patients to
be taken seriously in a hierarchical/patriarchal health care system. Another outcome of the study was
that female Turkish patients would actually be interested in gaining information on health, but only if
they themselves feel addressed. The problem in this context is that the majority of Turkish women are
almost exclusively interested in Turkish media, which makes it difficult to provide them with
information (cf. Hochleitner 2004).

**Illustrative Examples**

In the following, we would like to offer a few examples of how institutions and NGOs are trying to
deal with this special client group.

An interesting project in this context was a collaboration of twelve European hospitals. The project
was called “Migrant Friendly Hospitals” and was sponsored by the European Union. The Kaiser-
Franz-Josef clinic in Vienna was among them. Hospitals are quite often the immediate contact point
for migrants as well as other vulnerable groups due to the low threshold. According to Prof. Jürgen
Pelikan, head of the sociology department at the University of Vienna, clinics are therefore in charge
of an extraordinarily great effort to integrate them. According to Dr. Margit Endler’s point of view
(medical head of the Kaiser-Franz Josef clinic), one must be aware of the fact that most migrants do
not know the host country’s language nor do they understand the Austrian health care system.
Migrants hardly ever contact practice-based doctors, but are more likely to go to outpatient clinics in
huge hospitals. They often face serious problems there and going to hospital turns into a real
challenge for them (cf. Poznanski 2004: 42-44).

Not only the language, but different cultural concepts also lead to misunderstandings. Another model
of facilitating communication with non-German-speaking patients that has become popular in Austria
over the last few years is the training and use of cultural counsellors, who sometimes are also referred
to as cultural interpreters. These initiatives are mainly organized and arranged by NGOs and are
based on the following concept: A person of a migrant community is provided with information on
the Austrian health care system in order to be able to provide migrants and asylum seekers better
access to the health care system in Austria. This idea is based on a peer-to-peer concept, which means
that the person informed about the health care system is supposed to act as a replicator and distribute
relevant information amongst other members of his/her community. The “educated” migrant occupies
a gatekeeping position between other migrants and the health care system (Zebra 2003:82ff) and may
also work directly in the hospital to facilitate communication between medical staff and the migrant
patient (Der Standard 2008). In the course of other projects, the mediating people were referred to as
cultural mediators, e.g. LEFÖ (Schmidt 2007:26) or health replicators (GesundheitsmultiplikatorInnen), e.g. project of the PGA-Association (Land OÖ 2001:20), but the concepts are mainly based on the same idea.

Another example that illustrates the need for facilities that aim at helping people without insurance as
well as people who do not meet the criteria to enjoy the benefits of the Austrian health care system is
the Marienambulanz. It was opened in Graz in 1999. The Marienambulanz tries to offer uninsured
patients unbureaucratic and immediate medical care as well as primary health care in any possible
way (cf. Jahresbericht der Caritas Marienambulanz 2007: 9). Not only has an outpatient clinic been
established (general medical ordination, psychiatric support, an office hour specifically for women,
and special supply for people suffering from hypertension or diabetes), but mobile services are offered
as well to look after the patients at home (cf. ibid: 32).
In 2007, the patients’ main countries of origin were Chechnya, Austria, Rumania, Nigeria and Kosovo.
All in all, 1,250 patients made use of the services offered by the facility and 8,000 contacts were

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4 *Prophylaktische Gesundheitsarbeit: Association for Prophylactic Health Work*
recorded in 2007. Financial matters have mainly been taken care of by public funds and a lot of work has been done voluntarily by doctors as well as interpreters (cf. ibid. 31-34).

