

## **Background Report**

# **Inequalities and Multiple Discrimination in Access to Healthcare in Austria**

**May 2014**

# INEQUALITIES AND MULTIPLE DISCRIMINATION IN ACCESS TO HEALTH CARE IN AUSTRIA

## BACKGROUND REPORT

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# 1. Introduction

Discrimination and inequality with regard to access to public and private services have become a major area of concern in many European countries in recent years. In the beginning, these debates focused mainly on education, the labour market authorities or public housing, but later it also reached out to the complex area of health. Meanwhile, equality and discrimination-free access to medical treatment and care, quality of treatment and the removal of structural barriers in the health system have become major issues of health policies. In this respect, the ageing of societies, the growth of cultural diversity and diversity of lifestyles among the resident population and equal access for persons with disabilities have been identified as main challenges for the health-system.

In Austria, the debate on discrimination issues has not yet reached the health sector. Most public debates on discrimination concern the labour market, education, access to goods and services and harassment. Although the health sector has become more responsive to evaluation, quality control and the issue of patients' rights in recent years, the guiding paradigm of these endeavours have been based on medical considerations. Securing the quality of diagnosis, treatment and process management, effectiveness and efficiency of treatment and compensation for maltreatment have been the main issues guiding the development of quality-control instruments and procedures. Issues of cultural diversity or special needs of persons with disabilities have been taken up only hesitantly, and most often have been discussed in a medical framework of quality control and efficiency of treatment. Thus the ombudsmen established in the medical field concentrate their work on solving problems regarding maltreatment or lack of quality in treatment and services, which might include cases of rude behaviour or insulting communication, but hardly reflect systematically about their possible link to discrimination and unequal treatment.

On the other hand, also NGOs and public authorities active in the antidiscrimination field hardly collect cases concerning health. On the one hand, most patients experiencing discrimination first turn to the patient ombudsmen set up within the health system and do not contact institutions specialised on equality, on the other hand the evaluation of cases of alleged discrimination with regard to health requires a degree of medical competence most often not available within these institutions, thus also the specialists in the antidiscrimination field tend to neglect this area.

Due to complex character of the medical field it might well be questionable if the antidiscrimination framework is the most appropriate candidate to address inequalities and discrimination with regard to health. Nevertheless it is unquestionable that unequal

access to and unequal treatment within the health system requires more attention, as it does not violate basic human rights, but also negatively effects on the health status of a society. The authors hope, that this report will contribute to an improved debate on these issues leading to a better understanding of equality issues in the health system.

The following report is divided in three parts. The first part gives an overview about the main features of health policies in Austria and the structure of the Austrian health system and health entitlements, the second discusses the antidiscrimination framework in place with regard to the area of health, and the third part discusses the evidence of inequality and discrimination in access to health based on the analysis of statistical data and academic literature.



## Part I – General Policies on Health<sup>1</sup>

### 2. Health System

#### 2.1. Overall tenets of the health care system

##### 2.1.1. Evolution of the health care system

Austria's health care system is based on compulsory insurance in public health insurance fund. There exist 22 public health insurance fund, which cover around 99% of the population. The anchoring of the health care system in compulsory health insurance reflects the historical origin of the modern health system in the Bismarckian type of welfare system established after 1867 based on compulsory insurance contributions on salaries. Indeed, compulsory accident and health insurance for workers which were introduced in 1887/1888 were the first building block of the emerging welfare state, while insurance against other risks (old age, unemployment, etc.) followed only significantly later.<sup>2</sup> While the overall welfare state retained strong basis in employment, and in particular, in 'standard' forms employment (i.e. full time, permanent jobs, with an ordinary employment contract), privileging those in standard employment, health care was increasingly decoupled from 'standard employment' after World War II, extended to more groups of economically active and economically inactive persons, notably family members. As a result, the coverage of the health insurance system expanded from some 60% of the population in 1946 to some 86% in 1980 and today has de facto universal coverage (see also below).<sup>3</sup> The main groups excluded from health care are generally low income groups, and in particular individuals 'choosing' not to sign up to self-paid health insurance because they are without employment significant enough to generate an obligation to pay insurance fees or are unemployed but not eligible for unemployment benefits, irregular migrants, including informally employed citizens from new EU Member States relying on health insurance and health services in their country

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<sup>1</sup> This part has been authored by Bernhard Perchinig, with additional contributions by Albert Kraler (ICMPD).

<sup>2</sup> E. Tálos (2006) 'Sozialpolitik. 'Zwischen Expansion und Restriktion', in: H. Dachs, P. Gerlich, H. Gottweis, H. Kramer, V. Lauber, W. C. Müller & E. Tálos (eds.) *Politik in Österreich. Das Handbuch*, Vienna: Manz, pp.624-336

<sup>3</sup> H. Gottweis / E. Braumandl (1996) 'Gesundheitspolitik', in: H. Dachs, P. Gerlich, H. Gottweis, H. Kramer, V. Lauber, W. C. Müller & E. Tálos (eds.) *Politik in Österreich. Das Handbuch*, Vienna: Manz, pp.753-767

of origin and asylum seekers who have dropped out of the reception system.<sup>4</sup> In terms of coverage, therefore, Austria's health system does not differ fundamentally from universal, tax base systems such as the UK or mixed systems based on both health insurance and taxes such as Sweden. The main difference to these systems thus is of structural nature, which however has important implications not only for the financing of the health care system and the way chronic funding issues are tackled, but also for the organisation of the health care system and health policy making.

While the 1970s were still characterised by a major expansion of the health system, including the expansion of the coverage of health insurance system to ever more groups previously excluded, the expansion of the type of treatment covered by health insurance and the establishment of a series of preventive measures and vaccination programmes, the health system entered into a phase of financial crisis by the end of the 1970s, both because of the exponential rise of total health expenditures and the increasing gap between incomes from insurance contributions and expenditures by health insurance fund and the inability of health insurance fund to cover the rising costs both of health infrastructure and treatment. This led to recurrent health (financing) reforms, aiming, in particular to coordinate health infrastructure planning and cost-sharing for major health infrastructures (such as hospitals and expensive technical equipment) between different institutions and levels of government, notably the public health insurance fund, provinces and the federal government.

Social care has traditionally been totally separated from health care provision, with very few exceptions (e.g. such as rehabilitation and social care needs in case of accidents). In addition, social care has been the exclusive responsibility of the provinces and municipalities until the 1993 Federal Long-Term Care Allowance Act (Bundespflegegeldgesetz) introduced a level of regulation on the federal level.<sup>5</sup> Nevertheless, municipalities and provinces remain exclusively responsible for the social care infrastructure (e.g. homes for elderly, day centres, etc.) as well as other services (mobile care, etc.). In terms of type of care system, the Austrian social care system can be described as based on the normative principles of solidarity and subsidiarity.<sup>6</sup> To some extent, these normative principles can be seen as conflicting with each other, while

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<sup>4</sup> See for a study on the situation in 2003 M. Fuchs, G. Schmied & N. Oberzaucher N. (2003) Quantitative und qualitative Erfassung und Analyse der nicht-krankenversicherten Personen in Österreich. Wien: Bundesministerium für Gesundheit und Frauen

<sup>5</sup> M. Grilz-Wolf / C. Strümpel / K. Leichsenring / Kathrin Komp (2004), *Providing health and social care for older persons in Austria*. Project Report 'Providing integrated health and social care for older persons' (PROCARE), available at <http://www.imersomayores.csic.es/documentos/documentos/procare-providingaustria-01.pdf> (10.6.2011)

<sup>6</sup> Subsidiarity essentially means that the most local institution just capable of delivering a particular service or social good should be responsible for service provisions, while upper level institutions should only provide the framework (legal or financial) allowing local institutions to realize their tasks.

the principle of subsidiarity almost necessarily leads to major variations in the kind and scope of social care provided across Austria.<sup>7</sup>

### 2.1.2. Statutory and private health insurance

#### 2.1.2.1. Statutory health insurance

As outlined above, statutory health insurance is the main structural foundation of Austria's health care system. Statutory health insurance is organised according to vocational groups and regional aspects, with some very wide variations in arrangements. Health insurance provides the following benefits: medical aid, free medication,<sup>8</sup> hospital care, home nursing and midwives, psychotherapy and clinical psychological diagnosis, services of the medical-technical professions, mother-child medical card examinations, health examinations and preventive medical check-ups, travel and transport costs, grants for prosthetic materials and auxiliaries, sickness benefit payments in cases of occupational disability through illness, maternity benefits, social accident insurance and the nursing care. Although the health insurance systems do cover virtually all areas of medical aid and support, the wide differences with regard to type of insurance has to be criticised. This is particularly relevant with regard to dental care. The largest and most important health insurance fund based on region of employment ("Gebietskrankenkassen" [Regional insurance fund]) which cover the overwhelming share of the population do not cover fixed dental prostheses, like e.g. dental bridges, coronas or dental implements; the health insurance fund of civil servants or of self employed persons only cover a small part of the costs (e.g. Euro 100 for a dental corona, which might actually cost between Euro 500 and Euro 1500).<sup>9</sup>

Health insurance is mandatory and also covers dependants of the beneficiary. All workers, employees, unemployed persons receiving unemployment assistance, recipients of the minimum social protection, and asylum seekers admitted to the "basic

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<sup>7</sup> B. Trukeschitz, U. Schneider, (2011) Long-term care financing in Austria In: J. Costa-Font/C. Courbage (eds), *Financing Long-Term Care in Europe: Institutions, Markets and Models*. Basingstoke: Palgrave Macmillan, forthcoming. If the primary locus of responsibility is with the most localised institution (be it the individual, the family, the municipality or the province), variations in actual arrangements are a logical consequence.

<sup>8</sup> A prescription fee of currently Euro 5.10 has to be paid for each item on the prescription. As soon as the medication fees already paid in the current year has reached 2% of the net income of the person concerned, the fee is not charged any more. Persons with an income at or lower than the statutory minimum income or persons residing in a home for the elderly or a nursing home may be exempt from the prescription fee on request.

<sup>9</sup> As a result, many patients living close enough to the Czech, Slovakian or Hungarian and to a lesser extent Slovenian border use dentists in these countries for more expensive types of treatment, given the far lower costs of treatment (and prostheses) in these countries. Another consequence is that many dentists offer informal payments without taxes.

care system for foreigners in need for assistance and protection”<sup>10</sup> are insured by the statutory provincial health insurance fund for their province of residence<sup>11</sup> (“Gebietskrankenkassa”). Other occupational groups like e.g. farmers, civil servants, solicitors, miners, or entrepreneurs and self employed persons are covered by specific health insurance fund for their occupational group. Pensioners are covered by the health insurance fund they belonged to during their working life.

According to a study of 2003, 96.9% of the population above the age of 15 were covered by statutory health insurance at the time of the study.<sup>12</sup> According to the yearbook of the “Federation of Austrian Social Insurance Institutions”, an umbrella-organisation encompassing all public health insurance fund, 99% of the population was covered by public health insurance in 2009.<sup>13</sup>

The full cost of medical treatment has to be paid by persons holding no insurance. Hospitals are obliged to provide first aid in case of emergency independently of the ability of the patient to pay. They have to cover the expenses if the patient is unable to pay.<sup>14</sup>

### 2.1.2.2. Private health insurance

Private health insurance schemes only play a supplementary role. While private insurance in lieu of insurance with public insurance fund exists, it is only relevant for non-economically active foreign nationals (notably students) who can choose their health coverage, employees of international organisations and other diplomatic staff as well as certain temporary migrants. In 2006, 2.3 million private health insurance contracts existed, covering approximately 28% of the Austrian population.<sup>15</sup> Only very few

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<sup>10</sup> This system is based on an agreement between the provinces and the federal government according to Article 15a of the Federal Constitution.

<sup>11</sup> Austria is a federal state composed by nine provinces. In several fields, like e.g. in the area health, the provinces hold certain powers of decision.

<sup>12</sup> M. Fuchs, G. Schmied & N. Oberzaucher N. (2003) Quantitative und qualitative Erfassung und Analyse der nicht-krankenversicherten Personen in Österreich. Wien: Bundesministerium für Gesundheit und Frauen

<sup>13</sup> Hauptverband der Österreichischen Sozialversicherungsträger (2010) Die österreichische Sozialversicherung in Zahlen. Vienna, available at: [http://www.sozialversicherung.at/mediaDB/703989\\_Sozialversicherung\\_in\\_Zahlen\\_25\\_Ausgabe\\_August\\_2010.pdf](http://www.sozialversicherung.at/mediaDB/703989_Sozialversicherung_in_Zahlen_25_Ausgabe_August_2010.pdf)

<sup>14</sup> Platform for International Cooperation on Undocumented Migrants (2007) *Access to Health Care for Undocumented Migrants in Europe*, available at [http://picum.org/picum.org/uploads/file\\_/Access\\_to\\_Health\\_Care\\_for\\_Undocumented\\_Migrants.pdf](http://picum.org/picum.org/uploads/file_/Access_to_Health_Care_for_Undocumented_Migrants.pdf) (10.6.2011)

<sup>15</sup> Arbeiterkammer Wien (2008) Private Zusatzkrankenversicherung. Prämien und Leistungen für den Krankenhauskostentarif. Überprüfung der Änderungen im Sinne der Gleichbehandlungsrichtlinie, p. 7

companies offer private supplementary health insurance as a benefit for their employees.

Such complementary insurances may grant the insured person better accommodation in the hospital (single rooms, for example), coverage of the costs of treatment by a doctor who does not have a contract with the particular patient's health insurance, payment of daily benefits in cases of illness, or the imbursement of costs for complementary medical treatment procedures, e.g. homeopathy or other forms of naturopathic treatment.<sup>16</sup> Depending on the type of contract, the range of coverage varies widely. Depending on the contract, private health insurance contracts may (partly) cover the costs for privately paid treatment by practitioners and specialists not covered by public health insurance fund, refund fixed dentures up to 80%, until an annual maximum is reached, or refund adherent lenses or high quality glasses, which are not or only partly funded the public health insurance fund.

By law, private insurance must not lead to any privileged access to necessary medical treatment or surgery. Nevertheless, in practice, private insurance often nevertheless might lead to privileged access to necessary medical treatment, in particular elective treatment.<sup>17</sup> Private insurance is normally paid by the individual, private health insurance paid by the employer is uncommon.

Private insurance contracts are irredeemable for lifetime by the insurer. The insurer may only abrogate the contract if the client has not informed him about an existing relevant illness. The client may abrogate at the end of each year of contract. Rates depend on the type of public insurance scheme the client is member of, the type of contract, the age at time of the conclusion of contract, the individual health status and gender. Depending on the variables listed above, fees range between Euro 50 and well beyond Euro 150 monthly. Most companies require a medical test before concluding a contract.

In general, the fees rise with the age of the conclusion of the contract, thus contracts are only abrogated by clients who are not able or willing any more to pay the fees. Women regularly had paid higher fees than men, as pregnancy had been calculated as gender-specific risk. The implementation of the EU-antidiscrimination regulations in 2006 has lead to an abolishment of these risk fees on pregnancy. According to a study of the Viennese Chamber of Labour on the implementation of the Equal Treatment Act, which prohibits gender discrimination with regard to access to goods and services and thus makes the calculation of "pregnancy risk fee" illegal, since end of 2007 the fees for women were on average reduced by between 11% to 24%, depending on the insurance

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16 Bundesministerium für Frauen und Gesundheit (2005) Public Health in Austria

17 T. Cypionka, M. Kraus, M. Riedel & G. Röhring (2007) Warten auf Elektivoperationen in Österreich: eine Frage der Transparenz, Soziale Sicherheit, 4/2007 p. 5

company, whereas the fees for men were raised by 12% to 29%, again depending on the insurance company.<sup>18</sup>

The companies may refuse to contract with chronically ill persons and persons with disabilities or may demand higher fees in case of chronic illness or disability. Age limits for the conclusion of contract also are applicable; usually the insurance companies decline to conclude contracts with clients older than 60. A few companies accept contracts with clients up to age 70, however at extraordinarily high fees.

### 2.1.3. Different treatment standards and quality control

A major problem of the health services concerns the lack of transparency regarding waiting lists for elective surgery, in particular with regard to orthopaedic and ophthalmologic surgery, which may reach up to 255 days. Each hospital administers its own waiting list according to its own set of criteria, documentation of waiting lists does not exist at the regional or the federal level and a common waiting list management system is missing.<sup>19</sup> Despite the legal prohibition of privileged access to medical treatment to privately insured patients, these patients are granted privileged access according to reports of the provincial health ombudsmen.<sup>20</sup> The media regularly reports cases of bribery leading to advancement in the waiting lists for elective surgery. A typical case has been reported by the daily “Der Standard” on March 3, 2011: Mr. G., who would have had to wait for surgery to receive an artificial hip joint for more than two months, was offered surgery within two weeks after a payment of Euro 5.000 to the head surgeon of a public Viennese hospital. According to the report, patients holding a private supplementary health insurance on average have to wait half the time for surgery than other patients.<sup>21</sup> In response to recurrent reports on differential treatment of persons with supplementary private insurance, the Council of Ministers agreed to present a draft bill to parliament on May 17, 2011, obliging all hospitals to publish waiting lists for operation on the internet and forbidding hospitals to differentiate between patients with and without private insurance when fixing dates for surgery.<sup>22</sup>

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<sup>18</sup> Arbeiterkammer Wien (2008) *Private Zusatzkrankenversicherung. Prämien und Leistungen für den Krankenhauskostentarif. Überprüfung der Änderungen im Sinne der Gleichbehandlungsrichtlinie*, p.1

<sup>19</sup> Clinicum (2011) *Wartezeiten*, available at <http://www.clinicum.at/dynasite.cfm?dsmid=77031&dspaid=598614>

<sup>20</sup> T. Cypionka, M. Kraus, M. Riedel. & G. Röhrling (2007) *Warten auf Elektivoperationen in Österreich: eine Frage der Transparenz*. Beilage zur Fachzeitschrift Soziale Sicherheit

<sup>21</sup> G. John (2011) ‘Wer extra zahlt, kommt früher unters Messer’, in: *Der Standard* (3.3.2011), online at <http://derstandard.at/1297819490052/Zweiklassenmedizin-Wer-extra-zahlt-kommt-frueher-unters-Messer>

<sup>22</sup> N.N. (2004) ‘Transparente Wartelisten gegen Zweiklassenmedizin’, in *Die Presse* (17.11.2011), online at <http://diepresse.com/home/panorama/oesterreich/662842/Transparente-Warteliste-gegen-ZweiKlassenMedizin>

A further criticism concerns the lack of information about the quality of hospitals, practitioners and specialists. No public quality control system does exist yet, and there is no information available on for example, success and complication rates for different types of treatment and surgery for hospitals and doctors, and no benchmarking systems are implemented. Thus the patients have no possibility to make well informed choices about the institutions where they receive treatment.<sup>23</sup>

In order to improve quality control, the Federal Institute for Quality in the Health Sector (Bundesinstitut für Qualität im Gesundheitswesen) was founded in 2004. It has been commissioned to develop a quality control system for the health sector. The Health Reform Act of 2005 also included a Federal Act on the Quality of Health Services, which empowers the Federal Ministry of Health to develop quality standards and implement federal quality control procedures. Meanwhile rules for improved documentation in hospitals, general practitioners and specialists in private practice and the extramural sector, e.g. community care centres or homes for the elderly or nursing homes have been developed and are in the implementation phase. The Austrian Structural Planning Document for the Health Sector 2010<sup>24</sup> has defined quality criteria for central and local hospitals which are currently going to be implemented. These quality criteria strictly focus on management procedures for hospitals or nursing homes and minimal standards with regard to number of hospital beds and technical equipment per station, or with regard to procedures of patient management. No reference is made with regard to issues of accessibility, cultural mediation or the presence of translating services.

## 2.2. Institutional structure

Health care provision in Austria is jointly regulated by the federal government and the nine provincial governments. The main political responsibility and the legislative competencies are given to the Federal Ministry of Health. The enactment and implementation of legislation as well as the provision of inpatient care is the responsibility of the nine provincial governments.<sup>25</sup>

The main funding sources are contributions to the 22 mandatory public health insurance schemes, which amount to approximately 50% of the expenses of the health

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<sup>23</sup> T. Czypionka, M. Riedel & G. Röhring (2006) 'Qualitätssicherung in Praxen. Eine europäische Perspektive', *Soziale Sicherheit*, 2/2006, and T. Czypionka, M. Riedel & G. Röhring (2008) 'Qualität im Spitalswesen – mehr oder weniger Transparenz?', *Soziale Sicherheit*, 3/2008

<sup>24</sup> Bundesministerium für Gesundheit – BMG (2010). *Österreichischer Strukturplan Gesundheit – ÖSG 2010*, available at [http://bmg.gv.at/home/Schwerpunkte/Gesundheitssystem\\_Qualitaetssicherung/Planung/Oesterreichischer\\_Strukturplan\\_Gesundheit\\_OeSG\\_2010](http://bmg.gv.at/home/Schwerpunkte/Gesundheitssystem_Qualitaetssicherung/Planung/Oesterreichischer_Strukturplan_Gesundheit_OeSG_2010)

<sup>25</sup> U. Karl-Trummer, S. Novak-Zezula & B. Metzler (2009a) 'Managing a Paradox: Health Care for Undocumented Migrants in the EU', *Finnish Journal of Ethnicity and Migration*, 4/2, pp. 53-60.

sector. The other half is financed through tax subsidies from the federal and provincial governments (approx. 25%), from private insurances (8 %; i.e. fees for faster access and “special class” accommodation) and obligatory private contributions to the costs of medication and medical aid. Resources are pooled and reallocated by the Federation of Austrian Social Insurance Institutions, thus de facto a single national financing system exists.<sup>26</sup>

The obligatory public health insurance schemes are financed by income – related contributions based on type of occupation. Contributions to the nine provincial health insurance schemes, which cover the vast majority of workers and employees, are paid jointly by the employer and the worker/employee. These are calculated as a percentage of the gross income (employer: 3.7% to 3.83%; worker/employee: 3.82% to 3.95%). For the parts of the income above a fixed ceiling (currently at Euro 4.200 monthly, 14 times a year) no contributions have to be paid. A comparable regulation exists for civil servants of the federal state, the provinces and the municipalities, who are insured by their respective obligatory public health insurances schemes. Entrepreneurs and self employed persons pay a fee of 7.65% of their taxable gains, the fees for farmers are calculated according to the taxable value of the property they own.

Cost sharing applies to most health services. Whereas there is no difference between the health insurance schemes with regard to hospital treatment, there are huge differences with regard to the range of benefits provided for in the extramural sector (e.g. general practitioners and specialists in private practice, community care centres or homes for the elderly or nursing homes) in particular with regard to dental and ophthalmologic treatment, psychotherapy, physiotherapy, ergotherapy, and speech treatment and stays at spas. Whereas e.g. clients of the provincial obligatory health insurance schemes have to pay for fixed dentures themselves, clients of the health insurance schemes for civil servants receive subsidies up to approximately Euro 200.- for each fixed denture. On the other hand, clients of several health insurance schemes, e.g. the health insurance scheme for civil servants, the health insurance scheme for self employed and entrepreneurs or the health insurance scheme for farmers have to pay themselves 20% of the costs of each visit of a doctor who holds a contract with their health insurance scheme, whereas clients of the provincial health insurance fund receive free treatment from doctors holding a contract with their health insurance scheme. Clients of all public health insurance schemes have to share the costs of medication (a fixed fee of currently Euro 5.10 for each packaging unit until an annual limit of 2% of the net income is reached). Persons with a low income, children, and people with chronic illnesses are exempt from prescription charges (approximately 12% of the population).<sup>27</sup>

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<sup>26</sup> Bundesministerium für Frauen und Gesundheit (2005) *Public Health in Austria*; M. M. Hofmarcher & H. M. Rack (2006) ‘Austria. Health System Review’, *Health Systems in Transition*, Vol.8, No.3

<sup>27</sup> M. M. Hofmarcher & H. M. Rack (2006) ‘Austria. Health System Review’, *Health Systems in Transition*, Vol.8, No.3, p. 26



Three main actors define the organisational structure of the Austrian health care system: the public sector, private non-profit and private for-profit institutions.<sup>28</sup> The public sector consists of the federal and the provincial governments. In order to coordinate, they have concluded state treaties about the organisation and the financing of the health care system defining the respective roles and responsibilities.

## 2.3. Provision of services

### 2.3.1. Medical practitioners in private practice

Self-employed physicians in private practice, outpatient clinics and hospital outpatient departments deliver most of the necessary outpatient care.<sup>29</sup> There is no overall planning for general practitioners or specialists, who may open their medical practice as soon as they are licensed. Patients have a free choice of outpatient providers. If they choose a provider holding a contract with their insurance fund, they are – depending on their health insurance fund – treated for free or have to pay at most 20% of the costs. They also may choose a provider without a contract with their health insurance fund, but in this case have to pay the bill by themselves. In this case, the health insurance fund refund 80% of the costs the scheme would have paid for treatment at a medical practice holding a contract with the respective fund, which often only covers a small part of the real costs.

Thus although no overall planning for general practitioners or specialists exists, in practice the number of contracts with the public health insurance fund issued is a major planning instrument. As in particular the numbers of contracts for medical practices with the provincial health insurance fund are limited and the vast majority of the population is insured through these fund and receive free treatment with doctors holding a contract with them, practitioners or specialists holding a contract with a public health insurance fund care for the majority of the patients. Nevertheless, a large number of practitioners or specialists working at a hospital also run a private practice additionally to their work at the hospital and do not hold a contract with a health insurance fund.

While in principle general practitioners have a gate keeping function and are responsible for referring patients to specialist outpatient care or hospitals, a large number of patients seeking specialist care immediately refer themselves to a specialist outpatient hospital departments, often because of the limited opening hours of

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<sup>28</sup> M. M. Hofmarcher, H. M. Rack, H. M., (2006) 'Austria. Health System Review', *Health Systems in Transition*, Vol.8, No.3, p. 32

<sup>29</sup> M. M. Hofmarcher & Rack, H. M., (2006) 'Austria. Health System Review', *Health Systems in Transition*, Vol.8, No.3, p. 37

specialists in private practice<sup>30</sup> The distinction between primary and secondary care is thus only partly implemented, notably as referral and patients' trajectories in the health sector is concerned.

Day clinics operated by the health insurance fund to some extent act as an alternative to specialist care in private practice as well as outpatient hospital departments.

### 2.3.2. The hospital sector

In 2003, only 43% of the 19,209 self-employed physicians in private practice had a contractual relationship with one or more health insurance fund. Around 57% worked as non-contracted physicians.<sup>31</sup>

Both public, private non-profit (mainly churches) and private for-profit institutions run hospitals exist in Austria. Hospital planning is administered by the provincial governments through hospital plans. Out of the 257 hospitals in Austria 36 (14%) are private hospitals, they care for 4% of all acute inpatient treatment.<sup>32</sup>

At the end of 2008, 257 hospitals offering 64.267 beds (52.160 of them) for acute treatment existed in Austria. Of the 257 hospitals, 132 were organised by the provinces. 75% of all hospitals places available in Austria are offered by the hospitals owned by the provinces.<sup>33</sup>

Hospitals which are listed in the hospitals plan of a province are entitled to legally prescribed subsidies from public sources for investments, maintenance and running costs. The health sector reform strategy of the Ministry of Health envisages a stronger coordination and centralisation of hospital planning.

### 2.3.3. Other relevant actors

Since 2006, pharmaceuticals are licensed by the PharmMed Austria division of the Federal Office for Safety in Health Care within the Austrian Agency for Health and Food Safety. The

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<sup>30</sup> M. Laimböck (2008) *Die Zukunft des österreichischen Gesundheitssystems*. Vienna & New York: Springer, p.203

<sup>31</sup> J. L. Monteagudo & O. Moreno (2007) *E-health strategy and implementation activities in Austria*. Report for the e-health area project, p. 8, available at: [http://www.ehealth-era.org/database/documents/ERA\\_Reports/Austria\\_eHealth-ERA\\_country\\_report\\_final\\_18-04-2007.pdf](http://www.ehealth-era.org/database/documents/ERA_Reports/Austria_eHealth-ERA_country_report_final_18-04-2007.pdf)

<sup>32</sup> See press-statement of the Austrian Federal Economic Chamber, 29/11/2009, available at [http://reloaded.wko.at/wk/reloaded.wko.at/wk/format\\_detail.wk?AngID=1&StID=410241&DstID=299](http://reloaded.wko.at/wk/reloaded.wko.at/wk/format_detail.wk?AngID=1&StID=410241&DstID=299)

<sup>33</sup> Österreichisches Bundesinstitut für Gesundheitswesen – ÖBIG (2010) *Das österreichische Gesundheitswesen im internationalen Vergleich*, available at [http://www.goeg.at/media/download/berichte/Gesundheitswesen\\_2010.pdf](http://www.goeg.at/media/download/berichte/Gesundheitswesen_2010.pdf)

reimbursement of the costs of licensed medicines by social health insurance fund is decided by the Federation of Austrian Social Insurance Institutions, which is advised by the Medicines Evaluation Commission.<sup>34</sup>

The Health Sector is administered by the Federal Ministry of Health and respective governmental departments of the provinces. In all medical questions, the Ministry is advised by the Highest Medical Council (Oberster Sanitätsrat), an advisory body established by law at the ministry. The Austrian Medical Chamber is the most important self governing professional body of physicians. It administers the licensing of doctors, represents the interests of the medical professions and administers the health insurance scheme for self-employed physicians. In addition, its provincial branches also run arbitration boards as out-of court alternatives in cases of errors in treatment. The Austrian Dental Chamber is a similar structure for dentists and also maintains arbitration boards.

### 3. Health entitlements

#### 3.1. General description

Health care entitlements, summarily described already on p.10 of this report, are based on insurance coverage and treatment at a private practice holding a contract with the respective health insurance scheme.<sup>35</sup> Patients consulting a professional not in possession of a contract with these fund have to pay for treatment, but are partially refunded.

To be included into the public health insurance system, legal residence is a precondition. Persons not covered by a statutory health insurance scheme or a private health insurance are requested to pay the full costs of treatment. However, in cases of emergency, treatment at hospitals is mandatory by law, regardless of the patient's ability to pay. As there is no legal definition of "emergency", health professionals at hospitals have some leeway on the decision of treatment beyond actual emergency.<sup>36</sup> If a patient is unable to pay or cannot provide identification (identification is not

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<sup>34</sup> M. M. Hofmarcher, H. M. Rack (2006) 'Austria. Health System Review', *Health Systems in Transition*, Vol.8, No.3

<sup>35</sup> The vast majority of the Austrian hospitals hold contracts with all public health insurance schemes.

<sup>36</sup> U. Karl-Trummer, S. Novak-Zezula & B. Metzler (2009) 'Managing a Paradox: Health Care for Undocumented Migrants in the EU', in *Finnish Journal of Ethnicity and Migration*, 4/2 p. 12

compulsory), the hospitals are obliged to cover the costs or to try to regain them from the provincial health insurance fund.<sup>37</sup>

As legal residence is a precondition of access to health insurance, persons without legal residence are the most vulnerable group with regard to access to compulsory health insurance. This group mainly consists of irregular immigrants and those asylum seekers, who have not been accepted within the basic care system for foreigners in need of assistance and protection, and rejected asylum seekers, who have received an order to leave the country and have decided to go underground.

There is only a small group of legally resident third country nationals, who run the risk of lack of health insurance: Those persons, who are not a spouse or child of a person insured with one of the health insurance fund and who are earning below the insurance threshold (currently euro 374.02.- monthly). If legally resident, they may opt into membership of a provincial health insurance fund for a monthly fee of Euro 52.78.

In case of divorce compulsory membership to a health insurance fund as a spouse ends, except for former spouses of civil servants, who continue to be members with the respective health insurance scheme, as long as they enjoy the right to receive alimony payments from their former spouse. Persons, who have been insured as spouses of a member of the other health insurance fund, lose the right to insurance as a spouse after divorce. If they are not insured due to own employment, they have the right to opt into voluntary insurance for a monthly fee of Euro 52.78. Children have the right to insurance with their parents up to age of 27 as long as they receive alimony payments and are attending school or are studying in Austria, independent from their place of residence. Persons receiving an orphan's pension are automatically insured with the respective public health insurance fund.

A further group at risk are third country nationals with a temporary residence permit, who by definition do not have access to the basic benefit provisions scheme, which includes health insurance and hence, do not have access. Persons lacking health insurance are entitled to an annual health examination and to participation in cancer screening.

In 2009, the Austrian Medical Chamber estimated that 98.4% of the Austrian population was covered by one of the public health insurance schemes.<sup>38</sup> In its annual report for 2010, the Federation of Austrian Social Insurance Institutions reports 8,3 million members of the health insurance schemes (99% of the Austrian population). 46% were

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<sup>37</sup> C. B. Cuarda (2010) Policies on Health Care for Undocumented Migrants in EU 27. Country Report Austria for the project: Health Care in Nowhereland – Improving Services for Undocumented Migrants in Europe

<sup>38</sup> Österreichische Ärztekammer (2009) *News, facts, trends*, available at: [http://www.multiart.at/oeaek\\_newsroom/index.php?m=viewarticle&ar=987\\_der\\_gesamtbevoelkerung\\_ist\\_durch\\_soziale\\_krankenversicherung](http://www.multiart.at/oeaek_newsroom/index.php?m=viewarticle&ar=987_der_gesamtbevoelkerung_ist_durch_soziale_krankenversicherung)

economically active as employers, workers, employees or self-insured persons, 25% dependants of other members of the health insurance scheme, 25% pensioners and 4% belonged to the category “others”. Approximately 4,996,000 persons were members of a provincial health insurance fund, approx. 617,000 members of a health insurance fund for civil servants, approx. 473,000 members of the health insurance fund for employers and self employed persons and approx. 291,000 were members of the health insurance fund for peasants.<sup>39</sup>

Until 2010, persons receiving social assistance payments were not included into the provincial health insurance fund. Since September 2010, the social assistance system has been replaced by a system of minimum social protection payments. Since then, anyone receiving these payments automatically is included into the respective provincial health insurance fund. Thus a large group, which previously did not have proper access to health insurance, has been included into the mandatory health insurance system.

Although there are differences between the nine provincial health insurance schemes, all of them cover medically necessary outpatient or hospital treatment, including medication, surgery, therapeutic aid or rehabilitation. Differences concern e.g. the number of hours for physiotherapy or psychotherapy approbated, the approbation of less straining, but more costly methods of medical examinations (e.g. magnetic resonance examination vs. X-ray-examination), or the easiness of access to treatment at a health resort. These differences can be explained by the financial performance of the fund. As a rule of thumb, the western provinces of Austria are richer than the eastern and southern provinces, thus also their provincial health insurance schemes may offer better treatment to their clients.

### 3.2. Cost sharing

Cost sharing is applied in many areas. The degree of cost sharing and the areas of application depend on the public health insurance fund the patient is affiliated with. The health insurance schemes for civil servants, the scheme for self employed persons and the scheme for peasants as well as some smaller schemes (e.g. for notary publics, for attorneys, for practitioners or specialists in private practice) demand cost sharing of 20% for all treatments at the private practice of a general practitioner or specialist, only treatment in hospitals is free. There exists no comparable general cost sharing element with the provincial health insurance schemes.

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<sup>39</sup> Hauptverband der Österreichischen Sozialversicherungsträger (2010) Die österreichische Sozialversicherung in Zahlen. Vienna, available at: [http://www.sozialversicherung.at/mediaDB/703989\\_Sozialversicherung\\_in\\_Zahlen\\_25\\_Ausgabe\\_August\\_2010.pdf](http://www.sozialversicherung.at/mediaDB/703989_Sozialversicherung_in_Zahlen_25_Ausgabe_August_2010.pdf)

In general, there is no cost sharing with regards to hospital treatment, only a lump sum for food and lodging (currently between Euro 11.00,- and Euro 17.50,- per day, depending on province and hospital) is charged.

Prescription charges (currently Euro 5.10.-) apply to each packaging unit of medication up to an annual maximum of 2% of the yearly net income of the patient. Persons with low income, children and persons with chronic illnesses may be exempt from the charges.

Cost sharing with regard to medical aid appliances, dental surgery or glasses varies widely depending on the public health insurance scheme concerned. As a rule of thumb, the provincial health insurance schemes often offer appliances free of charge or for a low additional fee, but these most often do not reflect the latest state of the art in medical technology or design. Patients choosing higher quality products are refunded only the costs of the products offered by the health insurance fund. The smaller health insurance schemes – which most often charge a 20% retention for outpatient treatment – usually refund a higher percentage of the costs for latest state of the art medical and therapeutic aid appliances, dental surgery or glasses, but often do not offer any appliance free of any charge.

Psychotherapy, physiotherapy, ergotherapy and speech therapy or stays at spas most often are only partially refunded by the public health insurance schemes. Again as a rule of thumb the large provincial health insurance schemes are more restrictive with regard to access to therapy and refund a lower percentage than the smaller health insurance schemes. Alternative therapy, like e.g. homeopathy, is only refunded by some smaller health insurance schemes and is generally still marginalised by public health policy, despite the rising popularity of alternative forms of treatment.<sup>40</sup>

### 3.3. Preventive health schemes

A growing variety of preventive health schemes are on offer:

The general health screening scheme (“Vorsorgeuntersuchung”) is a standardised medical examination including, depending on age, certain elements of cancer screening (e.g. breast-cancer, prostate gland cancer). All members of the public health care

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<sup>40</sup> Thus, according to a survey conducted in 2004, roughly half of the population had made use of alternative forms of treatment. See H. Gottweis / E. Braumandl (1996) ‘Gesundheitspolitik’, in: H. Dachs, P. Gerlich, H. Gottweis, H. Kramer, V. Lauber, W. C. Müller & E. Tálos (eds.) *Politik in Österreich. Das Handbuch*, Vienna: Manz, p.758

schemes older than 18 are eligible once a year, persons without health insurance are eligible if they can prove residence in Austria.<sup>41</sup>

All school-children attending public and private schools are medically examined once a year by the respective school physician. Examinations are organised by the respective provincial school councils. Eligibility is based solely on registration as pupil of the respective school, neither residency nor citizenship criteria apply. Pupils attending compulsory schooling (nine years of schooling) are offered all immunisations recommended by the Highest Medical Council (“Oberster Sanitätsrat”) for free at the occasion of the annual health examination.<sup>42</sup>

### 3.3.1. Mother-child-card and reproductive medicine

The “mother-child-card” (“Mutter-Kind-Pass”) programme is by far the most important and also among the longest existing preventive health care schemes, being in place since 1974. It is offered to all pregnant women, independently of their insurance – status, as long as they have a registered residence in Austria (there is no need to proof legal residence for registration as a resident) and have got a proof of eligibility by the respective provincial health insurance fund, which is issued on proving registration of residency in Austria, and the medical examinations are done by physicians holding a contract with the programme. The programme consists of five gynaecological examinations of the mother during pregnancy, HIV-testing, and an oral test of glucose tolerance and three ultrasonic examinations of the baby during pregnancy and several medical examinations of the child up to the age of five. Attendance of the medical examinations is a precondition for the receipt of child-care benefit, the receipt of which is restricted to persons with a legal residence status in Austria.<sup>43</sup>

In vitro-fertilisation exists for heterosexual couples living in a marriage or in a partnership comparable to marriage. The use of third-party semen or eggs is not permitted, nor is surrogate motherhood.<sup>44</sup> In 2000, a specific fund has been set up to financially support childless couples if specific conditions prevail. The fund covers 70 per cent of the costs of treatment. Some form of health insurance is obligatory to be

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<sup>41</sup> Hauptverband der österreichischen Sozialversicherungsträger (2005) *Gesundheitsbericht der sozialen Krankenversicherung*

<sup>42</sup> See <http://www.wien.gv.at/ma15/gratisschulimpf.htm> (12.6.2011)

<sup>43</sup> Bundesministerium für Gesundheit (2010) *Unser Baby kommt. Begleithroschüre zum Mutter-Kind-Pass*, p. 102, available at [http://www.caritassteiermark.at/fileadmin/user/steiermark/fotos\\_pdf\\_medien/Hilfe\\_und\\_Einrichtung\\_en/fuer\\_Menschen\\_in\\_Not/Gesundheit/Marienambulanz/Downloads/MA\\_IB\\_2010\\_druckfertig.pdf](http://www.caritassteiermark.at/fileadmin/user/steiermark/fotos_pdf_medien/Hilfe_und_Einrichtung_en/fuer_Menschen_in_Not/Gesundheit/Marienambulanz/Downloads/MA_IB_2010_druckfertig.pdf)

<sup>44</sup> See Fortpflanzungsmedizingesetz, BGBl. Nr. 275/1992 (as amended), § 2

eligible for support by the fund. In the case of non-nationals, proof of at least three months of employment is additionally demanded.<sup>45</sup>

Abortion is regulated in §§96-98 of the penal code<sup>46</sup> and permitted within the first free months of pregnancy if carried out by medical doctor. It may be carried out later only if there are serious risks for the mother, if the mother was a minor when conceiving the baby or if there is a risk that the baby has a serious physical or intellectually disability. The costs of abortion have to be carried by the woman. The vast majority of abortions are thought to be carried out by gynaecologists in private practice and specialist reproductive care centres. The extent of abortions is not known, as only abortions carried out in hospitals are counted. An estimate in the late 1990s put the number of abortions carried out annually at between 19,000 and 25,000.<sup>47</sup>

### 3.4. Mental Health Care

Since the major reforms of mental health care sector in the 1970s, Austria has moved towards a decentralised, integrated mental health care system and away from institutionalised systems of care. This also included defining an occupational profile for psychologists and psychotherapists in the early 1990s and more recently, music therapists. As a result of this shift, the number of places in institutionalised care has dramatically decreased between 1970 and 2000, while it has been fairly stable afterwards. Thus, in 2008, there were 3,325 places in general psychiatric wards or specialised hospital, 397 for young persons with mental health problems and 905 places for drug addicted persons, with little changes in comparison to 2003. This represents a ratio of 0.11 places per 1,000 inhabitants for general psychiatric care and care for drug addictions and 0.04 places per 1,000 inhabitants for youth psychiatric places. The extramural sector catered for some 46,500 persons in 2005 or 0.7 per 1,000. The provision of places in day clinics varies dramatically between provinces, varying between 1.9 and 5.9 places per 10,000 inhabitants. Only four of the nine provinces have established psychosocial emergency services (amongst which Vienna, but not Styria).<sup>48</sup> Since the first edition of the Structural Planning Document for the area of health in 2006, provision with mental health care has been included in general national health planning, while most provinces have their own mental health care plans, developed since the early 1990s. The de-institutionalisation and an accompanying decentralisation of the mental

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<sup>45</sup> See <http://www.ivf-gesellschaft.at/index.php?id=107> (12.6.2011)

<sup>46</sup> BGBl. Nr. 60/1974 as amended

<sup>47</sup> Bundesministerin für Frauen und Öffentlichen Dienst im Bundeskanzleramt Österreich (2010) Frauenbericht 2010. Bericht betreffend die Situation von Frauen in Österreich im Zeitraum von 1998 bis 2008. Available online <http://www.bka.gv.at/site/7207/default.aspx> (12.6.2011)

<sup>48</sup> Gesundheit Österreich GmbH, Bundesministerium für Gesundheit (2009), Gesundheitsbericht 2009. Berichtsperiode 2005-2007. Vienna. Available at [http://www.parlament.gv.at/PAKT/VHG/BR/III-BR/III-BR\\_00410/imfname\\_194555.pdf](http://www.parlament.gv.at/PAKT/VHG/BR/III-BR/III-BR_00410/imfname_194555.pdf), p.68



health care system, however, have only been partially reflected in an expansion of the extramural mental health care sector. While the sector has indeed considerably expanded, provision with services is still deficient, while the financing of mental health care favours institutions and thus has left the institutionalised sector as one of the main cornerstone of mental health care provisions. This can be partly explained by the fact that public insurance fund only belatedly began to contract doctors in private practice specialised in any type of treatment for mental health problems, while at the same time favouring psychiatrists over psychotherapists, psychologists and other non-psychiatrist providers of services.<sup>49</sup> As a corollary, Austria's mental health care system is still largely focused on provision of treatment for patients with acute conditions, which applies equally to the extramural and the institutionalised sector. Day clinics have been advocated as an alternative to institutionalised care for more severe cases of mental health disorders and promoted since the mid-1990s. Since 2003, the number of cases of treatment has risen by 25%. In 2007, day clinics accounted for 11% of the totally available places for general psychiatric care with an average of 13 places per day clinic. Altogether, there were only 24 day clinics, with the provinces of Vorarlberg and Burgenland not yet having established any day clinic.<sup>50</sup>

While mental health care provision has received some attention in relation to asylum seekers, and in particular regarding mental health care for traumatised persons, the issue of mental health care provision for migrants and particular needs that there may be has so far remained a fairly marginal concern.

An important legal aspect in regard to mental health is the regulations around trusteeship for persons without or with diminished legal capacity. These have been amended several times since 2000. Suffice is to note here that the number of persons found to be without or with diminished legal capacity and for whom a custodian (whether a professional custodians or relatives) was assigned has been steadily on the rise from 31,184 cases in 2000 to 48,273 cases in 2009.<sup>51</sup> While the age group of persons over 75 account for the large majority of cases of custodianship, the younger age group (18-30) is significant too (some 10%). In addition, younger persons seem to be much more likely to be assigned a custodian than other age groups. Compared over time, custodianship on grounds of intellectual disability has been fairly stable between 1981

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<sup>49</sup> See H. Katschnig, P. Denk und M. Scherer (2004) Österreichischer Psychiatriebericht 2004. Vienna: Ludwig Boltzmann Institut für Sozialpsychiatrie & Universitätsklinik für Psychiatrie. Available at [http://www.bmg.gv.at/cms/home/attachments/8/5/0/CH1273/CMS1038920009809/oesterreichischer\\_psychiatriebericht\\_2004\\_katschnig\\_et\\_al.pdf](http://www.bmg.gv.at/cms/home/attachments/8/5/0/CH1273/CMS1038920009809/oesterreichischer_psychiatriebericht_2004_katschnig_et_al.pdf) (14.6.2011)

<sup>50</sup> Gesundheit Österreich GmbH, Bundesministerium für Gesundheit (2009), Gesundheitsbericht 2009. Berichtsperiode 2005-2007. Vienna. Available at [http://www.parlament.gv.at/PAKT/VHG/BR/III-BR/III-BR\\_00410/imfname\\_194555.pdf](http://www.parlament.gv.at/PAKT/VHG/BR/III-BR/III-BR_00410/imfname_194555.pdf), p.66

<sup>51</sup> A. Pilgram, G. Hanak, R. Kreissl, A. Neumann (2009) *Entwicklung von Kennzahlen für die gerichtliche Sachwalterrechtspraxis als Grundlage für die Abschätzung des Bedarfs an (Vereins)Sachwalterschaft*. Vienna: Institute for Criminal and Legal Sociology. Available at <http://www.irks.at/downloads/SWKennzahlen%20final.pdf> (14.6.2011), p.15

and 2001, while custodianship on grounds of mental disorders has greatly decreased. By contrast, custodianship on grounds of age related intellectual disability has considerably grown since the 1980s.<sup>52</sup> Some 49% of those having been assigned a custodian live in institutional households, of which 4% in psychiatric hospitals and 34% in elderly homes.<sup>53</sup> Evidence more over suggests that a large share of procedures regarding custodianship end in a custodian to be assigned.<sup>54</sup>

### 3.5. Long term and rehabilitative care

In principle, long term care is not considered a responsibility of the national health system, but a provincial responsibility. Long term care needs are thus addressed by social care facilities and services maintained by municipalities and provinces. Only rehabilitative care following a serious medical condition or an accident is partly located in the regular health system, although with considerable variations between individual provinces. Funding for rehabilitative care thus often is a mix of contribution from various insurance fund (notably the General Accident Insurance Fund – Allgemeine Unfallversicherungsanstalt, AUVA, but also the general Pension Insurance Fund – Pensionsversicherungsanstalt – PVA), principal health fund and other funding sources, while most health insurance fund maintain their own rehabilitation centres treatment in which is covered by health insurance. Generally, the rehabilitation system is thus considerably fragmented and access to (funded) rehabilitative care equally highly uneven.<sup>55</sup>

In 1993 a differentiated system of care allowances was set up on the national level through the Federal Long-Term Care Allowance Act (Bundespflegeldgesetz).<sup>56</sup> Complementing the act, a state treaty according to article 15a of the Constitution on “Needs and development plans for social care” was signed between the federal government and the provinces which established a coordination mechanism to plan

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<sup>52</sup> See A. Pilgram (2005) *Das neue Sachwalterschaftsrecht aus der Sicht der Sozialwissenschaften*. Available at <http://www.irks.at/downloads/Die%20neue%20Sachwalterschaft%20aus%20Sicht%20der%20Sozialwissenschaft.pdf> (14.6.2011), p.6

<sup>53</sup> See A. Pilgram (2005) *Das neue Sachwalterschaftsrecht aus der Sicht der Sozialwissenschaften*. Available at <http://www.irks.at/downloads/Die%20neue%20Sachwalterschaft%20aus%20Sicht%20der%20Sozialwissenschaft.pdf> (14.6.2011), p.10

<sup>54</sup> A. Pilgram, G. Hanak, R. Kreissl, A. Neumann (2009) *Entwicklung von Kennzahlen für die gerichtliche Sachwalterrechtspraxis als Grundlage für die Abschätzung des Bedarfs an (Vereins)Sachwalterschaft*. Vienna: Institute for Criminal and Legal Sociology. Available at <http://www.irks.at/downloads/SWKennzahlen%20final.pdf> (14.6.2011), p.19ff

<sup>55</sup> M. Laimböck (2008) *Die Zukunft des österreichischen Gesundheitssystems*. Vienna & New York: Springer, p.171

<sup>56</sup> BGBl. Nr. 110/1993 as amended

social care facilities and services.<sup>57</sup> Demographic changes, notably demographic aging and the resulting growth of the number of elderly persons in need of long term care, changing patterns of social care and the related growth of expenses for social care facilities as well the increasing difficulties of municipalities and provinces to finance the social care infrastructure, have led to intense discussions on a more far-reaching reform of social care which gained momentum in particular after the extent of informally provided social care by irregular care workers from Central and Eastern European countries became an issue of public debate in the course of 2006 (see below). In March 2011 the Ministry of Labour, Social Affairs, and Consumer Protection eventually announced the establishment of a social care fund financed to two thirds by the national budget and to one third by contributions from the provinces, while also announcing a harmonisation of the fragmented care allowance system<sup>58</sup>, with the federal government taking over the administration of the care allowances.<sup>59</sup>

The Federal Long Term Care Allowance act applies to anyone, who is in need of care for more than 60 hours per month, has his/her principal residence in Austria<sup>60</sup> and receives a public pension or other comparable funding. Persons not receiving a public pension (e.g. employed persons, relatives and children to whom health insurance coverage has been extended, civil servants of the provincial and the municipal administrations and persons receiving minimum social protection payments) are covered by the respective provincial long term care employment act. There are no differences between the federal act and the provincial acts with regard to the amount of payment.

Whereas the Federal Long Term Care Allowance Act only demands principal residence in Austria as condition and does not make any reference to the residence title, the provincial long term care allowance acts principally restrict access to long term care allowances to Austrian citizens, to citizens of a member state of the European Economic Area and to citizens of states holding a bilateral social security agreement with Austria, to persons recognised as refugees according to the Geneva Convention, and to spouses and dependent family members of these groups. The provincial long term care acts of

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<sup>57</sup> M. Grilz-Wolf / C. Strümpel / K. Leichsenring / Kathrin Komp (2004), *Providing health and social care for older persons in Austria*. Project Report 'Providing integrated health and social care for older persons' (PROCARE), available at <http://www.imersomayores.csic.es/documentos/documentos/procare-providingaustria-01.pdf> (10.6.2011), p.6

<sup>58</sup> Altogether 23 different institutions are responsible for administering social care allowance system. See Bundesministerium für Arbeit, Soziales und Konsumentenschutz - BMASK (2011) Einigung über Neufinanzierung der Pflege. Press Release. Available at <http://www.bmask.gv.at/cms/site/presseaussendung.html?channel=CH0016&doc=CMS1300265936039>

<sup>59</sup> Bundesministerium für Arbeit, Soziales und Konsumentenschutz - BMASK (2011) Einigung über Neufinanzierung der Pflege. Press Release. Available at <http://www.bmask.gv.at/cms/site/presseaussendung.html?channel=CH0016&doc=CMS1300265936039>

<sup>60</sup> Under certain conditions the allowance is also paid to persons residing in a member state of the European Economic Area.