II. 3. b. Current situation in Germany

Focusing on the situation in Germany, it can be stated that there are several reasons for the fact that migrants are often unable to make proper use of health care services:

Diversity amongst migrants became more and more visible with the increase in the number of asylum seekers and refugees in the 1980s and 1990s, and later with the group of migrants of German and Jewish origin (Spätaussiedler) from the former Soviet Republics. This led to the demand for new concepts of diversity management in the provision of healthcare services. In general, migrants are hesitant and in most cases quite “late” to use any medical service. Awareness for the concept of “preventive medical care” is quite low in many migrant communities, especially in the field of gynecology or other areas of internal medicine. The problem has two faces: One is certainly that health care services’ approach to patients is still largely either insensitive to any cultural specificity (and rather high-tech-oriented, meaning that there is a dehumanized understanding of care and treatment), or simply ethnocentrically Western-German-Christian. Especially in areas like palliative care, which is so rooted in the hospice movement, a Christian, church-based service, patients from non-western and/or Muslim backgrounds do not feel at ease and refuse to take advantage of the opportunities offered to them (cf. Bahadır+Dizdar 2004). On the other hand, the migrants themselves are not informed sufficiently and most of them do not know how to get the information, and are thus barred from access to regular care.

These days the same need for culturally sensitive, migrant-specific services that health care personnel mentioned way back in the 1980s is still stressed over and over again by many researchers in various medical areas, from psychiatry, psychosocial health and psychology to gynaecology, paediatrics and internal medicine (cf. e.g. Borde+David 2008; Mackovic-Stegemann 2005, Ostermann 1990, Zimmermann 2000). The “checklist” with parameters for medical institutions to be open to cultural diversity, which was prepared in 2004 by Theda Borde, professor and researcher at the Alice-Salomon-Fachhochschule Berlin, and by Matthias David, medical doctor and head of the department of gynaecology at the Charité Hospital in Berlin, clearly shows what the most important deficiencies are:

- language problems of the migrants and lack of communication and/or miscommunication between health care service providers and migrants
- lack of/insufficient prevention due to insufficient counselling: need for services in the mother tongue of migrants and for measures to make migrants interested in prevention programmes
- need for migrant-specific incentives and support in order to improve health education
- need for internal or external interpreting services in order to enable communication
- need for further training of bilingual medical staff as multipliers, counsellors, consultants, mediators and/or interpreters
- need for culturally sensitive incentives to develop and to encourage participation and autonomy of patients who have a migration background within the health care system
- need for further intercultural awareness-building and training of non-migrant medical staff
- need for client-oriented, i.e. culturally sensitive, approaches in consultation, diagnosis, therapy, treatment, medication, and care

(cf. http://www.mighealth.net/de/index.php/5_Qualit%C3%A4t_der_Behandlung_Entwicklung_von_An_s%C3%A4tzen_zur_good_practice_bei_der_Verbesserung_und_Anpassung_von_Leistungen_der_Gesundheitsversorgung_an_die_Anforderungen_von_Menschen_mit_Migrationshintergrund)
The situation in Germany is quite complicated: There are no clear directives at the federal level, no comprehensive health care policy for integrating migrants into the system, but only individual initiatives on the local and regional level. These individual projects are often very successful, but limited in scope or funded for a limited period. On the one hand, there are centres and institutions founded for the purpose of reaching migrants, i.e. informing and educating them, but also the German service providers, such as the Ethnomedizinisches Zentrum Hannover (http://www.ethnomedizinisches-zentrum.de/). On the other hand, some hospitals have established ambulant health care services specifically for migrants with staff who speak, for instance, Turkish or Russian (Migrantenambulanzen, e.g. at the Rheinische Kliniken in NRW (http://www.rk-langenfeld.lvr.de/behandlungsangebote/ambulanzen/migrantenambulanz.htm). Other hospitals cooperating with medical faculties like the Charité Hospitals in Berlin are renowned for their wide spectrum of empirical research on migrants’ behavioural patterns, expectations, needs, reactions etc. These quantitative and qualitative empirical studies are very significant as they have the very important task of raising awareness for the need to empower migrants.

II. 3. c. Current situation in Finland

According to a recent statistical survey (Gissler et al., 2006) with a large sample of migrants residing in Finland, migrants use medical services less than the “domestic” population when it comes to general and specialised services. An exception is young female migrants who often need services related to pregnancy and delivery. There are also big differences among different nationalities. Finnish residents coming from typical refugee countries visit a general practitioner more often than native Finnish people do: on average, male refugees pay 3.3 and female refugees 4.9 visits a year compared with 2.0 and 1.3 for the Finnish population. On the other hand, Finnish males go to outpatient clinics three times more often than refugees. (Gissler et al., 2006)