Lower Austria, the Tyrol and Vorarlberg also entitle third country nationals holding a permanent residence permit to receive provincial long term care allowance. All provincial acts contain a provision allowing waiving the citizenship requirement in case of social hardship, but do not establish a legal claim. Thus all third country nationals are legally excluded to claim provincial long term care allowance payments in all provinces except of Lower Austria, the Tyrol and Vorarlberg, where at least those holding a permanent residence permit are entitled to claim this allowance. There are no data available on how often the citizenship criterion has been waived to allow third country nationals access to provincial long term care allowance payments.

The amount of long term care benefits solely depends on the number of hours of care needed by the patient. The system is administered by the institution responsible for retirement payments for the person concerned and funded by taxes. In 2009, 440.000 persons received long term care benefits. Approximately 75% of all persons in need of long term care are cared for by their relatives at home.<sup>61</sup>

The number of hours needed is decided by experts of the respective institution. In the lowest echelon, defined by a need for between 60 and 85 hours of care monthly, a monthly amount of Euro 154.20.- is granted, in the highest of the seven echelons the amount is Euro 1655.80.-. The patient decides whom to employ for long term care. Furthermore, persons with disabilities may receive funding for the employment of personal assistants to allow them to take part in professional life and society.

Because the 1993 Federal Care Allowance Act strengthened the purchasing power of care recipients, it was instrumental in expanding the market for social care providers, and in particular the market for informal forms of care, specifically 'round-the-clock' care carried out mainly by migrants from Central and Eastern Europe.<sup>62</sup>

Indeed, by the early 2000s, the practice of informally employing central and eastern European carers became so widespread that general practitioners would routinely refer patients (and/or their families) to relevant individual carers or agencies arranging carers both in rural and in urban areas. Apart from the financial incentive structure contributing to the emergence and growth of informal care work, the growth of the sector also reflected the more general trend towards mobile and home-based care as opposed to institutional social care.

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<sup>61</sup> Bundesministerium für Arbeit, Soziales und Konsumentenschutz - BMASK (2009) Behindertenbericht 2008. Bericht der Bundesregierung über die Lage von Menschen mit Behinderung in Österreich, p.190, available online at [http://www.bmask.gv.at/cms/site/attachments/9/3/4/CH0009/CMS1299764062407/behindertenbericht\\_09-03-17.pdf](http://www.bmask.gv.at/cms/site/attachments/9/3/4/CH0009/CMS1299764062407/behindertenbericht_09-03-17.pdf) (12.6.2011)

<sup>62</sup> S. Gendra (2011), 'Gaining an insight into Central European transnational care spaces: Migrant live-in care workers in Austria', in: M. Bommers / G. Sciortino (eds.) *Foggy social structures. Irregular Migration, European Labour Markets and the Welfare State*. Amsterdam: Amsterdam University Press (forthcoming)

In 2006, it became public that the family of the then chancellor employed an irregular care worker from Slovakia, while families of several high ranking politicians were found to employ informal care workers too. This sparked major public debates both about informal care work in particular and what was termed the 'care crisis', of which informal employment of irregular or semi-regular migrants was seen only as an expression, on the other.<sup>63</sup> As a result of these debates, a regularisation scheme for irregularly employed care workers, targeting specifically citizens from new EU-Member States, while excluding third country nationals. The scheme established a sponsorship model for care recipients at level three or higher who employed two live-in personal assistants on a rotating basis. In addition, a new job profile was defined and minimum salary, taxes and social security contributions adjusted in a way that it remained affordable to care recipients and their families. While the scheme foresaw both self-employed and employed care providers, only a minority of the total 20,000 persons registered under the new scheme at the end of 2009 were employed.<sup>64</sup> Thus in July 2008, some 90% to 95% of the 9,000 persons then registered under the scheme were estimated to be employed, with the overwhelming majority being registered as self-employed care workers.<sup>65</sup>

The following table gives an overview of entitlements, equality in health and groups in risk of exclusion:

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<sup>63</sup> A. Kraler, D. Reichel, C. Hollomey (2008), *Clandestino Country Report Austria. Clandestino - Undocumented Migration: Counting the Uncountable. Data and Trends Across Europe* (Revised and updated October 2009). Available at <http://clandestino.eliamep.gr/category/projects-reports/country-reports-reports/>, p.44

<sup>64</sup> S. Gendera (2011), 'Gaining an insight into Central European transnational care spaces: Migrant live-in care workers in Austria', in: M. Bommes / G. Sciortino (eds.) *Foggy social structures. Irregular Migration, European Labour Markets and the Welfare State*. Amsterdam: Amsterdam University Press (forthcoming). It should be noted that the figures refer to the overall number of care workers registered under the new scheme, including Austrian nationals and migrant care workers taking up work as care workers after the establishment of the scheme and the 'care amnesty' that was implemented simultaneously. The figures thus can't be read as regularisations.

<sup>65</sup> A. Kraler, D. Reichel (2009), 'Austria'. In: A. Kraler, M. Baldwin-Edwards (Eds.), *Regime. Regularisations in Europe*. Amsterdam: Pallas Publications, p.179

Table 1: Entitlements and risks of exclusion

Health entitlements	Provincial health fund	Other health fund	No health insurance	Groups at risk of exclusion
<b>MEDICAL TREATMENT</b>				
<b>Hospitals</b>				
Emergency treatment	Yes, cost-free. Costs for lodging apply	Yes, cost-free. Costs for lodging apply	Yes, costs may be reclaimed	None
Non-emergency hospital treatment	Yes, cost-free. Costs for lodging apply	Yes, cost-free. Costs for lodging apply	No	Irregular migrants, rejected asylum seekers, non-refoulment cases, persons earning below the insurance threshold without private insurance, persons without access to minimum social protection payment. Knowledge of German may be an issue influencing access and quality of treatment.
Outpatient treatment at a hospital	Yes, cost-free. Costs for lodging apply	Yes, cost-free. Costs for lodging apply	In case of emergency	See above
<b>Private practice (practitioner, specialist)</b>				
Treatment at a private practice holding a contract with the respective health fund	Yes, cost-free	Yes, cost sharing applies (in most cases 20%)	No	See above, knowledge of German is important issue influencing quality of treatment.
Treatment at a private practice not holding a contract with the respective health fund	Patient has to pay and is refunded partially	Patient has to pay and is refunded partially. Refund often higher than from provincial health fund	No	See above

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Health entitlements	Provincial health fund	Other health fund	No health insurance	Groups at risk of exclusion
<b>Dentist</b>				
Fixed denture	Patient has to pay and is refunded partially (approx. 2% to 5%).	Patient has to pay and is refunded partially. Refund often higher than from provincial health fund (approx. 10%)	No	See above
<b>Medication and therapeutic aid</b>				
Glasses	Limited selection available for small statutory fee. Costs for items of the limited selection refunded for other choices	Patient has to pay and is refunded partially;	In case of emergency	See above
Contact lenses	In case of medical necessity, small statutory fee	Patient has to pay and is refunded partially	No	See above
Other therapeutic aid	In case of medical necessity, small statutory fee	Patient has to pay and is refunded partially	In case of emergency	See above
Medication	Fee of 5,10.- for each packaging unit of medication up to an annual threshold of 2% of net income	Fee of 5,10.- for each packaging unit of medication up to an annual threshold of 2% of net income	In case of emergency	See above
Psychotherapy	Free or small statutory fee	Patient has to pay and is	No	See above

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	only as a client of psychotherapy associations organized by the health fund< partial refunding in other cases	partially refunded (approx. 20%)		
Rehabilitation	Cost sharing	Cost sharing	No	See above
<b>PREVENTION</b>				
Annual health screening	Cost-free	Cost-free	Cost-free	None. Knowledge of German may be an issue influencing access and quality of treatment.
Mother-child/card	Cost-free	Cost-free	Cost-free	None. Knowledge of German may be an issue influencing access and quality of treatment.
<b>REPRODUCTIVE MEDICINE</b>				
In vitro fertilization	For married couples only, cost sharing (approx. 30%)	For married couples only, cost sharing (approx. 30%)	No	
Abortion	Within first three months of pregnancy, patient has to pay	Within first three months of pregnancy, patient has to pay	Within first three months of pregnancy, patient has to pay	
<b>CARE</b>				
Rehabilitative care	Regulations on duration, type of care and cost sharing depend on province and reason for rehabilitative care	Regulations on duration, type of care and cost sharing depend on province and reason for rehabilitative care	No	Irregular migrants, rejected asylum seekers, non-refoulment cases, persons earning below the insurance threshold without private insurance, persons without access to minimum social protection payment. Knowledge of German may be an issue influencing access and quality of treatment
<b>LONG TERM CARE</b>				



## Inequalities and Multiple Discrimination in Access to Health in Austria

Federal Long Term Care Allowance Act	All recipients of a public pension, independent of residence status	Irregular migrants, rejected asylum seekers, non-refoulment cases, persons earning below the insurance threshold without private insurance, persons without access to minimum social protection payment
Provincial Long Term Care Allowance Acts	Persons not receiving a public pension, including family members and spouses. Legal claim for third country nationals holding a permanent residence permit in Lower Austria, the Tyrol and Vorarlberg. No legal claim for third country nationals; except of spouses and children of Austrian and EEA/citizens and recognized refugees in all provinces.	Further to the groups above: Third country nationals of countries not holding a bilateral social security agreement with Austria, third country national spouses and children of third country nationals, third country nationals not accepted as asylum seekers

## 4. Specific health policies targeting vulnerable groups

Low income groups, including persons outside employment are the main target group of policy measures aimed at preventing exclusion from access to health as well as of initiatives aiming at improving access to health. As a corollary, there are actually few policies and initiatives targeting specific categories such as migrants. Section 4.1 will therefore describe general policies adopted in regard to vulnerable groups. Specific initiatives regarding migrants will be described in section 4.2.

### 4.1. General policies targeting vulnerable groups

Since 2011, recipients of basic benefit provisions (“Bedarfsorientierte Mindestsicherung”)<sup>66</sup> are included into the respective provincial health fund in case they are not insured yet, replacing the previous social assistance schemes. Unemployed persons receiving supplementary basic benefit provision payments, because their unemployment benefits lay below the basic benefit provision level, are insured in the respective provincial health insurance fund by the employment authorities (BMSAK 2011, pp. 6).<sup>67</sup>

Access to basic benefit provisions in case of lack of sufficient income is limited to the following groups:

- Austrian citizens
- EU and EEA citizens with an employment history in Austria
- Recognised refugees
- Persons eligible to subsidiary protection
- Third Country Nationals in possession of a permanent residence title (long term residence – EC, long term residence – family member, document of residence, permanent residence permit)

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<sup>66</sup> As of September 1, 2010, the social assistance system, which was administered by the provincial governments, was replaced by a federal basic benefit provision system (“bedarfsorientierte Mindestsicherung”). The scheme includes a monthly payment of Euro 752.94.- monthly and compulsory health insurance with the respective provincial health insurance scheme. The provincial social assistance system in place until August 30, 2010, did not include compulsory health insurance (BMSAK 2011, p.4).

<sup>67</sup> Bundesministerium für Arbeit, Soziales und Konsumentenschutz - BMSAK (2011) Bedarfsorientierte Mindestsicherung (BMS). Fakten statt Mythen. Vienna. Available at: [http://www.bmsk.gv.at/cms/site/attachments/0/6/8/CH0052/CMS1248767097932/fakten\\_statt\\_mythen\\_web.pdf](http://www.bmsk.gv.at/cms/site/attachments/0/6/8/CH0052/CMS1248767097932/fakten_statt_mythen_web.pdf)

Asylum seekers, legally resident third country nationals with a temporary residence permit and irregular immigrants do not have access to basic benefit provisions. Thus asylum seekers not covered by federal care provisions, legally resident unemployed TCN with a temporary residence permit, who are not insured as workers, employers or self employed persons and may not claim insurance as a relative of an insured person, as well as irregular immigrants, run the risk of not having health insurance in the case they cannot afford it. They do have access to an annual health examination (“Gesundenuntersuchung”) and the mother-child-pass – programme.

Furthermore, prescription charges are generally limited to 2% of the annual net income. In case of an income below Euro 793.40 monthly for a single person and Euro 1,189.56 for a couple, an exemption from prescription charges may be claimed. In 2010, 490,000 patients were exempted permanently from prescription charges.

As mentioned above, in case of emergency hospitals are obliged to provide the necessary medical treatment, independently of insurance status.

## 4.2. Policies targeting immigrants

### 4.2.1. Responding to cultural diversity

There are no policies regarding the access of persons with other languages to the health system. The prevailing definition of integration as competency in German negatively influences the debate about the need of multilingual competencies or translation services in hospitals and other health care institutions. Nevertheless, there are several projects touching on the issue, which have developed a pro-active approach towards meeting the needs of persons lacking adequate language competency in German, but these projects have so far not been implemented into the regular routines of the health sector. One project in this field is the project “Migrant Friendly Hospital”, which has been implemented in the “Kaiser Franz Josef Spital” in Vienna in Austria and eleven other hospitals in other European countries and includes professional translating services for patients, courses on pregnancy and birth for pregnant women in the main languages of migrant groups in Vienna and intercultural training for staff members.<sup>68</sup> During the project, cooperation with FEM Süd, a health care centre focusing on the needs of migrant women, and a Turkish community interpreting service was implemented.

In particular, a list of language competencies among the staff was made available on the intranet of the hospital, information leaflets have been translated into the main

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<sup>68</sup> See [http://www.mfh-eu.net/public/partners/pilot\\_hospitals/AT\\_pilot\\_hospital.htm](http://www.mfh-eu.net/public/partners/pilot_hospitals/AT_pilot_hospital.htm) (12.6.2011)

languages spoken among the immigrant population of Vienna, and medical dictionaries for the main immigrant languages have been made available to the medical staff.<sup>69</sup>

The project has resulted in the launch of the Amsterdam Declaration, jointly developed by the partners of the MFH project containing policy recommendations on the issue.

The declaration starts with a summary analysis of the current situation of hospital services for migrants and ethnic minorities in Europe, highlighting quality-related problems for patients and staff. It assumes that improving quality for migrants and ethnic minorities as specific vulnerable groups would also serve the general interest of all patients in more personalised services. This is an issue high on the agenda of the Health Promoting Hospital network. So improvements could be achieved for all by making hospitals more responsive to ethnic, cultural and other social differences of patients and staff. In the second part of the Amsterdam Declaration, twenty-six recommendations are made for specific contributions to quality improvement by hospital management and staff, by health policy, by patient organisations and the health sciences.

These include i.a. the recommendation to develop services and organisational cultures (recommendations 1-11), i.a. to invest into more individualised and person-oriented services (recommendation 1), to increase awareness of migrant population experiences and existing health disparities and inequalities (recommendation 2), and to invest in capacity building with regard to staff's cultural and linguistic competence (recommendation 11). Furthermore, it recommends to better prepare hospital staff in achieving competency in these issues (recommendations 12-16), to stimulate inclusion of patients' organisations and migrant community representatives (recommendations 17-19), to better reflect migrant issues in health policies (recommendations 20-21) and in health sciences (recommendation 22-26).<sup>70</sup>

The declaration has been endorsed by a large number of European and international organisations, representatives of which presented their perspectives on the Amsterdam Declaration at the conference: the European Commission, DG Health and Consumer Protection, WHO Centre for Integrated Care (WHO), International Labour Organisation (ILO), International Organisation for Migration (IOM), International Alliance of Patients' Organizations (IAPO), Standing Committee of the Hospitals of the EU (HOPE), International Union of Health Promotion and Education (IUHPE), Migrants Rights International, United for Intercultural Action, PaceMaker in Global Health.).

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<sup>69</sup> M. Endler (2004) *Das "migrant-friendly hospital"- Projekt im Kaiser Franz Josef Spital in Wien.* available at <http://lbimsgs-archiv.lbg.ac.at/present/jf24112004.pdf>

<sup>70</sup> The Amsterdam Declaration; Towards Migrant-Friendly Hospitals in an ethno-culturally diverse Europe, available at: [http://www.mfh-eu.net/public/files/european\\_recommendations/mfh\\_amsterdam\\_declaration\\_english.pdf](http://www.mfh-eu.net/public/files/european_recommendations/mfh_amsterdam_declaration_english.pdf), Last accessed 02.05.2011

Persons with other languages may find information about physicians speaking other languages than German on the webpage of the Austrian Medical Chamber. Most large hospitals in the cities and towns with a high percentage of immigrant population offer their information leaflets in several languages, e.g. English, Serbo-Croatian and Turkish. The provision of multilingual information material largely depends on the decision of the hospital provider, there are no general policies regarding the provision of multilingual information implemented. Most larger hospital also offered intercultural competency training for their staff at a voluntary base.

As a recent report has shown, migrants of high age (75+) living in Austria – a group of approx. 70.000 people<sup>71</sup> – are reporting health related problems by far more often than non-migrants of the same age group (80% as compared to 53%). In particular, they record high on indicators of psycho-social strain, in particular fear of loneliness (100% as compared to 36%) and depression (100% as compared to 78%). Only 30% (as compared to 94% among non-migrants of high age) report that they felt well and were happy (40% as compared to 85%). Nevertheless, their take-up rate of support services is extremely low: None of the migrants interviewed made use of household support services (non-migrants: 51%), or meals on wheels (non-migrants: 10%). 94% and 91% respectively reported unsatisfactorily housing and income conditions, as compared with 30% and 33% of among the seniors living in Austria since birth.<sup>72</sup>

The low take-up rate of support-service may be at least partly be explained by the lack of adaptation of these services to the growth of diversity among the elderly. According to a recent diploma thesis based on qualitative interviews with elderly persons of Turkish origin in Vienna, there was a lack of culturally sensible care within the institutions caring for the elderly. In particular, the homes for the elderly would not take enough care for religiously founded dietary needs (halal food) and cultural taboos regarding gender in the delivery of personal hygiene to persons in need of support. The public agencies offering home care for elderly persons would not be prepared to match the language competencies of their personnel with those of their clients, who often would not be fluent in German. Due to the lack of culture-conscious care, the lack of respect for religiously founded dietary needs and the lack of communication in their mother tongue, the option to move to a home for the elderly would be rejected by most interview partners. Furthermore, homes for the elderly would only be accessible to Austrian and EEA-citizens and third country nationals holding a permanent residence permit.<sup>73</sup>

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<sup>71</sup> Ch. Reinprecht (2009): Hochaltrige MigrantInnen. In: Büro für Sozialtechnologie und Evaluationsforschung (eds.): Hochaltrigkeit in Österreich. Eine Bestandaufnahme. Vienna (Federal Ministry of Work, Social Affairs and Consumer Protection, p. 253.

<sup>72</sup> Ch. Reinprecht (2009): Hochaltrige MigrantInnen. In: Büro für Sozialtechnologie und Evaluationsforschung (eds.): Hochaltrigkeit in Österreich. Eine Bestandaufnahme. Vienna (Federal Ministry of Work, Social Affairs and Consumer Protection, p. 256.

<sup>73</sup> N. Altintop (2010): Wie sich türkischsprechende Migranten in Wien ihre Zukunft im Alter vorstellen. Diploma Thesis, University of Vienna, p. 5.

Both studies hint at a prevalent lack of understanding of the challenge of ageing in an immigration society among the institutions responsible for delivering services in this area.

### 4.2.2. Initiatives targeting non-insured and other vulnerable migrants

Some hospitals – often with a confessional background, like the hospital of the Barmherzigen Brüder (“brothers of mercy”) offer free treatment for people without health insurance, many of them migrants. Every year around 20.000–30.000 patients without insurance get treatment there, of which 1.000–5.000 are hospitalised. The hospital offers the whole range of outpatient and inpatient services of a public hospital. It is funded by the provincial health fund of Vienna and by donations.<sup>74</sup>

Medical care for persons without health insurance is also provided by NGOs. The two largest of them active throughout Austria are AMBER-MED and the Marienambulanz.<sup>75</sup>

AMBER-MED is a joint project of the refugee service of Diakonie Austria, the main social assistance organisation of the protestant churches, and the Austrian Red Cross. AMBER-MED provides outpatient treatment, social counselling and medication for people without insurance coverage in Vienna. The services offered are free of charge and anonymous and include for example general medicine, gynaecological examinations, paediatric care and diabetes care. In 2007, 889 patients, the majority of whom were asylum seekers, refugees and homeless people, made use of the services. There are no data available about the insurance-status of the clients, but as AMBER-MED is targeting persons without insurance coverage, it is likely that the majority of their clients were not covered by a health insurance fund. Until 2006, AMBER-MED was financed exclusively through donations. In 2007, the organisation started receiving subsidies from the Federal Ministry of Health and the Fund for Social Affairs in Vienna (Fonds Soziales Wien), and since 2008, also from the Vienna Health Insurance Fund (Wiener Gebietskrankenkasse).<sup>76</sup>

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<sup>74</sup> Platform for International Cooperation on Undocumented Migrants (2007) *Access to Health Care for Undocumented Migrants in Europe*

<sup>75</sup> Ambulant-medizinische und soziale Beratung mit Medikamentenhilfe für Menschen ohne Versicherung – AMBER-MED (2008) Jahresbericht 2008. Available at *Caritas Marienambulanz*, Available at [http://www.caritassteiermark.at/fileadmin/user/steiermark/fotos\\_pdf\\_medien/Hilfe\\_und\\_Einrichtung\\_en/fuer\\_Menschen\\_in\\_Not/Gesundheit/Marienambulanz/Downloads/MA\\_IB\\_2010\\_druckfertig.pdf](http://www.caritassteiermark.at/fileadmin/user/steiermark/fotos_pdf_medien/Hilfe_und_Einrichtung_en/fuer_Menschen_in_Not/Gesundheit/Marienambulanz/Downloads/MA_IB_2010_druckfertig.pdf); M. Sprenger, C. B. Bruckner (2008) Ergebnisbericht Evaluation: Caritas Marienambulanz [http://www.rotekreuz.at/fileadmin/user\\_upload/PDF/GSD/Jahresbericht\\_AmberMed\\_2008.pdf](http://www.rotekreuz.at/fileadmin/user_upload/PDF/GSD/Jahresbericht_AmberMed_2008.pdf); Caritas (2010) *Jahresbericht 2010. Ambulatorium*

<sup>76</sup> Amber MED (2010) *Jahresbericht 2010*, available at [http://amber.diakonie.at/Data/content/MediaDB/content/AMB/content/downloadable-files-berichte/1301987969\\_xfsn765fmx/Jahresbericht%20Amber-Med%202010.pdf](http://amber.diakonie.at/Data/content/MediaDB/content/AMB/content/downloadable-files-berichte/1301987969_xfsn765fmx/Jahresbericht%20Amber-Med%202010.pdf)

Since 1999, the Marienambulanz in Graz, Styria, has provided primary health care for people without insurance coverage and for other marginalised groups. The Marienambulanz is a service of Caritas Austria. An outpatient department offers general medicine care as well as target group oriented care (e.g. diabetes, hypertension, psychiatric disorders). Furthermore, there is a mobile unit that visits different places in Graz once a week to provide medical and psycho-social care and counselling. In 2007, 7.954 documented contacts and 1.250 patients from 72 nations were treated and counselled in the outpatient department. About the half of the patients were without insurance coverage. The Marienambulanz co-operates closely with health authorities and institutions. It is financed by the Federal Ministry for Health, Family and Youth, the province of Styria, the Municipal Health Authority of the city of Graz and the Caritas.<sup>77</sup> (The high demand for these services can be partly explained by the fact, that the “Vinzenzgemeinschaft”, a charity close to the Catholic Church, runs a project supporting a large group of Roma from Slovakia, who come to Graz for begging, and also consult the Marienambulanz for medical treatment.

Other projects aiming specifically at migrants are the Centre for Womens’ Health F.E.M and F.E.M Süd in Vienna and the Centre for Mens’ Health M.E.N in Vienna, organised by the Association for Womens’ and Mens’ Health.<sup>78</sup> These centres are specialised in gender-sensible health information and counselling and offer interdisciplinary health advice also in the languages of the main immigrant groups (Bosnian/Croatian/Serbian, Turkish, Arabic, French, English).

“FEM SÜD” specifically targets women in risk of poverty and reaches out to women not reached by the regular health system. It offers a broad range of medical assistance and services and focuses on empowerment with regard to health and everyday life.<sup>79</sup>

The seven provincial Aids Federations offer free and anonymous HIV testing and give advice with regard to the medical, psychological and social aspects of HIV. The services are also offered to persons without insurance.<sup>80</sup>

### 4.3. Policies regarding disabled persons

Health care entitlements are universal and not targeted towards certain groups. Thus, persons with disabilities do have access to health services on the same basis as the general population. In practice, several measures are taken up primarily by persons with disabilities, in particular long term care benefits of the provinces or the federal state.

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<sup>77</sup> M. Sprenger, C. B. Bruckner (2008) *Ergebnisbericht Evaluation: Caritas Marienambulanz*

<sup>78</sup> <http://www.fem.at/>

<sup>79</sup> Institut für Frauen- und Männergesundheit (2009) *Tätigkeitsbericht 2009*, available at [http://www.fem.at/FEM\\_Sued/files/TKB\\_2009.pdf](http://www.fem.at/FEM_Sued/files/TKB_2009.pdf)

<sup>80</sup> See <http://www.aidshilfen.at/>

In 2009, the umbrella organisation of social services in Vienna – the “Dachverband Wiener Sozialeinrichtungen”, an association including 70 private welfare organisations and associations active in the field of inpatient and ambulant care, which has been founded by the City of Vienna and serves as the main contact point of the City government to the welfare organisations,<sup>81</sup> criticised the lack of equal access to health care for persons with disabilities. Persons with disabilities would suffer from unequal access to physicians and a lacking readiness of the medical professions to spend time and resources on their needs. Patients with disabilities often would be confronted with unclear diagnosis, premature release from hospital and insufficient medical care.<sup>82</sup>

The accessibility of medical practices is a further problem mentioned by the organisations of people with disabilities. Accessibility of the premises has become a criterion for contracting with the public health insurance fund recently, and the Austrian Medical Chamber has implemented a web-based data base about physicians specialised on treating persons with disabilities (<http://www.arztbarrierefrei.at/>). The new framework-contracts between the Austrian Medical Chamber and the public health insurance fund include provisions on subsidies for providing barrier-free access to medical practices.<sup>83</sup>

As only the name of the drug and not the instruction sheet has to be printed in Braille-scripture on the package of the medicament, the Chamber of Pharmacists has established a telephone-hotline for blind persons and persons with visual impairments, where callers are informed about the content of the instruction sheets of a medicament. The hotline (telephone number 1455), which also gives information about the location of pharmacies and opening hours, can be reached 24 hours at seven days a week and was opened on January 1, 2011. It can be used free of charge.<sup>84</sup>

The NGO “Bizeps”, which represents the interests of persons with disabilities, has tested and analysed the access of persons with disabilities to health services in Vienna and published a report listing all medical practices and institutions with barrier-free access and all medical practices and institutions particularly suitable for persons with disabilities.<sup>85</sup> The project was implemented jointly with the Austrian Medical Chamber in Vienna and is regularly updated. The publication also lists all organisations providing support to persons with disabilities and all public sector institutions active in this field

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<sup>81</sup> See the webpage of the association at <http://www.dachverband.at/ueber-uns/>

<sup>82</sup> Dachverband Wiener Sozialeinrichtungen (2009) *Positionspapier zur medizinischen Versorgung von PatientInnen mit Behinderungen in Wien*, p. 19

<sup>83</sup> K. Markarizer (2010) Barrierefreiheit: Ab 2016 drohen Strafen, in *Österreichische Ärztezeitung*, (25.11.2010)

<sup>84</sup> See <http://www.oebsv.at/home/129>

<sup>85</sup> BIZEPS (2010) *Krank, behindert, ungehindert.... In Wien*, Available at <http://www.bizeps.or.at/broschueren/krank/>



and contains a number of suggestions for improvement. The brochure can be downloaded free of charge.<sup>86</sup>

Persons with disabilities may receive a “disability card” (“Behindertenausweis”) by the Federal Social Welfare Authority after medical examination by a medic of the Federal Social Welfare Authority. The card gives information about the type of disability and percentage of disablement and is used when claiming benefits.

The Federal Disability Equality Act (Bundesgesetz über die Gleichstellung von Menschen mit Behinderungen (Bundes-Behindertengleichstellungsgesetz – BGStG) demands barrier-free access to buildings and other facilities, like e.g. streets, parks or sports premises, and to the public transport systems. Technical appliances, e.g. mobile phones or computers, have to be accessible without barriers. The Act allows delaying barrier-free access until January 1, 2016, and there are exemptions for unreasonable measures. Lack of barrier-free access to public institutions and buildings constitutes indirect discrimination.

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<sup>86</sup> See <http://www.bizeps.or.at/broschueren/krank/>).

## Part II – Discrimination, multiple discrimination and health<sup>87</sup>

### 5. General description of discrimination legislation

#### 5.1. Constitutional regulations

The Austrian Constitution grants the right to equal treatment to Austrian nationals (Article 7 B-VG). The Constitution also provides that privileges according to birth, sex, social status, class and religion are excluded and that no one may be disadvantaged on the basis of his/her disability. The list is merely demonstrative and does not exclude other grounds, like e.g. ethnicity or race, which have been judicated several times<sup>88</sup> (According to the jurisdiction of the Constitutional Court foreigners may be treated differently than Austrians in areas wherever permitted by law, but unequal treatment of different groups of foreigners is unconstitutional, except where explicitly permitted (e.g. different treatment of EU citizens compared to third country nationals). The constitutional equal treatment clause is only binding for the state and cannot be enforced against private actors, including i.a. private hospitals. The Equal Treatment Act (Gleichbehandlungsgesetz)<sup>89</sup> is the relevant provision prohibiting discrimination (see below).

According to the Constitutional Act BGBl 1964/59, the European Convention of Human Rights (ECHR) and its protocols have constitutional status. Furthermore, the Constitution contains several special provisions banning discrimination on the basis of race, language or religion based on state treaties (Art. 66 & 67 Treaty of St. Germain 1919) or on the basis of race, colour, descent or national or ethnic origin based on international conventions (Art. I Federal Constitutional Act for the Implementation of the Convention on the Elimination of all Forms of Racial Discrimination 1973).<sup>90</sup>

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<sup>87</sup> Part II of the report has been authored by Bernhard Perchinig

<sup>88</sup> D. Schindlauer (2009a) *Report on measures to combat discrimination. Directives 2000/43/EC and 2000/78/EC. Country report 2009*, p. 16

<sup>89</sup> BGBl. I Nr. 82/2005 last amended by BGBl. I Nr. 98/2008

<sup>90</sup> D. Schindlauer (2009a) *Report on measures to combat discrimination. Directives 2000/43/EC and 2000/78/EC. Country report 2009*, p. 14

According to Article 14 paragraph 6 of the Federal Constitution public schools, nurseries, day care centres and student homes are accessible to anyone regardless of among other things race, religion or language.

The Constitution also includes the commitment of the Republic of Austria to guarantee equal treatment of disabled and non-disabled persons in all areas of daily life (Art. 7 par. 1 B-VG) and to real equalisation of man and woman (Art. 7 par. 2 B-VG). In addition to those provisions of the federal constitution, some of the constitutions of the nine Austrian provinces contain fundamental rights, among them equality rights.<sup>91</sup>

## 5.2. The antidiscrimination legal framework

Since 2007, the EU antidiscrimination acquis is fully implemented into national law. The implementation is characterised by the basic legal structure of Austria. Austria is a federal state with nine provinces. Legislative powers are divided between the federal parliament and provincial parliaments. Legislative powers are defined by the Constitution, which explicitly lists all matters due to be regulated by the federal parliament. With regard to these matters, provincial parliaments do not have legislative power. Matters not explicitly defined by the Constitution as federal matters are to be regulated by the provincial parliaments.

The federation may implement antidiscrimination clauses only if the areas concerned are linked to matters falling into the legislative powers of the federation (e.g. most areas of labour law, public transport law, civil law, including e.g. consumer protection). Antidiscrimination legislation with regard to the employees and civil servants of the nine provinces and the local authorities, except of teachers at public schools and at certain agricultural schools, which are covered by federal legislation, falls exclusively into the legislative powers of the provinces. With regard to the area of labour law and labour protection of agricultural workers and employees legislative powers are divided between the federation (legislation of principles) and the provinces (implementing legislation).<sup>92</sup>

In other areas, e.g. self-employment, education/training and occupational organisations, legislative powers are divided between the provinces and the federation according to level of organisation or historical development. So the provinces hold e.g. legislative powers for kindergartens and juvenile educational institutions, hospitals or nursing homes, ambulance services, funeral-services, fire-brigades and chambers<sup>1</sup> of agricultural workers/employers (Art. 10 – 15 B-VG).

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<sup>91</sup> D. Schindlauer (2009a) *Report on measures to combat discrimination. Directives 2000/43/EC and 2000/78/EC. Country report 2009*, p. 15

<sup>92</sup> D. Schindlauer (2009a) *Report on measures to combat discrimination. Directives 2000/43/EC and 2000/78/EC. Country report 2009*, p. 4

Again it has to be mentioned, that the constitutional provisions prohibiting discrimination are only binding for the state and law-making authorities and have not been implemented in anti-discrimination clauses applicable to the private sector. This relationship is regulated by civil law, the respective antidiscrimination acts apply.

This basic and very complex constitutional framework does not allow the implementation of a single Antidiscrimination Act, but separate federal and provincial acts have to be implemented to cover all areas of relevance. In particular, all areas under legislative competence of the provinces have to be covered by respective provincial legislation. As the Constitution covers discrimination due to disability and already before the entrance into force of the EU antidiscrimination-acquis a federal act regarding disability issues and specific enforcement structures existed, the parliament decided to draft a separate bill regarding disability. This decision also had been the wish of the major NGOs active in the area of disability.

The federal legal framework basically consists of:<sup>93</sup>

- Equal Treatment Act (Gleichbehandlungsgesetz, Federal Law Gazette I Nr. 82/2005 last amended by BGBl. I Nr. 98/2008) containing federal equal treatment provisions binding private entities and fiscal activities
- Federal-Equal Treatment Act – (Bundes-Gleichbehandlungsgesetz], BGBl. I Nr. 65/2004), Federal Law Gazette I Nr. 65/2004) containing federal equal treatment provisions binding the federal administration
- Act on the Equal Treatment Commission and the Equal Treatment Office (Bundesgesetz über die Gleichbehandlungskommission und die Gleichbehandlungsanwaltschaft), BGBl. I Nr. 66/2004), both Federal Law Gazette I Nr. 66/2004 last amended by BGBl. I Nr. 82/2005, which installs and regulates the functions of the Equal Treatment Commission and the National Equality Body (for grounds of sexual identity and gender, ethnic affiliation, religion and belief, sexual orientation and age)
- Act on the Employment of People with Disabilities, (Behinderteneinstellungsgesetz, BGBl. Nr. 22/1970, last amended by Federal Law Gazette I Nr. 82/2005), which inter alia protects against discrimination on the ground of disability in employment and occupation including the concept of reasonable accommodation.
- Federal Disability Equality Act, (Behindertengleichstellungsgesetz], BGBl I Nr. 82/2005, Federal Law Gazette I Nr 82/2005), which regulates the non-employment part of protection against discrimination on the ground of disability, including access to and supply of goods and services, which are available to the public, including housing.

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<sup>93</sup> D. Schindlauer (2009a) *Report on measures to combat discrimination. Directives 2000/43/EC and 2000/78/EC. Country report 2009*, p. 5f

- Federal Disability Act, (Bundesbehindertengesetz), BGBl Nr. 283/1990, last amended by Federal Law Gazette I Nr. 82/2005), installing the Ombud for persons with disabilities.

In all provinces implementing legislation does exist.<sup>94</sup> As according to the federal constitution agriculture and forestry are the remit of the provincial governments, in all provinces, there are specific legal acts on equal treatment with regard to the labour market for agricultural and forestry workers.<sup>95</sup>

In Lower Austria<sup>96</sup>, the Tyrol<sup>97</sup> and Vienna<sup>98</sup> separate equality bills with regard to the employment with the provincial and the municipal workforce (civil servants and contracted workers for the public authorities) do exist. In these provinces, the non-employment scope of the directives is covered by specific legal acts.<sup>99</sup>

In the Burgenland<sup>100</sup>, Carinthia<sup>101</sup>, Salzburg<sup>102</sup>, Styria<sup>103</sup>, Upper Austria<sup>104</sup> and Vorarlberg<sup>105</sup> the employment and the non-employment scope of the directives are covered in a single provincial legal act.

In all provinces, specialised bodies for the implementation of antidiscrimination regulations in the areas covered by provincial legislation do exist. They vary widely with regard to organisational structure, level of activity, visibility and accessibility.<sup>106</sup>

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<sup>94</sup> D. Schindlauer (2009a) *Report on measures to combat discrimination. Directives 2000/43/EC and 2000/78/EC. Country report 2009*, pp. 88-97

<sup>95</sup> Burgenländische Landarbeitsordnung, LGBL. 37/1977, as amended 86/2009, Kärntner Landarbeitsordnung, LGBL. 97/1995, as amended LGBL. 10/2009, Niederösterreichische Landarbeitsordnung, LGBL. 185/1973, as amended LGBL. 5/2008, Oberösterreichische Landarbeitsordnung, LGBL. 25/1989, as amended LGBL. 44/2009, Salzburger Landarbeitsordnung, LGBL. 7/199, as amended LGBL. 44/2009, Steiermärkische Landarbeitsordnung, LGBL. 29/2002, as amended 8LGBL. 5/2008, Tiroler Landarbeitsordnung, LGBL. 27/2000, as amended LGBL. 38/2009, Vorarlberger Land- und Forstarbeitergesetz, LGBL. 28/1997, as amended LGBL. 1/2011, Wiener Land- und Forstwirtschaftliches Gleichbehandlungsgesetz, LGBL. 25/1980, as amended LGBL. 28/2008.

<sup>96</sup> Niederösterreichisches Gleichbehandlungsgesetz, LGBL. 69/1997, as amended 65/2004

<sup>97</sup> Tiroler Landesgleichbehandlungsgesetz, LGB. 1/2005, as amended LGBL. 39/2008

<sup>98</sup> Wiener Dienstrechtsordnung, LGBL. 42/2006, as amended LGBL. 20/2009

<sup>99</sup> Niederösterreichisches Antidiskriminierungsgesetz, LGBL. 45/2005, as amended LGBL. 148/2009; Tiroler Antidiskriminierungsgesetz LGBL. 25/2005, as amended LGBL. 41/2008; Wiener Antidiskriminierungsgesetz LGBL. 35/2004, as amended 13/2008.

<sup>100</sup> Burgenländisches Antidiskriminierungsgesetz, LGBL. 84/2005

<sup>101</sup> Kärntner Antidiskriminierungsgesetz, LGBL. 63/2004

<sup>102</sup> Salzburger Gleichbehandlungsgesetz, LGBL. 31/2006, as amended LGBL. 44/2009

<sup>103</sup> Steirisches Gleichbehandlungsgesetz, LGBL. 66/2004, as amended LGBL. 81/2010

<sup>104</sup> Oberösterreichisches Antidiskriminierungsgesetz, LGBL. 50/2005, as amended LGBL. 136/2007

<sup>105</sup> Vorarlberger Antidiskriminierungsgesetz, LGBL. 17/2005, as amended 49/2008

<sup>106</sup> D. Schindlauer (2009a) *Report on measures to combat discrimination. Directives 2000/43/EC and 2000/78/EC. Country report 2009*, p. 6

All provincial equality acts mention the field of health. This is particularly relevant with regard to hospitals, the majority of which is owned by provincial or local governments. As discussed below, there is no court decision yet available clarifying if issues of medical treatment have to be understood as based in civil or public law, thus the real impact of the provincial equality acts on the field of health has not been finally decided yet.

With regard to the health sector, a complex situation arises: With regard to all employment-related aspects, discrimination issues regarding the employment of employees or civil servants of provincial hospitals fall under the remit of the provincial antidiscrimination acts and thus are to be dealt with by the provincial equal treatment authorities. Discrimination issues regarding the employment of employees at private practices or private hospitals fall under the remit of the federal equal treatment legislation and thus are to be dealt with by the federal equal treatment authorities.

Discrimination issues regarding the relationship between patients and practitioners or specialists in private practice or between patients and private hospitals fall under the remit of the federal equal treatment legislation and thus are to be dealt with by the federal equality authorities, as the relationship between a patient and a private practice or a private hospital falls into the realm of civil law.

As no court decisions on discrimination with regard to provincial or municipal hospitals have been published yet, it is not clear, whether the relationship between patients and a provincial or municipal hospital or caretaking institution falls under federal or provincial legislation.

Among the legal experts contacted<sup>107</sup> four different opinions can be found: According to one school of thought, any medical treatment is based on an implicit civil law contract. This argument is supported by the fact, that patients are usually insured by a public health fund or a private insurance company holding a contract with the hospital or doctor.

According to this argumentation, all cases involving medical treatment and harassment of a patient by the staff of the hospital or institution fall under the remit of the Equal Treatment Commission, independently of the owner of the hospital or private practice. Only the disciplinary consequences in cases of harassment would have to be dealt with according to the regulations of the respective provincial equality legislation.

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<sup>107</sup> The following experts have been contacted: Dr. Karin Koenig, Head of Legal Section, Department for Integration and Diversity of the Magistrate of the City of Vienna, Mag. Dieter Schindlauer, Legal Expert for Austria, European network of legal experts in the non-discrimination field, Mag. Florian Panthene, Head of Legal Section, Equal Treatment Ombud, Mag. Johann Gibitz, Head of Legal Section, Disability Equality Ombud, Mag. Christoph Grager, Head of Legal Section, Patients' Ombud of the Province of Vorarlberg.

According to the view of the Head of the Legal Section of the Equal Treatment Ombud, Mag. Florian Panthene<sup>108</sup>, in the case of harassment of a patient or a visitor by another patient or visitor, the prohibition of harassment would imply third-party liability to be dealt with according to the respective article of the Civil Law Code.<sup>109</sup> Thus federal law would apply and the Equal Treatment Commission would be the relevant specialised body. The same would count for harassment of a visitor by a staff member, also in this case no contractual relationship could be assumed, but third-party-liability would apply. The Equal Treatment Ombud has published a legal expertise on this subject<sup>110</sup>, but the question has not been decided by a competent court yet.

The second school of thought is based on the assumption, that medical services offered in a public hospital must not be understood as a contractual relation based on civil law, but as publicly available social services. The area of social services is regulated by public law, thus for experts following this line of reasoning, the decisive factor is the type of legislation governing the respective institution – according to their view, discrimination cases in institutions governed by provincial law also have to be handled according to provincial equality legislation, as well with regard to treatment as to harassment. Securing a decent and discrimination-free atmosphere within the institution would be a task of the institution, thus also with regard to harassment by another patient or visitor provincial antidiscrimination legislation would apply. This view is supported by e.g. the legal expert of the City of Vienna contacted.<sup>111</sup>

According to the view of the Legal Services of the Government of Vorarlberg, the provincial antidiscrimination bills would be the relevant law and the Patients' Ombudsman of the province the relevant authority for all cases regarding discrimination in the health sector, including disability<sup>112</sup>. It has to be mentioned, that a regulation explicitly defining the provincial equality and antidiscrimination legislation as relevant for the health sector is enshrined only in the provincial antidiscrimination legislation of Vorarlberg, but cannot to be found in the other provincial equality and antidiscrimination acts; By reason of analogy, this provincial regulation may support the position outlined above.

A fourth legal opinion is presented by the Head of the Legal Section of the Disability Equality Ombud, Mag. Johann Gibitz<sup>113</sup>. According to the understanding of the Disability

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<sup>108</sup> Telephone conversation with Mag. Florian Pantene, July 18, 2011

<sup>109</sup> Art. 1313a ABGB

<sup>110</sup> B, Beclin (2010): *Gutachtliche Stellungnahme zur Frage der Haftpflichtigen und der Verantwortung für Dritte nach dem III. Teil des GIBG*. Available at: <http://www.gleichbehandlungsanwaltschaft.at/DocView.axd?CobId=42873>

<sup>111</sup> Telephone conversation with Dr. Karin König, Head of Legal Section, Department of Integration and Diversity of the City of Vienna, Julz 18, 2011.

<sup>112</sup> Office of the Government of Vorarlberg, Letter to the Patients' Ombudsman of Vorarlberg, 11-10-2011, PrsG-030.10

<sup>113</sup> E-Mail to the author, 2011/07/10.

Equality Ombud, discrimination with regard to access to medical treatment and to medical treatment would clearly fall under the remit of federal legislation, as a contractual relationship between the hospital and the patient and his/her private insurance fund or private insurance company would have to be assumed. Harassment of a patient or a visitor by a staff member would fall into the responsibility of the owner of the hospital/institution. Thus in case of ownership by a municipality or province, provincial equality and/or antidiscrimination legislation would apply. In case of harassment by another patient or visitor neither federal nor provincial equality and/or antidiscrimination legislation would apply, as neither a contractual relationship nor a responsibility of the owner of the hospital could be assumed. In this case penal law would apply and the victim of harassment would have to bring an action against the perpetrator at the respective criminal court with regard to a potential violation of the penal code.

These different legal views also effect on the correct choice of equality bodies.

Following the assumption, that all aspects of discrimination with regard to health fall into the remit of federal legislation, the Federal Equal Treatment Commission would be the correct institutional choice in all cases except of discrimination on the ground of disability or multiple discrimination involving disability, in this case the arbitration procedure at the provincial offices of the Federal Social Welfare Office would have to be chosen. Whereas in all discrimination cases except of discrimination on the ground of disability or multiple discrimination involving disability the potential victim would have the right to approach the respective court immediately or after the procedure at the Equal Treatment Commission, potential victims of discrimination on the ground of disability or multiple discrimination involving disability only would be entitled to approach the court after arbitration at the provincial offices of the Federal Social Welfare Office had failed.

Following the assumption, that all aspects of discrimination with regard to health, which had taken place at a provincial or municipal hospital or institution, would fall into the remit of provincial legislation, the respective provincial specialised body would have to be consulted in all cases regarding discrimination and/or harassment in the health sector. Also in this case, potential victims of discrimination because of disability or of multiple discrimination involving disability would only be entitled to approach the court after arbitration at the provincial offices of the Federal Social Welfare Office had failed.

Following the assumption, that all aspects of discrimination with regard to access to medical treatment and medical treatment fall under the remit of federal legislation, harassment by a staff member under the remit of provincial legislation, and harassment by a patient or visitor under civil and penal law, in case of discrimination with regard to access to medical treatment and medical treatment the Federal Equal Treatment Commission would be the correct institutional choice in all cases except of



discrimination on the ground of disability or multiple discrimination involving disability. In a case of discrimination on the ground of disability or multiple discrimination involving disability the arbitration procedure at the provincial offices of the Federal Social Welfare Office would have to be chosen.

In the case of harassment by a staff member the respective provincial specialised body would be the right choice. In the case of harassment by a patient or visitor the potential victim would have to bring an action against the perpetrator at the respective criminal court with regard to a potential violation of the penal code.

The provincial antidiscrimination act of Vorarlberg<sup>114</sup> defines the provincial patients' ombud as the relevant specialised body with regard to all areas of competence of the patients' ombud, which includes provincial hospitals (§ 11b); and the provincial ombudsmen board as the relevant specialised body with regard to all other areas.<sup>115</sup>

Thus in the province of Vorarlberg a specific situation might arise. Patients looking for advice or an amicable solution with regard to a case of discrimination regarding medical treatment in a provincial hospital or a provincial or municipal nursing home would have to approach the provincial patients' ombud, and the Vorarlberg equality and antidiscrimination legislation would apply. As the constitution safeguards the right of equal treatment, the patient would still have the right to approach the Federal Equality Commission to have the case examined and a conclusion passed, in case no amicable solution could be reached. If the patient wanted to seek compensation by a court decision, s/he would have to approach the respective court. As described above, there might be different legal views as to what type of legislation would have to be applied in this case.

Civil law is in principle in the competence of the federation, but the provinces may adopt the provisions "necessary for the regulation of subject also in the field of criminal and civil law." (Art. 15 Federal Constitutional Law) in their field of competence.<sup>116</sup> This provision is only of limited importance for the health sector, in particular the relationship between patients and health providers, which are regulated by federal civil law.

As in the majority of cases, a contractual relationship may be assumed and thus federal law applies, the federal level may be regarded as more important than the provincial level. The extremely complex and fragmented implementation of the EU-antidiscrimination acquis at the federal and the provincial level and the open questions with regard to applicable law and responsible specialised body may negatively impact

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<sup>114</sup> Vorarlberger Antidiskriminierungsgesetz, LGBl. 17/2005, as amended LGBl. 49/2008.

<sup>115</sup> A provincial ombudsmen board only exists in the province of Vorarlberg.

<sup>116</sup> D. Schindlauer (2009a) *Report on measures to combat discrimination. Directives 2000/43/EC and 2000/78/EC. Country report 2009*, p.5

on access to justice with regard to equal treatment: Potential victims of discrimination having chosen the wrong legal avenue and specialised body might miss legal deadlines for a procedure before the correct specialised body and thus might be excluded from access to justice with regard to equal treatment.

### 5.3. Grounds of discrimination covered

The Equal Treatment Act is divided into three parts. Section I covers equal treatment of men and women in the work life, Section II equal treatment in working life with regard to ethnic affiliation, religion or belief, age, and sexual orientation, Section III covers equal treatment with regard to gender and ethnic affiliation in the other areas, namely social protection and social security, including health, social benefits, education and access to and supply of goods and services, which are available to the public, including housing. Due to the federal structure of Austria, equal treatment with regard to gender and ethnic origin in employment and occupation in agriculture is regulated in a separate section.

In the Federal Equal Treatment Act, Section I covers equal treatment of men and women in work life, Section II equal treatment with regard to ethnic affiliation, religion or belief, age, and sexual orientation. As the Federal Equal Treatment Act only relates to the employment in federal public service, it contains no regulations regarding other fields.

The Act on the Employment of People with Disabilities covers equal treatment of people with disabilities with regard to employment and occupation, including the concept of reasonable accommodation.

The Federal Disability Equality Act regulates the non-employment related part of protection of discrimination on the ground of disability, including access to and supply of goods and services, which are available to the public, which also includes access to housing. This formula is usually understood to cover also access to publicly available health services.

Table 2, overleaf, shows the protected grounds covered by the provincial legal acts covering the non-employment scope of the directive. All provincial regulation except the Antidiscrimination Act of Lower Austria transcend Directive 2000/43 EG and include at least religion or belief, disability, age and sexual orientation. The Viennese Antidiscrimination Act also includes pregnancy and maternity as protected grounds.