A merely statistical survey based on data on services provided cannot answer the question of whether people really receive the service they need. In international studies, people with a migration background have been proven to subscribe to medical services less than the domestic population, taking into account the need of medical care and the frequency of succumbing to illnesses. (Gissler et al., 2006)

Based on an extensive report on mental health care (Rauta, 2005), specialised Finnish health care services are only able to reach migrants to a limited extent. The most common problem seems to be a lack of information and difficulties in spreading it – between units of basic and specialised health care, too. Health care personnel seem to lack experience in treating migrants to some extent, although the situation is better in municipalities that have centralised health care units for migrants. Furthermore, patients who are covered by the Finnish Integration Act (see WP3 report) have better access to social and health care services than those whose time limit for integration support has already expired (3-year period) and those who entered the country before the Act came into force. (Rauta, 2005)

As stated in the summary of a brand new country report on Finnish health care services (Wahlbeck et al., 2008), migration as a recent phenomenon in Finland has led to the low number of health services and research focusing on migrants. Even if the Finnish constitution guarantees the right to adequate social, health and medical services, the increase of private and occupational health care has led to somewhat unequal access. Those who are worst off have to rely on municipal services, which are still the biggest service provider, and wait longer for treatment than those who can afford other forms of service. (idem)
In the light of the well-known fact about the relatively poor socio-economic status of migrants, they probably belong to the most vulnerable groups in Finland when it comes to access to health care. On top of that, they may lack information on the system of service provision, cultural ideas of medical care may be differ, and the language barrier may often be a problem, too.

Communication and information

Municipalities and health care units usually have a contract on interpreting services with one or more service providers. When a doctor’s appointment or any appointment is made, the guidance personnel assess the need for interpreting services. If an interpreter is needed, they contact the booking number of the service provider and ask for an interpreter for the appointment. Patients should not bring their own friends or relatives with them and use them as interpreters. However, the knowledge among health personnel varies a lot and some professionals still do not pay enough attention to interpreting issues. However, it is the responsibility of the institution to order the interpreting service to ensure the quality and objectiveness of communication.

The availability of interpreters varies regionally. For some languages, like Burmese, there are not enough interpreters, but supply and demand situations can change quite quickly, for example, according to decisions of the Finnish government to choose refugees from a certain region. The interpreter coverage is quite good for the major migrant languages, especially in bigger towns and cities. Telephone interpreting has to be used if no other solution is available and a patient needs to be taken care of in one way or another.

However, many interpreters do not have any qualification, not in interpreting nor in medical matters. Local interpreting centres strive to guarantee some level of professionalism by choosing their interpreters carefully, guiding them into the profession and providing many kinds of support. There is reason to believe that merely commercial players do not always pay due attention to respective procedures, but aim at providing a vast offer of services at a reasonable cost ratio.

In institutions training health care personnel (other than doctors), multicultural work is part of the education, either voluntarily or compulsorily. Interpreting issues are usually dealt with in these courses. In doctor training, there seems to be no multicultural component, based on curricula of faculties offering education in medicine. However, at least in Tampere and Helsinki, guest lectures are given by personnel of interpreting centres on working with migrants and with interpreters.

II. 4. Specific medical problems of asylum seekers/refugees and migrants

This chapter tries to provide an insight into the particular and very complex situation of migrants in the partner countries and specifically the manifold problems they may face in the health care system. Summarizing the contributions of all the project partners makes it possible to see the initial situation from different angles. However, the problems in the different countries are similar for this clientele. Migrants face higher risks of being ill than the majority of the population.

II. 4. a. Perspectives of health research in Austria

Starting with the Austrian contribution, Horst Noack, Stronegger, Rasky, Freidl and Ruth Kronsteiner describe the fundamental set of problems very well.

In his article “Gesundheits sicherung von MigrantInnen – eine Aufgabe öffentlicher Gesundheitsförderung” (cf. 2004: 13ff.), Horst Noack points out that migrants are definitely at a disadvantage when it comes to health care. In Austria, social and health-related inequality becomes obvious in this respect as the following example clearly shows: Four-fifths of all the means provided
in the health sector are only used for one-fifth of the Austrian population. According to Wilkinson (cf. 2004: 6), inequality in our society is to be seen as one of the main reasons for health problems as studies have shown that the more equitable the income distribution in a society is, the higher the life expectancy will be.