**Table 2: Equality grounds covered by provincial anti-discrimination legislation**

<b>Province</b>	<b>Grounds covered</b>
Burgenland	Ethnic affiliation (“ethnische Zugehörigkeit”), gender, religion or belief, disability, age, sexual orientation
Carinthia	Ethnic affiliation (“ethnische Zugehörigkeit”), gender, religion or belief, disability, age, sexual orientation
Lower Austria	Ethnic affiliation (“ethnische Zugehörigkeit”), gender
Upper Austria	Ethnic or racial origin (“rassische oder ethnische Herkunft”), gender, religion or belief, disability, age, sexual orientation
Salzburg	Ethnic affiliation (“ethnische Zugehörigkeit”), gender, religion or belief, disability, age, sexual orientation
Styria	Racial and ethnic origin (“ethnische Herkunft”), gender, religion or belief, disability, age, sexual orientation and sexual identity
Tyrol	Ethnic affiliation (“ethnische Zugehörigkeit”), gender, religion or belief, disability, age, sexual orientation
Vienna	Race, ethnic origin (“ethnische Herkunft”), religion or belief, disability, age, sexual orientation, sexual identity, pregnancy, maternity
Vorarlberg	Ethnic affiliation (“ethnische Zugehörigkeit”), gender, religion or belief, disability, age, sexual orientation

*Source: own compilation, based on provincial anti-discrimination laws*

Neither the federal legislation nor six of nine provincial equality acts make use of the term “race”. “Race and ethnic origin” are represented by the term “ethnic affiliation” (“ethnische Zugehörigkeit”). “Race and ethnic origin” is used in the provincial legislation of Styria, Vienna and Upper Austria, but the wordings seem to be congruent in their scope.<sup>117</sup> The choice of the term was motivated by the strong linguistic and historical association of the term “Rasse” by the national-socialist dictatorship and was strongly supported by most NGOs.<sup>118</sup>

The institutional antidiscrimination framework at federal level is characterised by a strong compartmentalisation with regard to grounds of discrimination. The Equal Treatment Commission consists of three senates reflecting the three sections of the Equal Treatment Act. Senate I is responsible solely for equal treatment of men and women in the area of work, Senate II for equal treatment regarding ethnic origin, religion or belief, age or sexual orientation in the world of work, and Senate III for equal treatment regarding gender and ethnic origin in all other areas except of work. The senates are entitled to examine cases of alleged discrimination and find decisions suggesting solutions for the case, which are not legally binding. Any case regarding discrimination because of gender, ethnic origin, religion or belief, age or sexual orientation, may also be taken to the respective court without consulting the Equal Treatment Commission or after the Equal Treatment Commission has decided on the case. The time spent for the procedure in front of the Equal Treatment Commission is not counted towards the limitation of liability in time.

Within the Equal Treatment Commission, all cases involving gender in the area of work have to be dealt with exclusively by Senate I. In effect this regulations leads to a high number of decisions, where the claim to examine multiple discrimination in the field of work have been withdrawn as soon as sexual harassment was proven and compensated.

The Federal Disability Equality Act implements arbitration officers at the nine provincial offices of the Federal Social Welfare Office. All cases concerning disability discrimination have to be dealt with by these arbitration officers, only if no agreement was reached the claimant is entitled to take the case to court. The arbitration officers are not entitled to decide on whether discrimination has taken place, but are only entitled to work towards an amicable solution. All multiple discrimination cases including disability discrimination have to be referred to the respective provincial office of the Federal Social Welfare Office and must not be decided by the Equal Treatment Commission. As the Federal Social Welfare Office does not publish its cases, it is unclear if and how multiple discrimination is reflected in these decisions.

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<sup>117</sup> D. Schindlauer (2009a) *Report on measures to combat discrimination. Directives 2000/43/EC and 2000/78/EC. Country report 2009*, p. 19 ft4

<sup>118</sup> D. Schindlauer (2009a) *Report on measures to combat discrimination. Directives 2000/43/EC and 2000/78/EC. Country report 2009*, p. 19

At the provincial level the division between discrimination based on disability and discrimination on other grounds is repeated. The provincial equality bodies set up by the respective provincial laws are not entitled to deal with disability discrimination cases. Their organisational structure repeats the division into senates comparable to the federal level.

Evidence and trigger of reversal of burden of proof are regulated in the Equal Treatment Act, the Federal Equal Treatment Act, the provincial Equal Treatment Acts and the Federal Disability Equality Act in a comparable way: The claimant has to make his claim credible, and the accused party has to prove, that another motive than discrimination has motivated unequal treatment. As the free assessment of evidence by the judges is a founding principle of legal proceedings in Austria, no further regulations regarding evidence do exist.

The question of compensation is regulated in a similar vein in all laws on equal treatment: Personal damage caused by multiple discrimination has to be taken into due consideration when calculating the amount of compensation.

The question of the calculation of compensation in cases of multiple discrimination has lead to considerable debate among legal scholars, which has been reflected in a decision of the Supreme Court<sup>119</sup>. According to this decision, the majority of scholars prefer to judge each case on its own merits instead of cumulating the minimum compensation claims for each ground of discrimination.

Indirect discrimination is defined in all equal treatment acts in a similar way, which essentially follows the definitions in the EU equality directives.

### 5.3.1. Definitions of race, age, and disability

In the explanatory notes of the Equal Treatment Act, the term “ethnic affiliation” is defined as follows:<sup>120</sup>

*“Addressees of discrimination are persons who are perceived by others as being ‘strange’ because they are not seen as members of the regional majority population due to some distinct differences. Discrimination in these cases is related to differences which are perceived as natural due to myths of descent and affiliation and which cannot be modified by the affected persons.*

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<sup>119</sup> OGH, 80bA63/09m

<sup>120</sup> Austrian Parliament, 307 der Beilagen XXII. GP - Regierungsvorlage – Materialien, available at [http://www.parlament.gv.at/PAKT/VHG/XXII/I/I\\_00307/fname\\_010536.pdf](http://www.parlament.gv.at/PAKT/VHG/XXII/I/I_00307/fname_010536.pdf), p.14

*Common manifestations are discriminations on the grounds of skin-colour and other details of outward appearance as well as a mother tongue seen as 'strange'. Also ethnic groups are 'imagined communities' formed either by self-commitment or attribution by others, which can not solely be based on biologic or other factual differences. Ethnic groups refer to commonalities stemming from skin-colour, descent, religion, language, culture, or customs."*

"Disability" is defined in both the Act on the Employment of People with Disabilities and the Federal Disability Act in a related way, which only differs with regard to the areas regulated by the respective acts. The definition of the Act on Employment of Peoples with Disabilities reads as follows:<sup>121</sup>

*"Disability is the result of a deficiency of functions that is not just temporary and based on a physiological, mental, or psychological condition or an impairment of sensual functions which constitutes a possible complication for the participation in the labour market. Such a condition is not deemed temporary if it is likely to last for more than 6 months."*

The Federal Disability Equality Act (Article 3) essentially uses the same definition, but does not refer to "participation in the labour market", but to "participation in society".

At provincial level differing definitions are used. According to the study of Schindlauer<sup>122</sup>, "these definitions are (...) in line with – or even considerably broader than ECJ case C-13/05, Chacón Navas, Paragraph 43, according to which "the concept of 'disability' must be understood as referring to a limitation which results in particular from physical, mental or psychological impairments and which hinders the participation of the person concerned in professional life".

Regarding age, the explanatory notes of the amended Equal Treatment Act state:<sup>123</sup>

*"Regarding the criterion 'age' all workers are protected irrespective of minimum or maximum ages, unless specific requirements of training require the establishment of a maximum age for recruitment. Regulations restricting the access to a certain career with a certain maximum age are inadmissible. The ground 'age' also covers discrimination on the ground of young age."*

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<sup>121</sup> Act on the Employment of People with Disabilities, Article 3; Federal Disability Equality Act, Article 3

<sup>122</sup> D. Schindlauer (2009a) *Report on measures to combat discrimination. Directives 2000/43/EC and 2000/78/EC. Country report 2009*, p. 21

<sup>123</sup> Austrian Parliament, 307 der Beilagen XXII. GP - Regierungsvorlage – Materialien, available at [http://www.parlament.gv.at/PAKT/VHG/XXII/I\\_00307/fname\\_010536.pdf](http://www.parlament.gv.at/PAKT/VHG/XXII/I_00307/fname_010536.pdf), p.15

### 5.3.2. Material scope

At the federal level, the material scope of legislation (Equal Treatment Act, Federal Equal Treatment Act, Act on the Equal Treatment Commission and the Equal Treatment Ombud) covers all areas mentioned in the respective EU-legislation. In the Equal Treatment Act, access to health is mentioned only with regard to ethnic affiliation (“Ethnische Zugehörigkeit”), gender is mentioned with regard to access to goods and services available to the public. The Federal Disability Equality Act does not mention the area of health, but covers equal treatment with regard to access to goods and services available to the public, which, according to the view of most legal experts, includes access to publicly available health services. With the exception of Lower Austria, all provinces have chosen to guarantee the same level of protection in the employment and the non-employment field and have extended the grounds protected in the employment field to the non-employment field. Thus in all provinces except of Lower Austria health is also covered for gender, ethnic origin, age and disability, only in Lower Austria health is only covered with regard to ethnic origin<sup>124</sup>.

### 5.3.3. Types of discrimination covered, multiple discrimination

As well direct and indirect discrimination, harassment and victimisation are covered by both federal and provincial legislation. The definitions given follow the definitions of the respective directives.

Although as well on federal level as on provincial level specialised bodies do exist, due to the constitutional principle of the right to a legal judge, compensation for damages only may be awarded by court decisions, neither the federal nor the provincial specialised bodies may award compensation for damages.

Federal and provincial specialised equality bodies do exist. At the federal level, the Equal Treatment Commission (“Gleichbehandlungskommission”) has been set up at the Federal Ministry for Health and Women. The Commission is entitled to deal with all cases of alleged discrimination except of disability.

For the ground of disability a separate structure has been set up. The Ombud for Persons with Disabilities (Behindertenanwalt) has been appointed by the Minister of Social Security, Generations and Consumer Protection and is responsible for advice and support of people with disabilities. For disability, there is no body equivalent to the Equal Treatment Commission, but a compulsory attempt to settle individual cases in a joint dispute resolution process before the provincial offices of the Federal Social

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<sup>124</sup> D. Schindlauer (2009a) *Report on measures to combat discrimination. Directives 2000/43/EC and 2000/78/EC. Country report 2009*, p. 44

Welfare Office.<sup>125</sup> As all cases involving disability have to follow the provisions of the Federal Disability Equality Act or the Act on the Employment of People with Disabilities, cases of multiple discrimination involving the aspect of discrimination have to be dealt with the Federal Social Welfare Office, before they can be decided by a court. The Equal Treatment Commission consists of three specialised senates. The first senate is supposed to deal with issues related to equal treatment of women and men in the workplace; the second senate is responsible for discrimination in employment and occupation covering all other grounds mentioned in art 13 ECT except disability. The third senate is responsible for the non-employment related scope of the Racial Equality Directive. The Commission, which is a quasi-judicial body, may conduct examinations, trigger amicable solutions or pass findings regarding cases. Compensation only may be awarded by the respective competent court or tribunal.

At the provincial level, the structure, size, and institutional powers of the specialised bodies vary widely. As the Equal Treatment Commission on federal level, they are not entitled to decide cases or award damages, but may render quasi-judicial views in their conclusions.

Compensation for discrimination only can be awarded by the competent courts. None of the bills provide for criminal sanctions, the system of compensation is based on civil law. Only in the area of discriminatory job advertisement administrative penal proceedings are foreseen, with a maximum fine of Euro 360.

As a principle the victim of discrimination can choose between undoing the act of discrimination or compensation of pecuniary damage.<sup>126</sup> In cases of harassment a minimum compensation of Euro 720 has to be awarded. There are no specific regulations regarding multiple discrimination.

Lowering the burden of proof has been implemented into federal legislation rather weakly. According to Art. 26.12 of the Equal Treatment Act, the burden of proof does not completely switch over to the respondent, but in any case the respondent is obliged to prove the likelihood of established facts. The law states that the respondent has to prove that “it is more likely that a different motive – documented by facts established by the respondent – was the crucial factor in the case or that there has been a legal ground of justification”. So the respondent is obliged to prove the likelihood of established facts. These provisions have been ruled as being in line with the Directives.

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<sup>125</sup> D. Schindlauer (2009a) *Report on measures to combat discrimination. Directives 2000/43/EC and 2000/78/EC. Country report 2009*, p. 75

<sup>126</sup> In the case of non-recruitment or non-promotion, the victim only may claim damages – in both cases including the option to claim non-pecuniary damage.



On the provincial level, a full shift of the burden of proof applies.<sup>127</sup> In court the plaintiff only has to establish facts about the discrimination or victimisation and then the respondent has to prove that no infringement of the prohibition of discrimination or victimisation has occurred. There are no separate provisions regarding the burden of proof in cases of multiple discrimination.

The findings of the Equal Treatment Commission are not binding for the judge. Article 61 of the Equal Treatment Act defines the duty of the court to take the opinion of the Equal Treatment Commission into account and to give explicit reasons for a judgement contrasting the opinion of the Equal Treatment Commission. According to a recent report, in practice the value of the findings of the Equal Treatment Commission at court procedures would be low, “mainly due to the fact that the procedure before the Equal Treatment Commission does not meet most of the basic procedural standards of courts.”<sup>128</sup>

This fact reflects a fundamental conflict between the understanding of the rule of law in Austria and the concept of a quasi-judicial body. According to the Austrian Constitution any person has the right to a trial in front of a lawful judge.<sup>129</sup> According to the constitution, judges are free to consider the evidence of a case and not bound to follow decisions of other judges in the same case.<sup>130</sup> Arbitration commissions like the Equal Treatment Commission do not qualify as lawful judges, and thus must not pass any legally binding decisions. As judges are completely independent with regard to consider the evidence of a case, thus they have the sole right to decide on how to make use of the findings of the Equal Treatment Commission. Courts have to produce reasoned judgements in any case, thus “overruling” an opinion of the Equal Treatment

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<sup>127</sup> Burgenland: Gesetz vom 8. Juli 2005 über das Verbot der Diskriminierung auf Grund der ethnischen Zugehörigkeit, der Religion, der Weltanschauung, einer Behinderung, des Alters oder der sexuellen Orientierung (Burgenländisches Antidiskriminierungsgesetz – Bgld. ADG); Art. 26, Carinthia: Gesetz über das Verbot der Diskriminierung auf Grund der ethnischen Zugehörigkeit, der Religion, der Weltanschauung, einer Behinderung, des Alters, der sexuellen Orientierung und des Geschlechtes (Kärntner Antidiskriminierungsgesetz - K-ADG), Art. 25; Lower Austria: Niederösterreichisches Antidiskriminierungsgesetz, LGBL 9290, Art. 18.2; Salzburg: Gesetz vom 1. Februar 2006 über die Gleichbehandlung im Bereich des Landes, der Gemeinden und Gemeindeverbände (Salzburger Gleichbehandlungsgesetz – S.GBG), Art. 20.5; Styria: Gesetz vom 6. Juli 2004, mit dem ein Gesetz über die Gleichbehandlung im Bereich des Landes, der Gemeinden und Gemeindeverbände (Landes-Gleichbehandlungsgesetz Steiermark) erlassen wird, Art. 30.6; Tyrol: Gesetz vom 1. Februar 2005 über das Verbot von Diskriminierungen (Tiroler Antidiskriminierungsgesetz 2005 – TADG 2005), Art. 10; Upper Austria: Landesgesetz über das Verbot der Diskriminierung auf Grund der rassischen oder ethnischen Herkunft, der Religion, der Weltanschauung, einer Behinderung, des Alters oder der sexuellen Ausrichtung (Oö. Antidiskriminierungsgesetz – Oö. ADG), Art. 8.2; Vorarlberg: Vorarlberger Gesetz über das Verbot der Diskriminierung, Art. 7.4; Vienna: Gesetz zur Bekämpfung von Diskriminierung (Wiener Antidiskriminierungsgesetz), Art. 5

<sup>128</sup> D. Schindlauer (2009a) *Report on measures to combat discrimination. Directives 2000/43/EC and 2000/78/EC. Country report 2009*, p. 80

<sup>129</sup> BVG, Art. 83.2

<sup>130</sup> BVG, Art. 87, 88

Commission is no specific task. The self-understanding of judges in Austria heavily relies on their independence, thus it is extremely unlikely that judges will want to automatically follow the findings of a quasi-judicial body in their proceedings. Furthermore, judges are usually very sceptical with regard to quasi-judicial views, and thus their opinions and decisions might not be regarded as utmost relevant.

The complicated structure and weak role of the specialised bodies have led experts to consider the enforcement of the EU antidiscrimination acquis as deficient.<sup>131</sup> The fragmented nature of Austrian antidiscrimination legislation has also been criticised in the Concluding Observations of the Committee on the Elimination of Racial Discrimination on Austria in 2008. The report states: “While acknowledging that the State party has adopted around 30 different laws on nondiscrimination covering different aspects of the Convention, the Committee is concerned about the scattered character of this legal framework and its complexity, due to the different procedures and institutions associated with each of the discrimination laws. (art. 2 (1)). The Committee recommends that the State party review the effectiveness of its current legal framework on non-discrimination with a view to initiating a harmonization process while continuing its efforts to adopt adequate and comprehensive legislative provisions for the implementation of the Convention in its entirety. The Committee further recommends that the State party invite civil society to participate in such a process.”<sup>132</sup>

Neither the Federal-Equal Treatment Act nor the Equal Treatment Act do provide specific rules on how to deal with cases of multiple discrimination. Since the amendment of the two acts in 2008, both mention that multiple discrimination has to be taken into account when assessing damages. Art. 19a Federal-Equal Treatment Act and the articles 12/13, 26/13, and 51/10 Equal Treatment Act state: In a case of multiple discrimination this fact has to be considered when assessing the amount of the immaterial damages. The explanatory notes state that these regulations clarify that cases of discrimination based on multiple grounds need to be assessed in an overall view and that the claims cannot be separated or cumulated by grounds.<sup>133</sup>

In the field of disability, as well the Federal Disability Equality Act (Art 9.4) as the Act on the Employment of People with Disabilities (Art. 7j) state, that “in assessing the amount of the immaterial damages, the duration of the discrimination, the gravity of guiltiness, the relevancy of the adverse effect and multiple discrimination have to be taken into account.”

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<sup>131</sup> D. Schindlauer (2009a) *Report on measures to combat discrimination. Directives 2000/43/EC and 2000/78/EC. Country report 2009*, p. 5

<sup>132</sup> Committee on the Elimination of Racial Discrimination (2008): Consideration of Reports submitted by state Parties under Article 9 of the Convention. Concluding observations of the Committee on the Elimination of Racial Discrimination: Austria. CERD/C/AUT/CO/17; 22 September 2008, available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/441/71/PDF/G0844171.pdf?OpenElement>, p.3

<sup>133</sup> Austrian Parliament, 415 der Beilagen XXIII. GP - Regierungsvorlage – Erläuterungen, available at [http://www.parlinkom.gv.at/PAKT/VHG/XXIII/I/I\\_00415/fname\\_096505.pdf](http://www.parlinkom.gv.at/PAKT/VHG/XXIII/I/I_00415/fname_096505.pdf), p. 7

Other regulations concern mainly technical issues: According to Art 1 (3) of the Act on the Equal Treatment Commission and the National Equality Body – Equal Treatment Commission states, that cases of multiple discrimination have to be dealt with by Senate 1, which is in charge of gender discrimination. According to Art 1 (4) of the cited act all cases involving discrimination on the ground of disability have to be dealt with according to the Act on the Employment of People with Disabilities, or the Federal Disability Equality Act. These acts demand a compulsory attempt to settle the case before the Federal Social Service. Only if this conciliation process has ended unsuccessfully, a law-suit can be filed with the competent courts (civil and labour courts).

The reports of the Austrian Federal Ombudsman Board (Volksanwaltschaft) do not report cases, but report about areas of concern. The field of health is touched regularly, but not with regard to multiple discrimination. The reports i.a. mention e.g. problems with regard to receive compensation for damages for disabilities due to the use of contergan in pregnancy, lack of access to fixed denture for persons with a low income, problems with regard to access to a disability pension due to contradictory medical experts' opinions, or the exclusion of male homosexuals from the right to donate blood. None of the reports between 2005 and 2010 makes reference to the EU antidiscrimination acquis or reports cases of multiple discrimination in the field of health.

Although no multiple discrimination cases with regard to health have been reported, multiple discrimination as such is a subject tackled in the reports of the Equal Treatment Ombud.

According to the report of the Equal Treatment Ombud for the year 2006 and 2007 (Gleichbehandlungsanwaltschaft 2008) and for 2008 and 2009 (Gleichbehandlungsanwaltschaft 2010), the vast majority of multiple discrimination cases would touch the combination of age and gender discrimination, particularly dismissal of women when reaching pensionable age.

In Austria, women are entitled to old age pension when reaching the age of 60, men when reaching the age of 65. Only from 2020, the age threshold for women will be raised stepwise to 65. Many collective treaties, which are an important legal source for regulations on grounds for dismissal, allow dismissal after reaching the age threshold for an old-age pension. In the same vein, appeals against dismissal are regularly decided against the plaintiff, if s/he had reached this age threshold, as in these cases the courts tend to deny the duty of the employer to consider social hardship. Further to depriving women from the possibility to take part in the labour market, this regulation also massively impacts on women's income in retirement, as the number of months of payment into the respective compulsory public pension scheme is a decisive factor for calculating the height of the pension. As the employment-biography of women often is

interrupted by years of child-rearing, this regulation further contributes to the considerable gap between the income of retired men and women.

According to the view of the Equal Treatment Ombud this practice would be in violation with European Law and the constitution, as the different age thresholds were intended to allow women to receive an old age pension earlier than man as compensatory measure, and not to force them into retirement. The reports list several cases of dismissal at the age of retirement against the will of the person concerned, which have been brought before the court and had not been decided yet.

Further cases would concern widespread age discrimination of mainly women, who after the age of 40 would often be informed that they would be too old for the job or would not fit into a “young team”. The report lists a case of age discrimination against a female secretary aged 44, who, when applying, had been asked if she was ready to also cook coffee for the clients. Although highly qualified, she agreed, but nevertheless did not get the position, as she “would not fit into a young team”. The Chamber of Labour took the case to court, where the employer excused himself for the discriminatory decision and agreed to pay a compensation of two monthly salaries. Other cases reported concern harassment because of gender and age, e.g. with regard to a woman aged 50, who applied for a grant to write a habilitation thesis and was denied the necessary signature of the dean of the university because of her age and gender.

A number of cases reported concern the combination of gender, ethnic origin and marital or family status. One case concerns a man, who, when asking for care leave for his sick son, was told to decide whether his family or his work would count more and was dismissed. In a number of cases, as well men and women asking for care-leave for their sick children were criticized for their number of children and were told to better adapt to the family size usual in Austria.

A large number of cases concern the combination of gender, ethnic origin and religion, in particular with regard of the wearing of a headscarf. Many Muslim women would experience discrimination in the application process and denied a post because of their gender, their ethnic origin and the visibility of their religion. In other cases, Muslim women wearing a headscarf were ordered by their employers to remove it not only during work, but also during their journey to work, or not to refer to their Turkish name when talking with customers, or to colour their hair blond.

Further cases concern discrimination with regard to payment and harassment based on ethnic origin and gender, or dismissal because of pregnancy and wearing of a head scarf. In another case the Ombud found systematic discrimination of immigrant women with regard to payment and working conditions, in this company women from Eastern Europe systematically were paid less than the other employees in the same position.

The Equal Treatment Commission has published 16 decisions regarding multiple discrimination. All concern different aspects of employment, none relates to other aspects. Article 3 of the Equal Treatment Act defines eight areas in the employment field, which may be prone to discrimination based on gender, Article 17 mentions the same aspects with regard to discrimination based on ethnic origin, religion or belief, age and sexual orientation:

- Conclusion of employment
- Income
- Voluntary benefits not forming part of the income
- Training, further training and retraining
- Professional advancement, particularly promotion
- Other working conditions
- Cessation of employment

Harassment is mentioned in Article 6 (sexual harassment) and Article 21 with regard to the other grounds.

All cases decided by the Equal Treatment Commission concern one or more of the aspects mentioned above.

The vast majority of cases concern a combination of age and gender discrimination. Among the seven cases combining age and gender discrimination, four cases<sup>134</sup> concern women, who had been dismissed when reaching the age threshold for receiving an old age pension. In three of these cases, also promotion had been denied with the argument that they would reach pensionable age soon. In these cases, the Equal Treatment Commission regularly decided in favour for the claimant and suggested to declare the cessation of employment void or to award compensation reflecting the gravity of the damage to person, or to change the internal regulations allowing dismissal at reaching pensionable age. One case concerns discrimination with regard to severance payment and supplementary payments when retiring<sup>135</sup>. This case was decided against the claimant.

Two other cases concern men, who had allegedly been discriminated because of their age when applying. In both cases the Commission did not find a proof for the alleged discrimination.<sup>136</sup>

The combination of age and ethnic origin is reflected in three cases.<sup>137</sup> One case<sup>138</sup> concerns alleged discrimination because of age and ethnic origin when applying for a

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<sup>134</sup> GBK I/140/08-M; GBK I/175/09-M; GBK I/161/08-M; GBK I/155/08-M; GBK I/85/07-M

<sup>135</sup> GBK I/85/07-M

<sup>136</sup> GBK I/105/09-M; GBK I/153-08-M

<sup>137</sup> GBK II/44/07, GBK II/95/05, GBK I/185/09

post as IT-specialist. The man who applied was Austrian citizen of foreign origin, who spoke German well, but with a foreign accent. The Commission did not find proof for the alleged discrimination. One further case<sup>139</sup> concerns alleged age and ethnic discrimination with regard to termination of employment, also in this case the alleged discrimination could not be proven. A further case<sup>140</sup> concerns alleged discrimination because of age, ethnic origin and gender with regard to income, working conditions and termination of employment and harassment because of the grounds mentioned. In this case, the Commission found gender discrimination with regard to income proven, but did not find proof for the other allegations, and suggested payment of the income difference as compensation. As in these cases no discrimination or only discrimination on one ground was proven, there was no discussion of multiple discrimination and its effects.

There are two cases combining gender, ethnic origin, and sexual harassment.<sup>141</sup> In both cases sexual harassment was proven, and in effect the Equal Treatment Ombud withdrew the request to investigate discrimination with regard to the respective aspects of employment. One further case<sup>142</sup> concerns the combination of gender and belief and sexual harassment, also in this case only sexual harassment was proven and the Ombud withdrew the discrimination claims. In a further case<sup>143</sup>, alleged discrimination based on ethnic origin with regard to income, working conditions and termination of employment combined with sexual and ethnic harassment was examined. In this case, only sexual harassment was proven and a compensation payment of euro 720.- agreed. Also in these cases there was no debate on multiple discrimination. In general, these cases give the impression, that in cases handled by Senate I, the Equal Treatment Ombud tends to withdraw claims regarding discrimination in employment as soon as sexual harassment has been proven and compensated.