Recent studies in this area of research have shown that not only economic as well as living conditions affect one’s health, but one’s own attitude towards health and (social) relationships does, too. According to Noack (cf. ibid: 14-15), the afore-mentioned criteria are essential in order to strengthen one’s self-awareness and to improve social and human capital which is of tremendous importance for migrants (e.g. to counteract social isolation). It furthermore leads to heightened sensitivity and responsibility for one’s health.

Most importantly, Noack stresses that a sustainable, constitutional way of acting is only possible if physical and psychic disorders are treated effectively and in the case of social isolation have no influence on one’s life. Therefore, it is essential to take a holistic view of social aid, medical treatment, and health promotion as these aspects are not to be seen as separate, but intertwined and interdependent (Noack 2004: 15).

In addition, Noack highlights that in the case of migrants in particular needs-based health care most often not only involves medical treatment as problems are hardly ever of a merely physical nature. Very often, communicative and social services are particularly needed. Unfortunately, these are hardly ever provided due to scarcity of resources and lack of time.

Stronegger, Rasky, and Freidl also deal with the close link between poverty and illness in their article “Soziale Lage und Gesundheit – Von den Beziehungen zwischen Armut und Krankheit” (cf. 1996a: 28ff.). They come to the conclusion that being low on the social scale (either caused by low income or a low level of education) may often result in psychic as well as physical diseases. This fact has been shown in many studies in various countries. The lower a person is on the social scale, the higher a disease’s mortality rate and morbidity rate are.

In addition, a health-conscious and health-oriented lifestyle and health-related risk-taking behaviour are less prominent among people belonging to a lower social class (cf. Stronegger 1996b.). Psychosocial burdens also play a crucial role in that respect as these people often have to cope with a higher level of socio-emotional stress, hardly ever belong to strong social networks, and are hardly ever given credit for their jobs etc (cf. Stronegger/Rasky/Freidl 1996a: 28ff.).

All in all, the health condition of migrants living in Austria is mainly influenced by their living conditions –especially by the disadvantages they often have to face regarding accommodation, work and education. Unexpectedly, studies have nevertheless shown that foreigners are on average healthier than Austrians. But when the outcomes are looked at more closely, the reasons for this become obvious: On the one hand, the mean age of foreigners is usually lower than Austrians and, on the other hand, health-related questions are often misinterpreted as some sort of control and, consequently, foreigners often pretend to feel better than they in fact do (cf. Kronsteiner 2003: 50).

When discussing migration in a medical context, the following reasons are referred to as the main causes of health problems: Belonging to a low social class, which the majority of migrants in fact do, as well as language barriers. Needless to say that this group is therefore often forced to work jobs that put high mental and physical stress on them. In addition, poor working conditions most often lead to a high risk of injury. Not surprisingly, foreigners show extremely high accident proneness and often suffer injuries affecting the spinal column. Experts also consider subconscious longings to commit suicide because of depression as well as auto-aggression as possible explanations for the high accident rate among foreigners (cf. Kronsteiner 2003: 53).
their social background into consideration. Disregarding culturally specific views on health will certainly not lead to desired outcomes, such as better understanding. Moreover, proponents of explanations referring to language barriers as the main source of upcoming problems migrants have to face in the health care system always have to bear in mind that **language and culture are interdependent**. In order to minimize the discrepancy between internal and external apperception and, consequently, to abolish stigmatizations, the **individual situation** must be taken into consideration as well (cf. Kronsteiner 2003: 56-57).

### II. 4. b. Perspectives of health research in Germany

Concerning the situation in Germany, the development in society to integrate different groups of migrants into the health care system is shown. This summary reveals a basic need for more culturally sensitive and migrant specific services and refers to the most important deficiencies, which have to be addressed.

Way back in the 1960s, migration to Germany was mostly restricted to the “guest workers”. At the beginning, the German State even planned a “rotation programme/principle” according to which mostly male and to a smaller degree female guest workers would stay for about two years and then go back while new or rather ‘fresh’ guest workers would replace them. But this system of continuous exchange was not profitable for industry for which the capacity/productivity of workers grew parallel to the degree of adaptation to the production system. Companies started to sign long-term contracts with the cheap, strong and hardworking migrants. As most of these first generation “migrant labourers” (Arbeitsmigranten) were chosen after strict health checks, the need did not emerge for some time to fully integrate the migrants into the regular health care services (“Regelversorgung” which was a decisive characteristic of the German welfare system up until the 1990s).

Then, under the effect both of the complex migration phenomenon of **culture shock**, being foreign and far away from home (especially their families), and under the burden of difficult working conditions, the health situation of migrants started to call for the attention of the health care system in the 1970s. The acquisition of migrant labourers was stopped in 1973. But in the years that followed, families were allowed to come to Germany. Thus, the health problems of migrants became more diversified. Illnesses and disorders specific to migrants due to their experience of migration and due to migrant life in Germany were not comprehensively studied. Medical professionals were often not prepared to handle diverse populations. **Prejudices and stereotyping** were quite widespread in medical care. Health care staff and particularly medical doctors, who were not at all interculturally competent, referred to irregular and unknown pain behaviour or reactions to illnesses or health problems, for example, as “Mamma Mia Syndrome” in order to emphasize that Italians lamented more often and more loudly about pain (cf. also Zimmermann 2000), or “Anatolian headache” if there was a patient with headaches for which the cause could not be found out. For a very long time, especially in the field of psychology and psychiatry, migrants were very easily diagnosed as depressive, hysterical or as a hypochondriac. Pains were not really taken seriously and many migrants were taken to be simulating or exaggerating. The cultural specificity of pain behaviour, of the decision to enter therapy or to better inform themselves and of the doctor/patient relationship were factors rarely taken into account (cf. Collatz 1998, Zimmermann 2000, Dettmers et al 2002).

It is striking that there is a **double language problem** here: Many migrants of the first generation and quite a large number of the second generation are not competent enough to lead a reasonable conversation with medical staff to help them reach a dependable diagnosis. Interestingly enough the problem of ‘semilingualism’ comes to the foreground in the second and third generation: Although they know German enough to master their daily lives, they have big difficulties with the largely
technical language of the medical system. They may also have difficulties following, understanding and making use of this objective, distant high-tech discourse because they are used to different communication styles with a doctor, who, for example, in the culture of the migrant, is not only a doctor with a lot of technical knowledge, but also a healer, a saviour, and an authority with a holistic view of the illness etc. Most often migrants are not really aware that the doctor cannot fulfill all the expectations they invest in him/her. Their view of the doctor and health care is in many cases as all-encompassing as their perception of illness or pain. 

**Psychosomatic illnesses** are extremely widespread amongst migrants/refugees/asylum seekers. But it is often difficult for medical doctors to reach a definite diagnosis because migrants from cultures with rather indirect and/or hierarchical communication patterns and a lower degree of “health literacy” are often not very clear about the description of the location, intensity and type of problems they suffer from.

Recently public health researchers in Germany have started to reflect upon “health literacy” ("Gesundheitskompetenz") – a criterion which is vital for evaluating whether health care services are suitable for a certain group/culture or not. In other words, migrants need a special competence in order to speak an appropriate language and to understand the language of health care professionals. Health care literacy is thus defined as: “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions”. (http://nnlm.gov/outreach/consumer/healthlit.html; cf. also http://www.forum-gesundheitspolitik.de/artikel/artikel.pl?artikel=0851)

### II. 4. c. Perspectives of health research in Finland

In the following, a summary of specific medical problems that asylum seekers, refugees and migrants may face in Finland is provided.