The combination of gender, belief and sexual orientation with regard to income, advancement, working conditions and termination of employment was discussed in a further case<sup>144</sup>. In this case the Commission found gender discrimination with regard to income, working conditions and termination of employment proven and suggested compensation payments and equal treatment measures to be implemented at company level. The Equal Treatment Ombud withdrew the pledge to examine discrimination based on sexual orientation and belief, thus multiple discrimination was not discussed.

One case concerns the combination of gender, ethnic origin and religion and sexual, ethnic and religious harassment.<sup>145</sup> The case was already described in the report of the Equal

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<sup>138</sup> GBK II/44/07  
<sup>139</sup> GBK II/95/05  
<sup>140</sup> GBK I/185/09  
<sup>141</sup> GBK I/101/07-M; GBK I/166/09-M  
<sup>142</sup> GBK I/03-07-MG  
<sup>143</sup> GBK I/150/08-M  
<sup>144</sup> GBK I/126/08-M  
<sup>145</sup> GBK II/79/09

Treatment Ombud and concerned a young Muslim woman in a training contract, who was told not to wear her headscarf not only at work, but also on her way to work, and forbidden to mention her Turkish origin when talking with clients, she was also harassed at work. The contract was dissolved with the argument, that the clients would not want to be served by a woman of Turkish origin. In this case, the Equal Treatment Commission found discrimination on all grounds claimed and sexual harassment to be proven and suggested a compensation payment reflecting the damage done to the women because of multiple discrimination.

As in nine of the sixteen cases discrimination could not be proven and the cases were either decided negatively or the verdict only concerned harassment, the majority of the cases do not discuss the topic of multiple discrimination. Out of the seven multiple discrimination cases decided in favour of the claimant, four concern age and gender discrimination with regard to the different age thresholds for old age pensions for men and women. Only one of the cases combining ethnic origin with age, gender or religion has been decided in favour of the claimant, who was blatantly discriminated as Muslim women wearing a headscarf.

In particular with regard to the cases concerning the age threshold for the old age pension, the question arises, if the term “multiple discrimination” is appropriate: These cases only concern women of a certain age and concern a specific interaction of age and gender, not the accumulation of distinct experiences of discrimination, thus it might be more appropriate to understand them as cases of intersectional discrimination.<sup>146</sup>

In the cases decided in favour of the claimants, multiple discrimination is only discussed with regard to compensation. In all cases solved by compensation, the Commission demands that the compensation should reflect the damage done by multiple discrimination. When discussing evidence and the reversal of burden of proof, the decisions – as usual in Austrian court decisions – present the relevant paragraphs and then judge the plausibility and reliability of the arguments and proofs presented by both parties. There is no further discussion on the relationship between evidence and burden of proof and multiple discrimination.

Court decisions on multiple discrimination are rare. A research in the database on court decisions<sup>147</sup> using the legal term “Mehrfachdiskriminierung” as key-word triggers only one case<sup>148</sup>, which will be discussed further down. A cursory view at the cases found using the key-word “Diskriminierung” alone leaves the impression, that several cases on sexual discrimination also contained a connection to other forbidden grounds of discrimination, which were not reflected in the decision. So e.g. the case 1 2 Ra 7 1 /1 0p of the Regional Appeals Court of Upper Austria<sup>149</sup>, which concerns gender discrimination and sexual and ethnic origin harassment of a woman, only reflects sexual harassment and gender discrimination and does not comment on ethnic origin harassment. In the case 8ObA27/09t

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<sup>146</sup> See Makkonen 2002, p.4

<sup>147</sup> [www.ris.bka.gv.at/Jus/](http://www.ris.bka.gv.at/Jus/)

<sup>148</sup> OGH, 8ObA63/09m

<sup>149</sup> Oberlandesgericht Linz, 1 2 Ra 7 1 /1 0p

decided at the Supreme Court<sup>150</sup>, which concerns age and gender discrimination with regard to advancement, the Court found age discrimination proven, but denied gender discrimination arguing that the claimant would not have been the best qualified female candidate and would have lost against other female applicants in case no age discrimination had taken place, and thus did not reflect on multiple discrimination and its effects.

The only court decision discussing multiple discrimination at length concerns a case of proven gender and ethnic origin discrimination.<sup>151</sup> The claimant had appealed to the Supreme Court stating that the proven multiple discrimination had not adequately been reflected in the decision on the amount of compensation. The decision discusses at length on how to reflect multiple discrimination in compensation and defines two competing methods. The majority of legal literature on the subject would favour to decide the amount of compensation based on the merits of each single case, only a minority of scholars would favour to accumulate the minimum compensation for each ground for discrimination, which was proven in the trial. As in the concrete case, the compensation awarded would have surpassed the sum of the minimal compensation for each of ground of discrimination proven in the trial, the Court rejected the appeal and did not pass a decision on how to decide on the amount of compensation in cases of multiple discrimination.

There are no court decisions discussing indirect discrimination, questions of evidence and burden of proof.

The report of the Equal Treatment Ombud for 2006 and 2007<sup>152</sup> does not present a single case related to the health sector.

The report for 2004 and 2005 mentions a case of a Turkish women, who felt discriminated because of her nationality with regard to access to rehabilitation treatment. It turned out, that the case concerned the service of a provincial institution, thus it was transferred to the respective provincial equality ombud<sup>153</sup>. The patients' ombudsmen regularly publish activity reports. A few cases are mentioned regarding persons with disabilities. The report of the Viennese ombudsman contains a chapter "persons with special needs in hospitals" reporting of cases of complaints of persons with disabilities about insufficient or wrong medical treatment and about solutions to these complaints. The report gives the following statement:

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<sup>150</sup> OGH, 8 ObA27/09t

<sup>151</sup> OGH, 8ObA63/09m

<sup>152</sup> Gleichbehandlungsanwaltschaft Österreich 2008: Anwaltschaft für Gleichbehandlung. Gemeinsamer Bericht 2006/2007 gemäß § 24 des Bundesgesetzes über die Gleichbehandlungskommission und die Gleichbehandlungsanwaltschaft. Vienna. Available at <http://www.gleichbehandlungs-anwaltschaft.at/DocView.axd?CobId=39917>

<sup>153</sup> Gleichbehandlungsanwaltschaft Österreich 2005: Anwaltschaft für Gleichbehandlung. Gemeinsamer Bericht 2004/2005 gemäß § 24 des Bundesgesetzes über die Gleichbehandlungskommission und die Gleichbehandlungsanwaltschaft. Vienna, p. 149. Available at <http://www.gleichbehandlungs-anwaltschaft.at/DocView.axd?CobId=23404>



“Time and again relatives, trustees and employees of institutions taking care for physically or mentally disable persons, in particular of persons with multiple disabilities, turn to the ombudsman reporting, that hospitals are insufficiently prepared for these specific group of patients. Thus a number of problems regarding these groups occur. Relatives as well as care givers report of a lack of empathy, intuition and experience of the hospital staff regarding this group of patients.”<sup>154</sup> Hospital staff would not know about the specific needs of persons with disabilities, in particular not with regard to the degree of autonomy patients possess. In particular patients suffering from reduced or lacking speech capabilities would be dependent on their relatives or care takers, who would have to act as their advocates to secure quality treatment. In the case of mentally disabled persons “not the medical issues, but their specific communicative needs” would potentially lead to problems with regard to medical treatment.

Not all provincial equality ombuds have already published activity reports. There are no reports available for the Burgenland, Carinthia, Salzburg and Vienna.

The only available report of the antidiscrimination unit of the province of Lower Austria concerning the years 2005-2006 was published in 2007. The report mentions a case of harassment of a staff member of a hospital, who was allegedly called a “Nazi-pig” by patients, who, according to the report, “because of their appearance belonged to a different ethnic group”<sup>155</sup>. The staff member was counselled to approach his superior. No cases mentioned contain an element of multiple *discrimination*.

Neither the report of the Equality Ombud of Upper Austria for the period 2005-2007<sup>156</sup> nor the report for the period 2007-2009<sup>157</sup> contain a reference to a case of discrimination with regard to health or to multiple discrimination cases.

The only available report of the Styrian Equality Ombud concerns the period of 2008-2010 and reports ten complaints regarding health, but does not detail them.<sup>158</sup>

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<sup>154</sup> Wiener Pflege-, Patientinnen- und Patientenrechtsanwaltschaft (2009) *Bericht über das Jahr 2009*, p. 43, available at <http://www.wien.gv.at/gesundheit/wppa/pdf/taetigkeitsbericht-2009.pdf>

<sup>155</sup> Landesregierung Niederösterreich 2007: Bericht der NÖ Antidiskriminierungsstelle Zeitraum Mai 2005 – Dezember 2006, p. 11, available at [http://www.noe.gv.at/bilder/d10/AD\\_Taetigkeitsbericht\\_2005\\_2006.pdf](http://www.noe.gv.at/bilder/d10/AD_Taetigkeitsbericht_2005_2006.pdf)

<sup>156</sup> Oberösterreichische Antidiskriminierungsstelle 2007: Tätigkeitsbericht Juni 2005 – März 2007, available at [http://www.land-oberoesterreich.gv.at/files/publikationen/paes\\_antidiskriminierungsstelle\\_bericht.pdf](http://www.land-oberoesterreich.gv.at/files/publikationen/paes_antidiskriminierungsstelle_bericht.pdf)

<sup>157</sup> Oberösterreichische Antidiskriminierungsstelle 2000: Tätigkeitsbericht April 2007 – März 2009, available at [http://www2.land-oberoesterreich.gv.at/internetpub/Start.jsp?SessionID=SID-408FABBB-6F978E6F&xmliid=antidiskriminierung\\_DEU\\_HTML.htm&pbNr=1446](http://www2.land-oberoesterreich.gv.at/internetpub/Start.jsp?SessionID=SID-408FABBB-6F978E6F&xmliid=antidiskriminierung_DEU_HTML.htm&pbNr=1446)

<sup>158</sup> Büro der Gleichbehandlungsbeauftragten des Landes Steiermark und Geschäftsstelle der Gleichbehandlungskommission 2011: *Bericht der Gleichbehandlungsbeauftragten des Landes Steiermark 2008-2010*, p. 26, available at [http://www.verwaltung.steiermark.at/cms/dokumente/10169198\\_4632709/7abd4dbe/GBB\\_Bericht\\_0810.pdf](http://www.verwaltung.steiermark.at/cms/dokumente/10169198_4632709/7abd4dbe/GBB_Bericht_0810.pdf)

The only available report of the Equality Ombud of the Tyrol concerns the period of July 2008 – June 2010 and does not mention a case connected to the area of health. The report mentions a case of intersectional discrimination concerning age and gender: According to the report, the city of Innsbruck would issue senior citizen passes entitling to cheaper public transport and reduction at museums etc. to men having at the age of 65 and to women having at the age of 60, which would discriminate against men. The Ombud consulted the claimant, who decided to bring the case to court.<sup>159</sup>

In Vorarlberg, the provincial ombud has been defined as the specialised antidiscrimination body of the province by the provincial antidiscrimination legislation of Vorarlberg in 2005. The ombud annually publishes an activity report, which since 2006 also contains a specific chapter on antidiscrimination.

The report for 2006 mentions 17 cases examined by the ombud. The majority of them concerned discrimination because of ethnic origin, but no case related to health and no multiple discrimination case<sup>160</sup>. The report for 2007 mentions 15 cases, none of them related directly to the health-sector or multiple discrimination. The report mentions a case of alleged gender discrimination with regard to professional advancement in a provincial hospital and criticises, that in only one hospital a woman would work as chief of clinic<sup>161</sup>. The report for 2008 mentions 35 cases, none of them related directly to the health-sector or multiple discrimination. The report again criticises the low representation of women among the leading staff in the health sector.<sup>162</sup> The report for 2009 mentions 24 cases. One case concerns alleged discrimination of a disabled patient with regard to refunding of costs for medication and therapy. The report does not give details of the case.<sup>163</sup> The report for 2010 mentions 24 cases. One case concerns a

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<sup>159</sup> Landesregierung Tirol 2010: Tiroler Antidiskriminierung. Bericht der Antidiskriminierungsbeauftragten für den Zeitraum Juli 2008 bis Juni 2010, p. 24. Available at <http://www.tirol.gv.at/fileadmin/www.tirol.gv.at/themen/gesellschaft-und-soziales/frauen/downloads/TAD-Bericht2010.pdf>

<sup>160</sup> Landesvolksanwalt von Vorarlberg – Antidiskriminierungsstelle 2008: Bericht des Landesvolksanwaltes an den Vorarlberger Landtag gemäß Artikel 59 Absatz 6 der Vorarlberger Landesverfassung über seine Tätigkeit im Jahre 2006. 19. Beilage im Jahre 2008 zu den Sitzungsberichten des XXVIII. Vorarlberger Landtages, p. 22, available at <http://www.landesvolksanwalt.at/information/tatigkeitsberichte>

<sup>161</sup> Landesvolksanwalt von Vorarlberg – Antidiskriminierungsstelle 2009: Bericht des Landesvolksanwaltes an den Vorarlberger Landtag gemäß Artikel 59 Absatz 6 der Vorarlberger Landesverfassung über seine Tätigkeit im Jahre 2007. 10. Beilage im Jahre 2009 zu den Sitzungsberichten des XXVIII. Vorarlberger Landtages, p. 48, available at <http://www.landesvolksanwalt.at/information/tatigkeitsberichte>

<sup>162</sup> Landesvolksanwalt von Vorarlberg – Antidiskriminierungsstelle 2009: Bericht des Landesvolksanwaltes an den Vorarlberger Landtag gemäß Artikel 59 Absatz 6 der Vorarlberger Landesverfassung über seine Tätigkeit im Jahre 2008. 10. Beilage im Jahre 2009 zu den Sitzungsberichten des XXVIII. Vorarlberger Landtages, p. 44, available at <http://www.landesvolksanwalt.at/information/tatigkeitsberichte>

<sup>163</sup> Landesvolksanwältin von Vorarlberg – Antidiskriminierungsstelle 2010: Bericht der Landesvolksanwältin an den Vorarlberger Landtag gemäß Artikel 59 Absatz 6 der Vorarlberger

chronically ill pensioner with Turkish nationality, who was cared for by his wife at home. Due to his nationality he was excluded from the receipt of additional support payments. The case was still open at the time of the publication of the report.<sup>164</sup>

NGOs active in the field of antidiscrimination regularly report cases of alleged discrimination, which have not been decided before a court. These cases are reflected in the regular reports of the Austrian National Focal Point for the RAXEN network. The reports for 2009 and 2010 both mention exemplary incidents and cases regarding ethnic and racial discrimination. According to the report of 2009, which refers to the annual report of the NGO “ZARA” and “helping hands Graz”, one case concerned a nurse in the emergency ward, who addressed an Austrian patient of Turkish origin in a depreciative way. Another case concerned an employee of Turkish origin who was forbidden to speak to the patients in Turkish and was bullied by one of her colleagues, and the third case concerned a female Muslim medical doctor who was denied a job in a rehab centre because of her headscarf.<sup>165</sup>

The report of 2010 mentions the case of an employee of a home for asylum seekers, who had to make an emergency call because one of her clients suffered from shortage of breath and cardialgia one night. The person who answered the phone told her in a deprecatory manner that she should not be worried about the client because “those asylum seekers are always simulating anyway.” Another case concerned two women, who had had been rejected as donators of blood plasma because both of them were in a relationship with men of African origin. They had to fill in a questionnaire at the blood donation centre which contained the information that persons who were from Africa or persons, who had a sexual relationship with an African, were excluded as donators because they had an increased risk of being HIV-positive. In response to a letter of the NGO “ZARA”, which wrote a letter of complaint to the centre, the institute re-examined its policies for donating blood plasma and the general exclusion was restricted to a 12 month lasting exclusion for people originating from high risk areas<sup>166</sup>. Four further exemplary cases were reported by the Viennese Ombudsman to the FRA and are cited in the summary report of this study on p. 42 ff:

A complaint was made by a patient with spasms who has difficulties to speak and needs time to express himself. After an accident he stayed in the hospital for the removal of

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Landesverfassung über seine Tätigkeit im Jahre 2009. 32. Beilage im Jahre 2010 zu den Sitzungsberichten des XXIX. Vorarlberger Landtages, p. 36, available at

<http://www.landesvolksanwalt.at/information/tatigkeitsberichte>

<sup>164</sup> Landesvolksanwältin von Vorarlberg – Antidiskriminierungsstelle 2011: Bericht der Landesvolksanwältin an den Vorarlberger Landtag gemäß Artikel 59 Absatz 6 der Vorarlberger Landesverfassung über seine Tätigkeit im Jahre 2010. 55. Beilage im Jahre 2011 zu den Sitzungsberichten des XXIX. Vorarlberger Landtages, p. 39, available at

<http://www.landesvolksanwalt.at/information/tatigkeitsberichte>

<sup>165</sup> Austrian National Focal Point for RAXEN 2009: Country Report 2009, p.4

<sup>166</sup> Austrian National Focal Point for RAXEN 2009: Country Report 2009, p.5

glass splinters. After that he visited the hospital several times and received outpatient aftercare. He repeatedly told the doctors that he is suffering from pain, but the doctors did not examine the cause. After a month he came back accompanied by his sister who talked to health staff. He was examined and it was found out that they forgot to remove a glass splinter in his back, surgery was necessary. His sister notified the Patient's Ombudsman that her brother's suffering has not been taken seriously enough because of his disability. He was compensated for damages due to malpractice.

The second case concerned refusal of treatment. Here a patient with Down syndrome and Parkinson's disease had an acute skin disease. His carers complained that he did not receive the appropriate treatment because the doctors in duty did not know how to receive a person with disability for inpatient care (The carer heard the phone calls the person on duty made to the dermatology department and the psychiatric department of the hospital). The result of the Ombudsman's examination was that the hospital did not deny the medical indication for inpatient care. They said that they just did not have a place for him (They were "full"). No compensation (the patient got well without inpatient care, the Ombudsman requested the written comments/opinions from the health staff involved.)

The third case related to harassment and delay of treatment. Here a patient from a migration background had surgery and was asked to leave the hospital on the following day. He said to the doctors that he was still suffering from pain, but he was not taken seriously. According to the complainant, the doctors called it 'Balkan syndrome'. There was no further examination. Later in the evening he had to have surgery due to internal bleeding. After surgery the hospital cared properly for him. The patient complained about the delay of treatment because the doctors assumed that he was simulating or exaggerating just because he was a foreigner. The Ombudsman requested a statement. The hospital denied racist comments, and stated that the bleeding was considered to be a typical complication. There was no fault on part of the hospital. The Ombudsman was of the opinion that it could not be excluded that the pain was caused by bleeding and that there had been a delay in treatment, but there were difficulties to prove the exact time frame and the causal relation to the damage. The patient was offered compensation by the Patient's Compensation Fund. Harassment could not be proved.

In the fourth case, concerning malpractice, a patient complained that his experience with physical disability had not been taken seriously by the hospital. He has a spastic leg and he had to undergo heart surgery where the vein of one leg should be removed. Before surgery he asked the doctor to remove the vein from his healthy leg because he knew from his experiences that injuries to the spastic leg are followed by severe pain and an increase of disability. The patient told the Ombudsman that he asked to document his wish in the medical history (Krankengeschichte), but the doctor refused it by answering, that the patient doesn't understand enough about it. In the end, the vein was taken from the spastic leg which according to the patient led to an increase of pain and spasticity of

the affected leg. The Ombudsman requested a statement of the hospital. The hospital denied that there was a relationship between the surgery and the increase in disability. They commented that they had to spare the healthy leg. The case has not yet come to a conclusion.

## 6. International Law

### 6.1. International instruments signed and ratified

Austria has signed and ratified as well the European Convention on Human Rights and the Protocols No.1, No.2, No.3, No.4, No. 5, No.6, No.7, No.8, No.9, No.10, No.11, No.13 and No.14. It has signed, but not ratified the Protocols No.12 and No. 14 bis. The Convention has been declared constitutional law (B-VG vom 4.3.1964, BGBl. 59/1964). Thus, all ratified protocols also are constitutional law.

The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) has been signed and ratified by Austria, with a reservation regarding Art. 4 (implementation into domestic law). Thus the Convention is not directly incorporated into Austria's domestic legislation <sup>167</sup>(Treaty Body Monitor 2008, 1), it is not considered to be directly enforceable. In order to implement the Convention Austria passed a constitutional law (Federal Act on the Implementation of the International Convention on the Elimination of All Forms of Racial Discrimination), which prohibits every form of racial discrimination. Article 1 paragraph 1 of the Law on the Implementation of the ICERD prohibits different treatment for foreigners unless objectively justified and only insofar that the different treatment is proportionate. The ICERD is binding for state bodies and law makers, which are thus not allowed to differentiate between foreigners and citizens in an unproportionate way. It is not directly enforceable and thus has not effect whatsoever on contractual relations covered by civil law.<sup>168</sup>

Austria has signed and ratified The International Convention on the Elimination of All Forms of Discrimination against Women. Furthermore, in the year 2000 Austria ratified the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women and implemented in national legislation (Federal Law Gazette III No. 206/2000). The Convention itself has not been ratified at constitutional rank. However, the following provision was incorporated into the Federal Constitution as Article 7 paragraph 2 with the amendment to the Federal Constitution by Federal Law

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<sup>167</sup> Treaty Body Monitor (2008) International Convention on the Elimination of all Forms of Racial Discrimination, 73<sup>rd</sup> session. Austria, 15<sup>th</sup> – 17<sup>th</sup> reports 7-8 August 2008, Available at <http://www.ishr.ch/treaty-body-monitor/cerd>

<sup>168</sup> See <http://www.legislationline.org/topics/subtopic/37/topic/10/country/44>

Gazette I No. 68/1998: "The Federation, the provinces and the Communities commit themselves to de facto equality of women and men. Measures aimed at promoting the de facto equality of women and men, particularly through the elimination of any inequalities that actually exist, shall be admissible."<sup>169</sup>

The basic constitutional guarantee of equal treatment of nationals also includes gender. Gender equality provisions are found as well in constitutional law as in simple law, depending on the legal character of the area regulated. The most important domestic law in this field, the Equal Treatment Act, which specifically mentions the Convention, has the character of simple law.

According to experts, the legislation in Austria is intended to be in line with its international commitments to promoting gender equality. Statistically, Austria with its 20 per cent rate of women suffering domestic violence and gender inequality in the employment marketplace, still has much ground to cover to improve the factual situation of women with regard to domestic violence and discrimination at the labour market.<sup>170</sup>

The Convention on the Rights of the Child has been signed and ratified in Austria in 1992. In 1993, the parliament decided to implement the Convention by simple law. In the last years parliament has discussed to implement at least parts of the Convention into the federal constitution. In February 2011, the parliament passed a Federal Constitutional Act on the Rights of Children. The Explanatory Memorandum of the Act makes a clear reference to the Convention. The Austrian network on children's rights as well as opposition parties have criticised, that the Act mentioned includes a reservation in regard to the economic wellbeing of Austria and security issues, and thus allows the state to declare the constitutional rights of children void in the area of immigration and asylum.<sup>171</sup>

Austria has signed and ratified the International Convention on the Rights of Persons with Disabilities. It has been implemented by simple law, in particular three acts regarding equality of people with disabilities.

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<sup>169</sup> UN Committee on the Elimination of Discrimination Against Women (CEDAW), *Consideration of reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women : 6th periodic report of States parties : addendum : United Kingdom of Great Britain and Northern Ireland (overseas territories of the United Kingdom)*, 14 June 2007, CEDAW/C/UK/6/Add.2, p. 24, available at:

<http://www.unhcr.org/refworld/docid/478b5df52.html>, p. 24

<sup>170</sup> See <http://www.legislationline.org/topics/country/44/topic/7>

<sup>171</sup> See <http://www.kinderhabenrechte.at/index.php?id=112>

## 6.2. Relevant case law

There are no cases regarding discrimination with regard to health or cases regarding multiple discrimination referred to in the last Country Report on Austria of the UN Committee on the Elimination of Discrimination against Women<sup>172</sup> and in the last Country Report on Austria of the UN Committee on the Elimination of Racial Discrimination.<sup>173</sup>

The First State Report of Austria on the implementation of the UN Disability Rights Convention<sup>174</sup> contains a chapter on women with disabilities. According to the report, “women with disabilities are still less likely to have completed some sort of vocational training than men with disabilities, which not only has a negative effect on their careers opportunities and financial situations, but also has an unfavourable effect on their psychosocial condition.”<sup>175</sup> It would be necessary to create new careers and training opportunities, and to break down old occupational clichés regarding women with physical disabilities (unskilled workers in kitchens, laundries and cleaning jobs). No cases are presented.

Among the forty cases regarding discrimination in Austria in the ECHR-HUDOC database one single case concerns the area of health and none multiple discrimination. In the case of S.H. and others vs. Austria<sup>176</sup>, the applicants challenged the prohibition of heterologous techniques in artificial procreation, while accepting as lawful only homologous techniques, as unlawful discrimination. The case has been referred to the Grand Chamber in October 2010 and has not been decided finally at the time of writing the report.

The news-report of the European Network of Legal Experts in the Non-discrimination Field of September 3, 2010<sup>177</sup> reports the decision of a ECHR-case dealing with the impossibility to have the cover of one partners health and accident insurance extended to include the other partner in a same-sex partnership.