Most of the time, immigrants’ **state of health** is worse than that of the “domestic” population. It goes without saying that the epidemiological situation of the countries of origin affects the health profile of migrants to a certain extent. For instance, tuberculosis and hepatitis B are more common among migrants than the domestic population; the covering clothing some migrants use provokes illnesses due to lack of vitamin D; and anaemia is also common among migrants and many times of a familial nature, not only deriving from a lack of iron. Since refugees are chosen and asylums are granted partly on a humanitarian basis, many people who belong to these groups already suffer from different chronic health-related problems when they come to Finland. (Oroza, 2007)

**Socio-economic factors** play an important role in the state of health. Statistical evidence shows that migrants face high rates of unemployment and divorce. They also form a large part of the clientele of shelters for victims of violence etc. There is significant evidence of social exclusion and a lack of contact with the ethnic majority. (Rauta, 2005)

More specifically, **many stress factors** are combined with the life of migrants, and refugees have also had to deal with a lot of stress before migrating: Families used to a life in close communities have split, and relatives of refugees often have been forced to stay behind in the unstable circumstances of the home country. If elderly relatives or parents fall ill in the country of origin, migrants may feel they have let them down because they are not obeying their duty to take care of the previous generation. Spouses who come to Finland with their Finnish partner are often very lonely. In general, insecurity and the effects of big life changes go on in the new country of residence for quite some time, combined with the challenges of adapting to a new culture, learning a new language etc. The situation of asylum seekers in particular is difficult, since on top of it all they do not know whether they will be allowed to stay in Finland or whether they will be sent back to the often dangerous circumstances they tried to escape. (Halla, 2007)
According to international studies, the risk of schizophrenia is multifold in migrants compared to domestic populations, which is thought to be due to increased social stress. The risk is highest among refugees. Depression and post-traumatic stress disorder are exceptionally common in this group of people. Most of the time, depression remains unnoticed at the reception of a GP – this is the case in 25 to 40 per cent of Finnish patients and probably even more often with migrant patients. According to some estimates, 5 to 35 % of refugees are victims of torture, which means that there could be up to 5,000 people in Finland today suffering from different physical and mental consequences of torture. (Oroza, 2007; Ruuskanen, 2007)

In Finland, very few studies have been done in this area, but the few results are in line with international studies. No studies on psychic disorders have been done concerning the entire migrant population of Finland. (Halla, 2007) One factor that makes gathering information about the state of health of migrants and their use of health services difficult is that a migrant background is not visible in statistics in this area. Therefore, we lack information on the well-being of migrants. (Rauta, 2005)

II. 4. d. Perspectives of health research in Slovenia

In Slovenia, there was not much information available on this topic. But it can be stated that asylum seekers, in particular, suffer more often from psychological problems than physiological ones, as they are usually young and have gone through traumatic experiences. Elderly migrant people mainly tend to suffer from diabetes or arthritis, i.e. from illnesses typical of old age. Sexually transmitted diseases are common with people who are engaged in prostitution or are drug addicts (Umek 2008).

II. 5. Culturally specific concepts of health/illness

There was not much information provided on culturally specific concepts of health/illness, but this part of the report may give an insight into different approaches to this topic. The German project partner provided information on the culturally specific aspects of migrants’ attitudes towards health, illness, health care and medical personnel, and the Austrian project partner delivered an insight into the different cultural concepts of pain and culturally influenced ways of coping with pain.

II. 5. a. Culturally specific aspects of migrants’ attitudes towards health, illness and health care

Undoubtedly, there are culturally specific aspects of migrants’ attitudes towards health, illness, health care and medical personnel. But what is even more important in this context is that migrants are not “pure” anymore and that it is therefore not enough to study Turkish culture in Turkey in order to try to understand Turkish migrants’ behaviour in Germany. All migrant cultures have certain points in common which have to be taken into consideration when attempting to reach migrants for health care services and programmes:

- Migrant cultures are hybrid and hybridising. Elements of the cultures, regions, and ethnic communities of the country of origin are mixed and mingled with elements of the country/culture/region/ society/communities they now live in/with. The content of the
mixture depends upon the degree of acculturation to the host country and the intensity of contact with the culture of origin.

- As migrant cultures experience the trauma of migration, thus becoming minority cultures right from the beginning, there is a tendency towards overprotection of their roots against the majority culture (fear of being assimilated). Thus, migrant cultures tend to be more conserving if not conservative and less dynamic than the culture/community of origin they had left.

- At the same time, this hybridisation and conservation is also valid for religious identities. Muslims in Germany are not the same or even similar to Muslims in other parts of the world of Islamic societies. As Muslims, they are a minority group in a society with a Christian majority. This leads to totally different behavioural patterns and approaches when compared to Islamic states where Muslims are in the majority.

- Thus, a set of parameters come to the fore such as ethnicity, religion, gender, education, and age within the large framework of culture(s). For example, Islamic taboos might be gender-specific or related to a certain age or specific region.

In general, it is always very important to keep in mind that minimalistic and reductionist, stereotyping and false awareness-raising might be as harmful and discriminating as no awareness. Of course, wrong anamnesis/diagnosis/treatment is often the consequence. Therefore, each and every migrant should be seen as an individual, and treated as an individual example of his/her migrant community and not as the representative of it.

II. 5. b. Different cultural concepts of pain

It is assumed that the concept of pain is not congenital, but a product of learning and adaptation to the environment, i.e. the perception or – better said – the interpretation and tolerance of pain is a culturally based behaviour. Kohnen has published many books and articles concerning the cultural matter of pain. He categorizes the term pain (Schmerzbegriff) into pain sensation (Schmerzempfindung), pain perception (Schmerzwahrnehmung), pain tolerance (Schmerztoleranz), and pain expression (Schmerzäußerung), and has investigated these four concepts in different cultures. According to Kohnen, the point at which pain sensation is perceived is the same in each culture, but the pain limit that one bears differs from culture to culture, i.e. pain tolerance as well as ways of expressing pain are different. The interpretation, the value and the importance that are attached to pain depend on the culture. A good example of this is the Cabuntoguesños (Philippine people). Illnesses whose treatments cost a lot of money are more painful to them than those that do not. Furthermore, Kohnen has carried out surveys in different cultures to investigate the term pain and its meaning in different cultures within and beyond the borders of Europe. According to his studies, the pain tolerance of Italian women is the lowest whereas American and Irish women are more tolerant to pain and demonstrate almost no pain expression (see Kohnen 2003).

Some syndromes and clinical pictures of migrant patients have also been given special names such as the Mediterranean Syndrome, the Morbus Balkanikow or the Mamma Mia Syndrome (Bunge 2004:1). On the one hand, a lot of information on Turkish health concepts and Muslim patients as well as their ways of supporting ill family members or friends can be found in German literature (Zimmermann 2000, Kellnhauser/Schewior-Popp 1999, Domenig 2001, et al.). Specific information on patients from the Arabic area is given by Eddaoudi (2003) but she also puts an emphasis on Muslim patients in general. For patients with an African background, no information on their health concepts, or possible misunderstandings that may arise between physician and patient when they come in contact in the Austrian health care system have been found, apart from the publications by Nzimegne-Gölz. One reason for that may be that the media paint a quite undifferentiated picture of Africa in most European countries, and Austria is no exception (Nzimegne-Gölz, no year). Another reason may be
that the tradition of African migration to Austria does not have the same history as, for instance, Turkey.

II. 6. Specific treatment of traumatized persons

As there was hardly any information provided on the topic of culturally specific taboos, we have decided instead to add a brief report by Uta Wedam, psychotherapist and leader of the rehabilitation centre at ZEBRA, about the conditions and effects torture victims are confronted with. The fact that there are victims of war, torture and other forms of political violence who are traumatized in our society is very often neglected. This chapter starts by giving an insight into the life situation of traumatized refugees in exile and then describes the effects of traumatized situations on the persons concerned.

It is a very sad fact that a lot of persons around the world are suffering at present from traumatizing conditions such as war, torture and various other human rights abuses. Refugees, who flee to our countries and apply for asylum, come from various conflict areas around the world, and they are victims of war, torture and political violence. What they have in common is that they left their countries and are not able to speak our language. And the locals are not able to speak theirs either. Speech is an essential requirement to express themselves, to be heard and especially if people are ill and need medical support. Speech is often an instrument for being accepted. Refugees experience speechlessness again and again. Being speechless means being powerless. Therefore, it is necessary to create the chance to ‘empower’ these people to speak.