The applicants – a homosexual couple – claimed they had been victims of discrimination given the impossibility to have the coverage of the second applicant’s health and accident insurance extended to include the first applicant. The provision limiting the

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<sup>172</sup> Committee on the Elimination of Discrimination against Women 2004: Consideration of reports submitted by States parties under Article 18 of the Convention on the Elimination of All Forms of Discrimination against Women Sixth periodic report of States parties: Austria, CEDAW/C/AUT/6

<sup>173</sup> Committee on the Elimination of Racial Discrimination: Consideration of Reports submitted by State Parties under Article 9 of the Convention. Concluding observations of the Committee on the Elimination of Racial Discrimination. Austria. CERD/C/AUT/CO/17, 22 September 2008

<sup>174</sup> BMASK 2011: UN-Disability Rights Convention. First State Report of Austria. Vienna (bmask). Available at [http://www.bmask.gv.at/cms/site/attachments/9/3/4/CH0009/CMS1299764062407/1\\_\\_staatenbericht\\_crp\\_d\\_englische\\_endfassung\\_-\\_stand\\_20\\_10\\_2010.pdf](http://www.bmask.gv.at/cms/site/attachments/9/3/4/CH0009/CMS1299764062407/1__staatenbericht_crp_d_englische_endfassung_-_stand_20_10_2010.pdf)

<sup>175</sup> BMASK 2011: UN-Disability Rights Convention. First State Report of Austria. Vienna (bmask). Available at [http://www.bmask.gv.at/cms/site/attachments/9/3/4/CH0009/CMS1299764062407/1\\_\\_staatenbericht\\_crp\\_d\\_englische\\_endfassung\\_-\\_stand\\_20\\_10\\_2010.pdf](http://www.bmask.gv.at/cms/site/attachments/9/3/4/CH0009/CMS1299764062407/1__staatenbericht_crp_d_englische_endfassung_-_stand_20_10_2010.pdf), p. 11

<sup>176</sup> Case o S.H. and Others vs Austria ((*Application no. 57813/00*))

<sup>177</sup> Schindlauer, D. (2010) ECtHR case of P.B. and J.S. vs. Austria. News report of the European network of legal experts in the non-discrimination field

extension of health insurance to cohabitating persons of the opposite sex was amended in 2007, restricting the scope of application to relatives. It is thus formulated in a neutral way concerning the sexual orientation of cohabiters.

On July 7, 2010, the ECHR decided, (Decision of the ECHR App. No. 18984/02 dating from 22.07.2010), that there has been a violation of the European Convention of Human Rights. As meanwhile the provision limiting the extension of health insurance to cohabitating persons of the opposite sex had been amended, the court further declared that after the entry into force of the amended regulation Austria was no longer in breach of the Convention.<sup>178</sup>

The case law database of the FRA does neither contain entries on case law regarding discrimination with regard to access to health nor on multiple discrimination for Austria.

## 7. Review of direct and indirect discrimination in healthcare

### 7.1. Discrimination cases relating to access to health

Court cases regarding direct or indirect discrimination with regard to the health system are extremely rare. As the judicial database of the Federal Government (RIS – Rechtsinformationssystem) only collects cases decided by the High Courts<sup>179</sup>, there is no possibility to gain an overview about cases decided at lower levels. Only two cases, both not dealing with healthcare per se, but with access to health insurance, could be identified in database and reports of national or international bodies and NGOs. The first case has been decided by the ECHR and is presented in chapter 6.2. The second case concerns the refusal to provide travel insurance to a person with a disability, decided on October 16, 2006<sup>180</sup>:

The plaintiff, a man who using a wheelchair, held a travel insurance contract with an insurance company for many years. So far no payments had been made to him by the company. An extension of the duration of his insurance contract was refused by the

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<sup>178</sup> Schindlauer, D. (2010) ECtHR case of P.B. and J.S. vs. Austria. News report of the European network of legal experts in the non-discrimination field

<sup>179</sup> Depending on the case these might include the regional appeal courts, the Constitutional Court, the Administrative Court and the Supreme Court.

<sup>180</sup> D. Schindlauer (2009a) *Report on measures to combat discrimination. Directives 2000/43/EC and 2000/78/EC. Country report 2009*, p. 11



insurance company with the explanation that given his disability, further insurance was not possible.

The claimant attempted to settle the dispute before the Federal Social Service; As the respondent was reluctant to acknowledge discrimination, the settlement failed. So the plaintiff filed a claim with the ordinary court. In the course of the proceedings, the respondent fully acknowledged direct discrimination on the ground of disability and agreed to a court settlement demanding the payment of Euro 1.500,- to the claimant in compensation for immaterial damages and the payment of the cost of the proceedings (Euro 1.200,--).<sup>181</sup>

As the respondent fully acknowledged direct discrimination on the ground of disability, the District Court for Commercial Cases in Vienna did not examine the substance of the case, and thus did not consult the view of the Disability Arbitration Commission, but accepted the full acknowledgement and decided fully in favour of the plaintiff. The decision is final.

## 8. Review of complaints' mechanism in place in the health sector

### 8.1. Complaints mechanisms in place

In all provinces a patients' ombud exists. The patients ombud is an independent institutions established by law. It is not bound by instructions. It has the aim the secure the rights and interests of patients with regard to all aspects of the health care system. The patients' ombuds are organised at the provincial level.

Although there are small differences with regard to organisation and competencies between the different provinces, usually the patients' ombudsman is responsible for all areas of the health system. In particular, his areas of competency include:

- Hospitals and nursing homes holding contracts with a public health fund
- Emergency rescue services, ambulance services and patient transport
- Physicians and specialists in private practice
- Pharmacies
- Midwives
- Dentists

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<sup>181</sup> BG HS Wien, 001 C 133/08b-9

- Other services in the health sector

As the ombudsmen are also responsible for nursing homes, a part of their work concerns the area of long time care giving, which is closely associated with the disability issues.

Making use of the complaints procedure is free of charge. The ombud has the right to handle complaints, to get access to all data and files necessary to deal with the complaint, and to mediate in complaint cases. It neither has the right to decide a case nor to represent a claimant before the court

All public health fund also have institutionalised ombudspersons, who also may handle complaints regarding the health system, if the complainant is insured with them and the institution concerned holds a contract with the respective public insurance fund. These ombuds have comparable rights and duties like the provincial patients' ombudsman.

The Federal Ombud for Equal Treatment for Persons with Disabilities, established at the Federal Ministry for Work and Social Affairs, is responsible for the support and consulting of persons with disabilities. It may solve conflicts by mediation, but is not entitled to represent victims before the courts. The areas of protection cover the field of employment and self employment, access to goods and services and the activities of the federal administration. Thus it may cover access to health insurance contracts and to health services provided by private enterprises.

The Equal Treatment Commission and the Equality Authority are accessible free of charge and entitled to analyse cases, conduct examinations, try to find amicable solutions and pass opinions with regard to cases of alleged discrimination. Until yet, the reports of the Commission do not include cases in the area of health, but the Commission clearly is entitled to take cases in this sector.

The provincial offices of the Federal Social Welfare Office offer arbitration in cases of discrimination on the ground of disability free of charge. Trained mediators are paid by the Federal Social Welfare Offices if demanded by the client, as are translation services for sign language. The cases are managed by a trained arbitration officer. If no agreement is reached, a confirmation on a failed arbitration is issued and the case may be taken to court.

Both the Austrian Medical Chamber and the Austrian Dental Chamber maintain arbitration offices (*Schlichtungsstellen*) for cases of alleged errors in treatment or inadequate treatment offering a quasi-judicial form of out of court settlement, set up separately in each province. Only cases regarding complaints of a purely medical nature are heard while other complaints (e.g. conduct of health staff, abusive language used,

conditions in hospitals etc.) are not permissible.<sup>182</sup> Neither information on the kind of cases heard nor on the number of cases brought before these arbitration boards is available.

Finally, also the large regional health insurance funds (Gebietskrankenkassen) maintain ombud offices. These do not formally arbitrate, but informally mediate in case of complaints. In terms of functionality, these ombud offices basically serve to address customer complaints and improve customer satisfaction and thus have an important systemic function for complaints relating to the area of responsibility of the health insurance fund.<sup>183</sup>

In summary, therefore, the provincial patients' ombudsmen are by the far the most complaints mechanism in place to promote patients' rights and address their complaints.

## 8.2. Areas of complaints

The patients' ombuds regularly publish activity reports. A cursory overview about the report of the ombuds of Vienna, Lower and Upper Austria gives the clear impression that the ombudsmen exclusively deal with issues of quality of treatment, refusal of treatment, medical malpractice, costs, or unfriendly treatment of clients and patients.

The reports of the Viennese ombud mentions, that 8% of the complaints concerned communication and behaviour of the staff, the area most prone to discrimination. The author has contacted the ombuds of Vienna, Lower and Upper Austria with the request to get access to the cases by phone, but has been informed, that due to data protection clauses the ombuds are not allowed to disclose their files to private bodies or persons.

According to the report of the Equal Treatment Ombud of 2009 with regard to the non-employment field, 34% of the cases concerned access to goods and services, 6% education, and 5% the field of social protection.<sup>184</sup> In 2008, a total of 2% of the cases concerned cases regarding health or pension insurance, in 2009, the percentage rose to

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<sup>182</sup> See the website of the Vienna Medical Chamber on the Viennese arbitration board <http://www.aekwien.at/index.php/patientenrecht/behandlungsfehler--schiedsstelle> (12.6.2011). The remit of other provincial arbitration boards of the Austrian Medical Chamber as well as of provincial arbitration boards of the Austrian Dental Chamber is defined in similar ways.

<sup>183</sup> Complaints will thus mainly relate to (non-)approval of certain kinds of treatment, medication and rehabilitation; complaints about (non-)reimbursement of costs, (non-approval) of certain monetary benefits under the responsibility of insurance fund (notably sickness benefits, confinement benefits, etc.) and general complaints regarding the processing of claims, treatment at customer centres, etc.

<sup>184</sup> Anwaltschaft für Gleichbehandlung (2009): Gemeinsamer Bericht 2008/2009, available at <http://www.gleichbehandlungsanwaltschaft.at/DocView.axd?CobId=42115> p. 81

10%<sup>185</sup>. The vast majority of cases concerns access to goods and services and access to housing.

A cursory overview of the reports of the provincial equal treatment ombuds shows, that the majority of cases concern gender, disability, age and ethnic origin, among the latter a large number of cases based on nationality discrimination.

Among the cases decided by the Equal Treatment Commission, cases regarding discrimination in the field of work with regard to gender are by far most prominent, followed by discrimination on the ground of age in employment. Among the non-employment cases discrimination because of ethnic origin with regard to access to goods and services, including housing, are most common.

### 8.3. Accessibility of complaints mechanism

The provincial patient ombuds are entitled to counsel patients with regard to their rights, to analyse cases and to get access to files and documents and to solve problems by mediation<sup>186</sup>. They are not entitled to represent patients before the courts or to pass legally binding decisions, but have full power of attorney in settlement procedures in front of the arbitration commission of hospital trust. Their offices are usually established in the provincial capitals, but they may hold consultation days at other cities and municipalities.

The complaints mechanism is easily accessible and free of charge. The majority of the cases are solved within less than two years. According to the report of the Viennese Patient Ombud, approx. 12.000 contacts are registered each year. In 2009, out of a total

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<sup>185</sup> Anwaltschaft für Gleichbehandlung (2009): Gemeinsamer Bericht 2008/2009, available at <http://www.gleichbehandlungsanwaltschaft.at/DocView.axd?CobId=42115> p. 83, 88

<sup>186</sup> The patient ombuds are regulated by provincial legislation. All provincial laws on the patient ombuds include the right to counsel the patients, to examine cases, to get access to then necessary files and to hear the ombud whenever provincial law regarding the health sector is amended. The provincial bills governing the patient ombuds are:

Burgenland: Gesetz über die Burgenländische Gesundheits-, Patientinnen-, Patienten- und Behindertenanwaltschaft - Bgld. GPB-A-G, LGBL 51/2000

Carinthia: Gesetz über die Patienten-anwaltschaft und die Pflege-anwaltschaft (K-PPAG), LGBL Nr 53/1990

Lower Austria: NÖ Krankenanstaltengesetz, LGBL 9440

Upper Austria: Oö. Krankenanstaltengesetz 1997 - Oö. KAG 1997, LGBL 132/1997

Salzburg: Salzburger Krankenanstaltengesetz 2000, LGBL Nr 24/2000

Styria: Gesetz vom 13. Mai 2003 über die Patientinnen-/Patienten- und Pflegevertretung (Patientinnen-/Patienten- und Pflegeombudsschaft), LGBL 66/2003

Tyrol: Tiroler Krankenanstaltengesetz - Tir KAG, LGBL.5/1958

Vorarlberg: Gesetz über Einrichtungen zur Wahrung der Rechte und Interessen von Patienten und Klienten, LGBL 26/1999

Vienna: Gesetz über die Wiener Pflege-, Patientinnen und Patienten-anwaltschaft, LGBL 59/2006

of 11.165 contacts approximately 8.200 concerned requests for information by telephone. Around 2600 contacts lead to a formal complaints procedure.<sup>187</sup>

In 2009, in 348 cases financial compensation with the sum of Euro 2.401.263.- was granted. Since the foundation of the Ombud in 2006, for a total of 2.008 cases 13,5 Million Euro of compensation were paid out<sup>188</sup>.

The Equal Treatment Ombud has offices in Vienna, Innsbruck, Graz and Klagenfurt. The complaints mechanism is easily accessible and free of charge. Cases are usually solved within between half a year and two years.

Also the provincial equal treatment ombuds are easily accessible and the procedures are free of charge.

The Ombudsman Board has its main office in Vienna, but regularly organises consultation days in the larger cities and municipalities in the provinces. The Ombudsman Board is entitled to analyse cases, to get access to files and documents, to solve problems by mediation and to publish recommendations. The procedures are free of charge.

### 8.4. Satisfaction with the handling of complaints

There are no studies available regarding the satisfaction of the patients with the outcomes of complaints or the effectiveness of the complaints mechanism. It has to mentioned, that private hospitals and nursing homes not holding a contract with one of the public health fund do not fall into the remit of the ombudsmen. In these cases, complaints only can be dealt with by the respective courts. There are also no studies available regarding the effectiveness or ineffectiveness of complaints.

### 8.5. Evaluation mechanisms

The Austrian Ombudsman Board may initiate formal examinations of any public institution, including the public health fund.

Evaluation mechanisms of the quality of hospitals are currently being developed by the Austrian Institute for Health. According to the report of the Austrian Institute for Health<sup>189</sup> they will be based on electronic databases collecting all quality-relevant

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<sup>187</sup> Wiener Pflege-, Patientinnen- und Patientenanwaltschaft (2009) *Bericht über das Jahr 2009*, p. 10

<sup>188</sup> Wiener Pflege-, Patientinnen- und Patientenanwaltschaft (2009) *Bericht über das Jahr 2009*, p. 20

<sup>189</sup> Gesundheit Österreich GmbH (2009) *Jahresbericht 2009*, available at:  
[http://www.goeg.at/cxdata/media/download/berichte/GOEG\\_JB\\_2009.pdf](http://www.goeg.at/cxdata/media/download/berichte/GOEG_JB_2009.pdf)

information, in particular information on diagnosis and treatment which will allow to evaluate efficiency of treatment. The data will be used to develop benchmarks and define best practices.<sup>190</sup> They will only be accessible to health fund and the health authorities, but not to the general public.

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<sup>190</sup>

Gesundheit Österreich GmbH (2009) *Jahresbericht 2009*, p. 5

## Part III – Review of Evidence of Inequality and Discrimination in Access to Health<sup>191</sup>

### 9. Availability of Data and Reporting

The first chapter describes availability of data on health and access to health in Austria and provides a brief overview of the official health reporting based on this data.

#### 9.1. Data on Health

Statistics on health status and access to healthcare is synthesised from a variety of sources. However, only few surveys provide current, comprehensive and systematic information on health issues. The following selected data sets contain representative information on health status:

##### **Austrian Health Survey (2006 / 2007)**

The most up to date and comprehensive source of information on multiple discrimination or inequalities with respect to health and access to health care is the “Österreichische Gesundheitsbefragung 2006/2007” [Austrian Health Survey 06/07] conducted in the years 2006 and 2007 by Statistik Austria [Statistics Austria]. This survey was developed on basis of the draft modules of the European Health Interview Survey (EHIS)<sup>192</sup> and was funded by the Austrian Federal Ministry of Health, Family and Youth and the Bundesgesundheitsagentur.

With a gross sample of more than 25,000 persons aged 15 years and above, it is a very robust survey tool. The data set includes 15.474 cases. The questionnaire does not only cover a wider range of indicators of health and health behaviour, but also contains demographic background categories, which prove very useful for the study at hand.

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<sup>191</sup> Part III of the report has been authored by Edith Enzenhofer and Julia Edthofer of the Research Institute of the Red Cross

<sup>192</sup> The harmonised *European Health Interview Survey* will be conducted every five years. Member States can either implement a new survey tool or use existing population surveys, see Eurostat (2007) *European Health Interview Survey / EHIS. First Round 2007/2008. Background and Rationale of the Questions*, available at: [\(http://circa.europa.eu/Public/irc/dsis/health/library?l=/methodologiessandsdatasc/healthsinterviewsurvey/2007-2008\\_methodology/background\\_2007pdf/\\_EN\\_1.0\\_&a=d\)](http://circa.europa.eu/Public/irc/dsis/health/library?l=/methodologiessandsdatasc/healthsinterviewsurvey/2007-2008_methodology/background_2007pdf/_EN_1.0_&a=d) (11. 5. 2011)

Following the basic design of the EHIS, the Austrian Health Survey covers a wide range of health related topics such as health status and morbidity, including *general self-perceived health status, quality of life, mental health, impairment, pain prevalence, chronic diseases*. In addition, it investigates *health behaviour* (smoking, alcohol and drug consumption, adiposity, physical activity, food consumption patterns etc.), and *use of medical services and preventive care offers*.

The data contains information on *citizenship* and *country of birth*, which can be combined to the category *migration background* covering both migrants who have kept their nationality and inhabitants with migrant origin who have obtained Austrian citizenship. Members of the “second generation”, however, who were already born in Austria and are Austrian citizens, are not included in this definition. Data can be disaggregated for the two largest migrant groups. A rather serious limitation is the fact that the survey has been conducted in German, thus, particular risk groups might have been excluded.

### **EU-SILC survey (continually)**

The EU-SILC (EU-Community Statistics on Income and Living Conditions") survey is conducted on an annual basis following the EC regulations on statistics and funded by the EC and the Austrian Federal Ministry for Labour, Social Affairs and Consumer Protection. EU-SILC contains health related questions, which in turn are part of the European Health Information System (EHIS).

The survey sample covers persons in private households with the minimum age of 16 years. The gross sample is drawn on household basis and provides valid data about approximately 11.000 respondents per annum. EU-SILC data can be disaggregated by *gender, age, citizenship, country of birth, and parents' country of birth*.

The survey contains few rather general questions on respondents' *self-perceived health status* including *permanent impairment, access to health care*, and questions regarding *health insurance*. The questions concerning permanent impairment allow for an approximation of the Austrian disability prevalence. However, it has to be mentioned that respondents living in care institutions are not covered by the survey. The survey is conducted in German as well as in Turkish and Bosnian-Croatian-Serbian (BCS) Language.

### **Austrian Micro-Census Module on Disability and Impairment (2007 / 2008)**

Sample surveys on health issues have been conducted in Austria in irregular intervals since the 1970s, usually as ad-hoc modules of the Micro-Census.



The micro-census module on disability and impairment contained questions on disability and impairment. 8.195 persons in private households with a minimum age of 15 years answered the questionnaire. The restriction on home-dwelling respondents leads to an under-representation of people with severe disabilities which require inpatient care and treatment, which leads to a serious limitation of the results. Data can be disaggregated by *gender, age, citizenship, country of birth, and parents' country of birth*.

The survey follows a very broad conception of impairment, including *visual impairment, hearing impairment, speaking difficulties, restriction of mobility, intellectual problems and learning difficulties, mental health problems, other forms of impairment and multiple impairment*.

The subsequent survey on disability and impairment started in 2011.

### **Austrian Micro-Census ad-hoc Module on Occupational Accidents (2007)**

In 2007, an ad hoc-module of the Austrian Micro-Census Labour Force Survey contained questions on work related health issues.

19.343 persons with minimum age 15 who are currently employed or have been employed in the past answered the questionnaire. The survey covers *occupational accidents, work related health issues* including *mental health issues*, and *work related stress* and their consequences.

Data can be disaggregated by *gender, age, citizenship, country of birth, and parents' country of birth*. The face-to-face survey is realised in German, telephone interviews in Turkish, BCS, and English language can be realised on demand.

### **SHARE (2004, 2006 / 2007, 2008 / 2009)**

The Survey of Health, Care and Retirement in Europe, 50 + in Europe (SHARE) focuses on health issues of the older population. Austria has so far participated in three survey waves (in the years 2004, 2006 / 2007, and 2008 / 2009).

SHARE covers a wide range of health issues and contains information on *self-perceived health status, pain prevalence, physical health status, mental health status, health behaviour, health care expenditures*. The questionnaire also covers selected issues of *access to health care* as well as *medical treatment and medication* such as the kind of interventions made by the *GP*, the up-take of selected *preventive screenings*, and *medication* with respect to orthopaedic problems.

The survey covers people aged 50 and over in private households. Data can be disaggregated by *gender, age, citizenship, country of birth, and parents' country of birth*, and in analysis, socio-economic inequalities are taken into account. However, small sample sizes (1.893) and the fact that the survey took place in German only make it less useful for research on the health situation of migrants.

**Table 1 Availability of basic health indicators**

Variable	Gender	Age	Ethnicity or Proxy	Disability	Data source	Notes
Life expectancy	Y	Y	Y	N	Statistik Austria Population Statistics	
Mortality	Y	Y	Y	N	Ibid.	
Fertility rate	Y	Y	Y	N	Ibid.	
Infant mortality	Y	Y	Y	N	Ibid.	
Maternal mortality					Ibid.	
Infectious diseases	Y	Y	N	N	Electronic reporting system	Only diseases subject to registration
General self reported health status	Y	Y	Y	N	Austrian Health Survey	
Cardio Vascular Health Issues	Y	Y	Y	N	Austrian Health Survey	
Ulcer and Cancer	Y	Y	Y	N	Ibid.	
Respiratory diseases	Y	Y	Y	N	Ibid.	
Diabetes	Y	Y	Y	N	Ibid.	
Diseases of the Musculoskeletal System	Y	Y	Y	N	Ibid.	
Diseases of sensory Organs	Y	Y	Y	N	Ibid.	
Disability and Impairment	Y	Y	Y	N	Ibid.	
Allergies	Y	Y	Y	N	Ibid.	
Mental Health	Y	Y	Y	N	Ibid.	

Variable	Gender	Age	Ethnicity or Proxy	Disability	Data source	Notes
Tobacco consumption	Y	Y	Y	N	Ibid.	
Alcohol consumption	Y	Y	Y	N	Ibid.	
Drug consumption	Y	Y	Y	N	Ibid.	
Physical behaviour	Y	Y	Y	N	Ibid.	
Adipositas (obesity)	Y	Y	Y	N	Ibid.	

Other data sources which can be consulted in the wider context of health are the administrative register such as the **Statistics on Deaths** and **Statistics on Persons Discharged from Hospitalised Care** (Spitalsentlassungsstatistik). Both allow distinguishing migrants by country of birth and citizenship. Death statistics provide information on causes of death, while statistics on persons discharged from hospitalised care provide detailed information on the reason for treatment and the treatment itself.<sup>193</sup>

## 9.2. Data on Access

Systematic, comprehensive and representative data on access to health provisions is rare, most data consist of so called “service based data”, which is collected by individual service institutions and is thus not representative. Most health related data sources only briefly touch on the topic of access, if at all. For Vienna, a study on quality of Life in Vienna contains some information. However, in publically available material, this information is not further disaggregated. The data is only available on formal demand.

Again, the **Austrian Health Survey (2006 / 2007)** proves to be the best data source as it contains representative and comprehensive information on access to health provision. The questionnaire covers access to *GPs, outpatient departments and emergency units, hospitalisation, medication*, access to specialist health care such as *gynaecologists, dentists, internal specialists, orthopaedic specialists, ophthalmologists, otolaryngologists, urologists, dermatologists*, as well as on access to *immunisation* and different types of *preventive screenings*. To mention a limitation, no representative and systematic data on access to pre-natal preventive provisions is available.

<sup>193</sup> A. Kraler, C. Hollomey, A. Wöger (2009) *PROMINSTAT. National Data Collection Systems and Practices. Country Report Austria*, available at:  
[http://www.prominstat.eu/drupal/?q=system/files/PROMINSTAT\\_Austria.pdf](http://www.prominstat.eu/drupal/?q=system/files/PROMINSTAT_Austria.pdf)

All data can be disaggregated by *gender, age, and migration background*.

## Inequalities and Multiple Discrimination in Access to Health in Austria

Access to..	Gender	Age	Ethnicity or Proxy	Disability	Data source	Notes
GPs	Y	Y	Y	N	Austrian Health Survey	
Outpatient departments and emergency units	Y	Y	Y	N	Ibid.	
Gynaecologists	Y	Y	Y	N	Ibid.	
Dentists	Y	Y	Y	N	Ibid.	
Internal Specialists	Y	Y	Y	N	Ibid.	
Orthopaedic Specialists	Y	Y	Y	N	Ibid.	
Ophthalmologists	Y	Y	Y	N	Ibid.	
Otolaryngologists	Y	Y	Y	N	Ibid.	
Urologists	Y	Y	Y	N	Ibid.	
Dermatologists	Y	Y	Y	N	Ibid.	
Immunisation	Y	Y	Y	N	Ibid.	
General preventive screening	Y	Y	Y	N	Ibid.	
Mammography	Y	Y	Y	N	Ibid.	
Pap smear test	Y	Y	Y	N	Ibid.	
PSA test	Y	Y	Y	N	Ibid.	
Preventive colonoscopy	Y	Y	Y	N	Ibid.	
Pre-natal screening	--	N	N	N		
Users satisfaction	Y	Y	Y	N	Wiener Lebensqualitätsstudien	Vienna only; available only on formal request

### 9.3. Health Reporting

Health reporting in Austria is conducted in a comprehensive and regular manner since 2000. Gesundheit Österreich GmbH / Geschäftsbereich Österreichisches Bundesinstitut für Gesundheitswesen (GÖG / ÖBIG) [Health Austria Inc. / Austrian Federal Institute for Health Care] is responsible for the Austrian health reporting systems and commissions reports on a national as well as on a regional level<sup>194</sup>. The “Austrian platform on health reporting” is part of “Health Austria Inc.” and responsible for the quality standards. The platform points to the fact that Austrian health reporting is done in a quite inconsistent manner, which impairs its comparability. Thus, the platform has worked out guidelines for producing comparable reports.<sup>195 196</sup>

In this chapter, selected examples of the Austrian Health reporting will be presented. The selection only encompasses reports, which contain an intersectional approach in the sense that they include at least two of the discrimination categories gender, age, ethnicity, and disability.<sup>197</sup>

#### **“Sozio-demographische und sozio-ökonomische Determinanten von Gesundheit” / Report of Statistics Austria on “Socio-demographic and Socio-economic Determinants of Health” (2008)**

The Statistics Austria Report on “Socio-demographic and socio-economic Determinants of Health” (2008) based on the Austrian Health Survey 2006/2007 is a comprehensive and recent both on health and access to health. The report provides an in-depth analysis of the inter-relatedness of health with social status and living conditions. Thus, the study at hand refers to the central findings with particular consideration of the categories “migration background”, “gender” and “age”.