Life situation of refugees living in exile

Asylum seekers’ migration is affected by the break with their native society and an uncertain future in the host society. At first, and this may last many years, refugees live in a transitional period, in a kind of temporary solution. They share little space in refugee quarters and ‘wait’ for their future. They wait for decisions in the asylum procedure, which they can hardly influence after the first interviews at the public authority. But these decisions are essential to their lives, to their sheer existence. This very stressful situation causes afflictions of many kinds – psychosomatic diseases, mental pressure, states of stress, fear of being uprooted, fear of the future, hopelessness, despair, resignation and mental crisis.

The importance and the effects of social structures on the living conditions and life situations of people have been visible both in the past and in the present. The relevance of socio-political and intra-mental processes becomes clear among this clientele and should be understood as a process, since a treatment for traumatized refugees that is reduced to symptoms won’t be sufficient. When dealing with socio-political traumatizations, trauma and its treatment must not disregard the structures in which the traumatization process was introduced and the structures that antagonize the healing process or even re-traumatize in the present. The aftermath of traumatic experiences may be seen at many levels. These effects and levels not only affect the individual, but every one us. It’s not enough to simply treat the person concerned and to make her/him responsible for her/his own recovery. The general public, society and its attitude toward the suffering of the individual are part of the process. War, torture, and political persecution do not happen outside of contemporary history, but are a part of it.

Aftermath of war, torture and other forms of political violence

Survivors of torture, war or other forms of political violence can only dissociate themselves from their traumatic experiences with great difficulty or cannot dissociate themselves at all. These people are living with the consequences of the atrocities they experienced. For them, their losses and suffering
remain a part of their lives and their characters. There are injuries of various natures. Some of them can be treated, while others will remain a visible stigma for the rest of their lives. This stigma is both mentally and physically engraved.

The aftermath of war and torture is part of the trauma. On the one hand, there are physical and mental afflictions, and on the other hand, there are many losses accompanying escape, like insecurity and unfamiliarity in the new culture.

The aftermath of war and torture has to be considered in connection with the original incident and as part of the traumatization. Parts of this aftermath are the poor living conditions in the context of escape and migration.

The common psychiatric diagnoses of traumatized refugees are posttraumatic stress disorder and depression, but there are also many individual sufferings from chronic pain.

Treatments and care require close cooperation between professionals—psychotherapists, psychiatrists and somatic specialists. The clients have a lot of different symptoms. Refugees suffer from psychological and physical traumata, stress and states of arousal—‘their bodies remember’. The consequences of experiences of war and torture cannot be looked at separately; they are a mixture of psychological states of arousal, muscular imbalance and deconditioning due to an improper reduction of activity.

Among the somatic causes of pain are injuries to the muscular system due to torture and abuse as well as diffuse pain due to the muscular structure. Some persons say they cannot feel their legs or arms, they feel weak, unsure to stand up, and they have a lot of different symptoms of pain, such as headaches. To distinguish between organic pain and psychogenic pain is difficult.

The chronic pain of a traumatized person is somatic and psychological—it reminds the person of the causes of pain. If there are wounds, you will find the picture in the body, the person is marked. Pain can be the place of memory and also the expression of the transitional situation in which refugees live; even these kinds of situations can be expressed by chronic pain.

You might find these psychological phenomena expressed in different languages, too: in German, we say ‘Heimweh’, in English ‘homesickness’, in French ‘mal du pays’ or in Greek ‘Nostalgie’, meaning a condition of separation from your home country, family and friends, and it’s very painful.

**Conclusion**

Drawing a conclusion from all the information provided in this report, we can say that we simply lack data on health care and medical services for asylum seekers/refugees and migrants. Areas of study such as “Health Care for Multicultural Societies” or “Diversity Management in Health Care” should be the focus of medical studies.

Migrants often lack the consciousness, knowledge and adequate information in order to make use of health care services in an appropriate way. To overcome this obstacle, comprehensive professional medical interpreter services and counselling services in migrant languages would be an effective and implementable solution.

Health care professionals also need more knowledge and information to respond to the urgent need of client-oriented services for migrants to improve their access to the regular care system as well as to preventive medicine programmes. Therefore, awareness-raising measures regarding the demand for professional medical interpreting services are needed amongst medical professions as early as possible in their professional education.
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