With respect to *ethnicity*, non-migrant Austrians are compared with members of the two main migrant groups of the country: Turks and Ex-Yugoslavians and/or people with the respective ethnic or national backgrounds. The definition of “migration background”

<sup>194</sup> For a comprehensive statement on Austrian health reporting see: <http://www.bmg.gv.at/home> (16.5. 2011).

<sup>195</sup> Gesundheit Österreich GmbH (2009) Jahresbericht 2009, available at [http://www.goeg.at/cxdata/media/download/berichte/GOEG\\_JB\\_2009.pdf](http://www.goeg.at/cxdata/media/download/berichte/GOEG_JB_2009.pdf)

<sup>196</sup> See for the guidelines: [http://www.bmg.gv.at/cms/home/attachments/5/1/9/CH1066/CMS1295609039169/empfehlungen\\_gb\\_e.pdf](http://www.bmg.gv.at/cms/home/attachments/5/1/9/CH1066/CMS1295609039169/empfehlungen_gb_e.pdf) (16.5. 2011).

<sup>197</sup> Other reports, such as the Austrian Report on Public Health (2009), the Report on Health and Diseases in Austria (2009), the Report on Infectious Diseases (2006), the Men’ Health Report (2004) and the Austrian Report on Psychiatric Diseases (2004) do not address inequalities in health from an intersectional perspective and thus have been left out.

combines citizenship and country of birth, thus covering both migrants who have kept their nationality and inhabitants with migrant origin who have obtained the Austrian citizenship. The health status of members of the “second generation”, however, who were already born in Austria and are Austrian citizens, might not be detected in the data. A further and rather serious limitation is due to the fact that the survey has been conducted in German, thus, particular risk groups might have been excluded.

As the age structure of Austrian inhabitants with and without migration background differs considerably – Austrians without migration background (as well as members of EU 27 and EFTA-states) are older in average – all data analysis in the Statistics Austria report is standardised for age respectively presented by age groups. *Gender* is included in all analyses.

The report proves to be the most comprehensive information basis for tackling the issue of multiple and intersectional discrimination with respect to health. The report focuses on influencing factors such as *income, education, occupational status, unemployment* and *ethnic background* in isolated chapters, and an intersectional analysis or discussion is available only for selected issues such as *smoking, adipositas, diabetes, chronic anxiety* and *depression, allergies, immunisation, uptake of preventive health screenings, and subjective health status*. Thus, some inequalities in health status that are attributed for example to migration background might as well reflect the effect of other aspects of social inequality.

### **“Gesundheitsbericht Wien 2004” / “Vienna Health Report 2004”**

The Vienna Health Report<sup>198</sup> (2004) summarises the information collected in other health reports and includes academic literature. Data is taken from Statistics Austria; main data sources are secondary analyses of the Austrian micro-census (predominately 1999) and the Austrian Statistical Yearbooks (2003, 2004) as well as the Austrian Year Books on Health (2002, 2003).

The report encompasses chapters on general epidemiology including the *subjective health status, chronic diseases, cardiovascular diseases, cancer, infectious diseases, mental health* and *health behaviour*.

The report also contains sections on the Austrian *social and health care system* in general and illustrates three selected areas of *preventative health provisions*: reproductive health provisions such as the “mother-child-card” (“Mutter-Kind-Pass”) and parent’s counselling centres (“Elternberatungsstellen”), the Vienna Vaccination Scheme (“Wiener Impfkonzzept”), and preventative screenings (“Vorsorgeuntersuchung”).

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<sup>198</sup> Stadt Wien (2004a) *Wiener Gesundheitsbericht*

*Age* and *gender* are considered as the health status and special health issues are discussed with reference to different social groups such as women and men, children, adolescents and old people.

In the chapter on social inequalities, *migrants* (with focus on people with Turkish and Ex-Yugoslavian background and asylum seekers) are included as a category of special interest. The discussion of social inequalities covers *gender*, *socio-economic status* including *income status*, *educational status*, and *occupational status*; and the report discusses influencing factors such as *poverty*, *migration*, *unemployment*, *working conditions* including *work accidents*, as well as *housing conditions* and *residential segregation*.

### **“Chronische Krankheiten in Wien “ / “Report on Chronic Diseases in Vienna” (2004)**

The Report on Chronic Diseases in Vienna<sup>199</sup> (2004) mainly draws on existing health reports such as the Vienna Reports on Health (2001, 2002), the Vienna Survey on Health and Social Issues (2001) and the Vienna Report on Life-Expectancy and Mortality (2003). Furthermore, it uses statistical information drawn from Statistics Austria and focuses on general Yearbooks on Health (2001, 2002) and from the Austrian Micro-census 1999, 2001 and 2001. Also academic literature is included.

The report contains an overview of selected chronic diseases such as *cardiovascular diseases*, different forms of *cancer*, *diseases of the musculoskeletal system*, *respiratory diseases*, *metabolic diseases* including *diabetes*, other chronic diseases, and *mental health issues*.

Data is disaggregated by *gender* and *age*. With the exception of a discussion of the bad subjective health perception and the high prevalence of chronic diseases in migrant communities, the report rarely considers the situation and health conditions of migrants and people with migration background.

### **“Österreichischer Frauengesundheitsbericht 2005 / 2006” / “National Report on Women’s Health 2005 / 2006”**

The National Report on Women’s’ Health<sup>200</sup> refers to a variety of data sources. Statistical data is mainly drawn from Statistics Austria demographic and Statistical Year Books 2002 and 2004, the Statistics Austria Yearbook on Health Statistics 2002, the Austrian

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<sup>199</sup> Stadt Wien (2004b) *Chronische Krankheiten in Wien*

<sup>200</sup> Bundesministerium für Gesundheit, Familie und Jugend - BMGFJ & Ludwig Boltzmann Institute for Women’s Health Research (2005) *Österreichischer Frauengesundheitsbericht 2005 / 2006*



Micro-Census (1991-2004), and Statistics Austria information on the life situation of elderly people (2002), gender-specific inequalities (2002), and the use of health services (2002). Furthermore, data of the Austrian “Hauptverband der Sozialversicherungsträger” [Main Association of Austrian Social Security Institutions] as well as academic literature are included.

The report covers health issues such as *chronic diseases, cardio-vascular diseases, reproductive health, cancer, infectious diseases, and mental health*. Furthermore, it differentiates between specific health topics for girls and young women, for women in the reproductive age, and for older women.

A discussion of the situation of women with mental and physical *disabilities* is included. “*Disability*” is discussed as a category, which leads to multiple discriminations of women regarding reproductive health issues and the access to health services as well as to education and employment.<sup>201</sup> However, no additional information is given on disabled women with migration background.

In the National Women’s Health Report, there is a focus on social dimensions of health. Social inequalities are addressed by the categories *gender, age, migration background (by county of birth or citizenship), and marital status* as well as *education, income, and occupational status*. There is no systematic discussion of the influencing factor *migration background* in all chapters. However, migrant women are explicitly addressed in the context of poverty, effects of straining life conditions on mental health (e.g. depression), as well as regarding the access to health services and regarding barriers concerning the use of health provisions.

Special chapters are dedicated to social issues such as *occupational inequalities and discriminatory gender-relations* within domestic settings, *violence against women, work and environment-related health issues, homelessness, drug addiction, and sex work*.

The National Women’s Health Report discusses the use and *availability of female-specific health care*. However, this chapter includes only service based data of few selected institutions with focus in women’s health, which also address migrant women. A special chapter is dedicated to health status and access to health services of female migrants. In this context, multiple discriminations based on *legal and social discrimination* of minority groups are mentioned.<sup>202</sup>

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<sup>201</sup> Bundesministerium für Gesundheit, Familie und Jugend, (2005) *Österreichischer Frauengesundheitsbericht 2005 / 2006*, p. 261ff

<sup>202</sup> Bundesministerium für Gesundheit, Familie und Jugend(2005) *Österreichischer Frauengesundheitsbericht 2005 / 2006*, p. 252f

**“Österreichischer Frauengesundheitsbericht 2010 / 2011” /  
“National Report on Women’s Health 2010 / 2011”**

The current National Report on Women’s Health<sup>203</sup> uses statistical information from Statistics Austria’s Demographic and Statistical Year Books 2002, 2004, and 2010, the year Book on Health Statistics 2008 and 2010, as well as from special statistic reporting on poverty (2009), fertility and demography (2009), migrants’ living and working conditions (2009), and includes academic literature.

The report is divided into sections regarding socio-demography, epidemiology, gender-specific living environments and living conditions, social-epidemiology and a special focus on gender-related health prevention and health promotion.

Specific covered health issues are *reproductive health, cardio-vascular diseases, cancer, mental health, and infectious diseases*. The social groups in focus are girls and young women, women in the reproductive age and older women, working women, migrant women and disabled women, and women in special health and living conditions.

The extra section on migrant women contains a reflection of the category *migration background*. An intersectional approach is taken in the sense that the report emphasises the fact that migrant women are not a homogeneous group, but that differing ethnic, cultural and national backgrounds, as well as structural factors such as the legal and the socio-economic status or the person’s age have to be taken into account.<sup>204</sup> Thus, a special section is dedicated to health status and access to health of asylum seekers.

Another special chapter is dedicated to *disabled women* and discusses socio-demographic and intersectional aspects of female disability. The therein specified health issues include violence against female disabled persons, barriers concerning the use of health services, and reproductive health issues as well as a discussion of the right for reproduction. The section on intersectional issues concerning female disabled persons mentions multiple discriminations on differing levels, encompassing socialisation, the access to education and employment, and the enforced effectiveness of societal stereotyping concerning sexuality and intimate partnerships, body norms and reproductive issues.<sup>205</sup> Furthermore, it is emphasised that disabled women – above all

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<sup>203</sup> Bundesministerium für Gesundheit – BMG (2011) *Österreichischer Frauengesundheitsbericht 2010/2011*

<sup>204</sup> Bundesministerium für Gesundheit (2011) *Österreichischer Frauengesundheitsbericht 2010 / 2011*, pp. 349, 354

<sup>205</sup> Bundesministerium für Gesundheit (2011) *Österreichischer Frauengesundheitsbericht 2010 / 2011*, p. 364f

women with mental disabilities – are more likely to become victims of sexualised and sexual violence than non-disabled women.<sup>206</sup>

### **“Vienna Report on Women’s Health 2006” / “Wiener Frauengesundheitsbericht 2006”**

The Vienna Report on Women’s Health<sup>207</sup> mainly draws on data collected by Statistics Austria’s demographic and statistical year books. Besides this, it summarises reports of the City Council Vienna (Stadt Wien) on health, reports of the Austrian Federal Institute for Health Care (ÖBIG), and reports of the Ludwig Boltzmann Institut für Frauengesundheitsforschung [Ludwig Boltzmann Institute for Women’s Health Research]. Besides this, academic literature is integrated.

The mentioned health issues encompass *cardio-vascular diseases, cancer, metabolic diseases* including *diabetes, respiratory diseases, musculoskeletal diseases, reproductive health* including *menopause, ageing, mental health*, and *domestic violence* as specific gender related issue.

*Access to health* and especially the access to *psycho-social services* is only broadly mentioned and not backed with systematic data.

The discussion of inequalities and specific health needs focuses on specific social groups and issues such as single mothers, migrant women, homosexual women, homeless women, and female sex workers.<sup>208</sup>

The report systematically includes the health situation of migrant women in all chapters and additionally dedicates an extra chapter to the discussion of their health status. However, the definition of *migration background* is not clear and only sometimes specified by *citizenship*. The report stresses the lack of data on health status and access to health of women with migration background and emphasises their risk of being discriminated on intersecting levels. The chapter on the health situation of migrant women covers topics such as barriers regarding the access to health services, aging and migration, social and health care for older migrants, intercultural challenges, and violence against migrant women.<sup>209</sup>

### **“Behindertenbericht 2008” / “Report on Disabled Persons 2008”**

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<sup>206</sup> Bundesministerium für Gesundheit (2011) *Österreichischer Frauengesundheitsbericht 2010 / 2011*, p. 365

<sup>207</sup> Stadt Wien (2006), *Wiener Frauengesundheitsbericht*

<sup>208</sup> Stadt Wien (2006) *Wiener Frauengesundheitsbericht*, p. 379ff

<sup>209</sup> Stadt Wien (2006) *Wiener Frauengesundheitsbericht*, p. 384ff

The Austrian “Report on Disabled Persons 2008”<sup>210</sup> is an important source of information concerning the intersectional discussion of the categories *disability*, *age*, and *gender*.

The report points out that representative data on the prevalence of disabilities is hardly available, apart from so called “service based data”, which is collected in service institutions for disabled persons. This is partly due to the fact that access to surveys on prevalence is legally restricted due to data protection. The Federal Data Protection Law permits the collection of data on disabled persons only if it is a necessary precondition for legal changes. As a consequence, the prevalence of disabilities is only screened according to differing types of disabilities, and it is thus not reflecting multiple disabilities. The main statistical data sources are the Austrian Micro-Census 2008 and the EU-SILC survey 2006.

Due to the lack of data, the report mainly focuses on the discussion of policies and legal measures in different relevant social fields (work, education, health, etc.). It encompasses a discussion of *policies on disability* on the European and on the national levels, *legal regulations* with focus on anti-discrimination legislation, and *barriers to social and health care*. Special chapters regard topics such as childhood and adolescence, education and vocational training, work market, partnership, sexuality and family life, social and health care, custodianship, living environment and structural measures to ensure accessibility, transport, tourism, sports, culture, religion, technical aids and taxes.

Special groups that are mentioned are for example *old people with disabilities*, *disabled women* and *migrants with disabilities*.

The report dedicates a special chapter to “disability and migration”, in which the categories *ethnicity*, *citizenship*, and *residence status* are discussed. However, the chapter does not provide empirical data but summarises legal regulations. Rather, it illustrates the EU anti-discrimination guideline and distinguishes between the categories *EU-migration background*, which is tackled by the EU anti-racism guideline (2000/43/EG) and *third-country-citizenship*. Another category, *asylum seeker*, is a sub-category of third-country-citizens. It is specifically addressed with respect to the equal treatment of disabled persons, which ensures f. e. interpreters of sign-language for asylum seekers. Furthermore the Austrian legislation concerning the right of residence and asylum procedures are screened.

### “Altern in Gesundheit” / “Vienna Healthy Aging Profile” (2007)

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<sup>210</sup> Bundesministerium für Arbeit, Soziales und Konsumentenschutz - BMASK (2009) *Behindertenbericht 2008. Bericht der Bundesregierung über die Lage von Menschen mit Behinderung in Österreich*

The Report on Healthy Aging<sup>211</sup> mainly draws on national and Viennese health reporting with a special focus on report on health in older age and the “Report on Seniors” (2000). Besides this, various Viennese reports on the general health status (2002) and special health topics such as chronic diseases (2003), aging and health (1997), life styles and health (2003), and mental health (2004) are important sources of data. Lastly, Statistics Austria’s Demographic and Statistical Year Books 2002 and 2004, and the Statistic Austria Yearbook on Health Statistics 2002, 2003 and 2004 are used as data sources.

The report illustrates demographic trends and prognoses and touches topics such as *health status and social and health care* for older people in general with special focus on nursing services. The discussion of social inequalities and influence factors includes *income and social status, environmental and living conditions* and their influence on the old persons’ health status; furthermore *work life and further education*, and lastly *social inclusion* of older people. A special chapter discusses barriers regarding the access to social and health care for *older migrants*.

### “Raxen Reports 2009 / 2010”

The “Raxen Reports” (Racism and Xenophobia Network) 2009 and 2010<sup>212</sup>, which provide human rights monitoring and the monitoring of discrimination, have been included in the review.

The reports focus on racist practices and structural discrimination in health care and in access to health and social services and stress that data on discrimination in the health care system is not systematically collected. Thus, predominantly service based data, mostly provided by NGOs in the field of anti-racist work (ZARA, Helping Hands) is available and usually does not explicitly address health.

Due to this lack of data the Raxen Reports focus on the *illustration of good practice and exemplary racist incidents*. “Good practices” are discussed mostly at the legal level including the National Action Plan on Integration (NAPI) in 2010 that encompasses migrants’ access to health care as well as the amendment of the medical law 2009 that regulates the access to the labour market for third country citizens.

The only Austrian report that focuses on racist stereotyping and prejudices as obstacles concerning access to health for migrants is a study by the Institute of Conflict Research.<sup>213</sup>

### “Statistisches Jahrbuch Migration and Integration” / “Statistical Yearbook Migration and Integration” (2010)

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<sup>211</sup> Stadt Wien (2007), *Altern in Gesundheit – Vienna Healthy Ageing Profile*

<sup>212</sup> FRA (2009), *RAXEN Report. Health Care*; FRA (2010), *RAXEN Report. Health Care*

<sup>213</sup> H. Amesberger, K. Auer & B. Halbmayer (2001) *Zugewanderte PatientInnen im Wiener Gesundheitssystem*, Vienna: Institute for Conflict Research

The Statistical Yearbook Migration and Integration<sup>214</sup> is edited by the Austrian Integration Fund and focuses on relevant topics regarding migration, such as demographic change, immigration and emigration, language and education, work, security, living and spatial contexts, identification and subjective attitudes regarding the “climate of integration”. A special chapter discusses social and health issues. Mainly, the Austrian Health Survey 2006 / 2007 is used as data basis.

The rather short chapter on health mentions briefly the following issues: *life expectancy, mortality, fertility*, selected health issues such as *diabetes, hypertension, allergies, migraine, chronic anxiety and depressions*, and work related chronic diseases, which are linked to heavy manual labour, such as *musculoskeletal diseases* (especially dorsal issues). Also the *access to primary and special health care and preventive screenings* is mentioned, however very roughly.

Data is presented by *migration background* (Turkish and Ex-Yugoslavian Background) and occasionally by *gender*, but not by age, which might lead to wrong conclusions due to the different age distribution between migrants and the majority society.

### **“Monitoring Integration Vienna” (2010)**

This report<sup>215</sup> is based on the Austrian Health Survey (2006 / 2007), Statistik Austria Micro-Census data, and a study on quality of life in Vienna.<sup>216</sup> The present lack of consistent data and the necessity of regular and coherent monitoring on a national level are discussed in the report.<sup>217</sup>

The Monitoring Integration Vienna Report discusses indicators for integration and demographic changes. Special topics such as legal regulations, education, work and labour market, income and social security, living conditions, political participation and social cohesion and security are mentioned.

A short chapter is dedicated to health. It discusses migrants’ *health status*, access to health services such as *GPs, outpatient and emergency departments, special health care, hospitalisation*, and the use of *preventative health services*.

Data is not systematically presented by gender or age. *Older migrants* are mentioned as particular group of interest, e.g. with respect to social and health care for the elderly including palliative care.

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<sup>214</sup> Österreichischer Integrationsfonds (2010) *Statistisches Jahrbuch Migration und Integration. Daten und Fakten*, available at:

[http://www.integrationsfonds.at/publikationen/zahlen\\_und\\_fakten/statistisches\\_jahrbuch\\_2010/](http://www.integrationsfonds.at/publikationen/zahlen_und_fakten/statistisches_jahrbuch_2010/) (3. 4. 2011)

<sup>215</sup> Stadt Wien (2010), *Monitoring Integration Wien*

<sup>216</sup> Stadtentwicklung Wien (2009)

<sup>217</sup> Stadt Wien (2010) *Monitoring Integration Wien*, p. 125ff

With respect to access to health, the report comes to the conclusion that social inequalities in general, but also the differences in national health systems are possible causes for inequalities in access to health care. Concluding, the report stresses the need for combating various forms of discrimination in access to health provisions and for developing suitable addressing strategies for different groups of migrants.

## 10. Demographics, Migration, and Diversity

In the year 2009, the Austrian Population stood at 8.363 million people. At reference date January 1st, 2010, the age distribution was as follows: 21 per cent of the population (1.745 millions) were children and adolescents up to 19 years. 62 per cent (5.145 millions) of the inhabitants were between 20 und 64 years old. 18 per cent (1.464 millions) of the population were aged 65 or older.<sup>218</sup>

In the year 2009, the *life expectancy at birth* was 77.4 years for males and 82.9 years for females. Currently, the *further life expectancy* of a 60 years old man will be 21.2 years, for a woman 25.1 years.<sup>219</sup>

The *peri-natal mortality* in Austria was 5.6 per thousand, the *stillbirth rate* 3.8 per thousand. *Maternal mortality* within 6 weeks after birth, interruption, or abortion was 2.6 per 100.000 live births, the mortality rate during pregnancy 5.6 per 100.000 life births, maternal mortality from 6 weeks until 1 year after birth, interruption, or abortion 6.5 per 100.000 live births.<sup>220</sup>

Currently, 17.8 per cent of the Austrian population have a *migration background*. This proportion includes people with foreign citizenship, people who were born abroad and have obtained the Austrian citizenship, and people whose parents were born in another country than Austria, regardless of the person's own citizenship. The largest groups with migration background are Germans, followed by migrants from Serbia, Montenegro, Kosovo, Turkey, Bosnia and Herzegovina, and Croatia.<sup>221</sup>

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<sup>218</sup> Statistik Austria (2010a) *Bevölkerung nach Alter und Geschlecht*, available at: [http://www.statistik.at/web\\_de/statistiken/bevoelkerung/bevoelkerungsstruktur/bevoelkerung\\_nach\\_alter\\_geschlecht/031384.html](http://www.statistik.at/web_de/statistiken/bevoelkerung/bevoelkerungsstruktur/bevoelkerung_nach_alter_geschlecht/031384.html) (25.02.2011)

<sup>219</sup> Statistik Austria (2010b) *Indikatoren zu Sterblichkeit und Lebenserwartung*, available at: [http://www.statistik.at/web\\_de/statistiken/bevoelkerung/demographische\\_masszahlen/demographische\\_indikatoren/023576.html](http://www.statistik.at/web_de/statistiken/bevoelkerung/demographische_masszahlen/demographische_indikatoren/023576.html) (25.02.2011)

<sup>220</sup> Statistik Austria (2010c) *Müttersterblichkeit in Österreich seit 2002 nach Todesursachen und Alter*, available at: [http://www.statistik.at/web\\_de/static/muettersterblichkeit\\_in\\_oesterreich\\_seit\\_1946\\_nach\\_todesursache\\_n\\_und\\_alter\\_021991.xls](http://www.statistik.at/web_de/static/muettersterblichkeit_in_oesterreich_seit_1946_nach_todesursache_n_und_alter_021991.xls) (25.02.2011)

<sup>221</sup> Österreichischer Integrationsfonds (2010) *Statistisches Jahrbuch Migration und Integration. Daten und Fakten*, available at:

Representative data on persons with *disabilities* are hardly available due to legal restrictions on grounds of data protection. The prevalence of disabilities is only known by different types of disabilities, not taking into account multiple disabilities. According to projected Micro Census Data of the years 2007 and 2008, 20.5 per cent of the respondents living in private households (projected: 1.7 millions) reported permanent impairment. However, this figure includes very heterogeneous issues and covers persons with minor visual impairment as well as people with mental health problems or complete restriction of mobility.

# 11. Inequalities in Health Status

The main data source for the following chapters is the Austrian Health Survey 2006 / 2007 data set because it provides the most recent data on both health status and access to health provision in Austria. The sample size and information on citizenship and country of birth allows for disaggregation by migration background, with exception of members of Austrian born members of the “second generation”, who are not covered by the scope of this definition. A notable limitation of the data is that the survey has been conducted in German, thus, particular risk groups might not have been included in the survey.

In the following chapters, non-migrant Austrians will be compared to members of the two main migrant groups of the country: Turks and individuals from the former Yugoslavia and/or people with the respective backgrounds. As the age structure of Austrian inhabitants with and without migration background differs – the population without migration background (as well as members of EU 27 and EFTA-states) is older in average – all data analysis will be presented by age groups.

All calculations are based on projected data. Thus, only clear trends and differences will be interpreted in order to avoid misleading conclusions.

The information based on the Austrian Health Survey will be supplemented by other sources of information, if appropriate.

## 11.1. Life Expectancy and Mortality

In the year 2009, the *life expectancy at birth* for Austrian-born Austrian citizens was 77.3 years for men and 82.8 for women. The life-expectancy of people with Ex-Yugoslavian background did only marginally differ from the life-expectancy of the Austrian majority

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[http://www.integrationsfonds.at/publikationen/zahlen\\_und\\_fakten/statistisches\\_jahrbuch\\_2010](http://www.integrationsfonds.at/publikationen/zahlen_und_fakten/statistisches_jahrbuch_2010)  
/ (3. 4. 2011)



population. As well, for men with Turkish background only small differences were found. Interestingly, women with Turkish background have a life expectancy of 85.3 years which is 2.5 years above the average of the majority society. The same is true for migrants from other countries.

Accordingly, the *further life expectancy* of Turkish women and of both men and women from other countries is higher when compared to the respective reference groups without migration background.

There is a discussion whether this finding is related to non-reported decease abroad or whether this might due to a „healthy migrant effect“. This effect describes the fact that in general rather young and healthy persons manage to migrate to other countries and also have been recruited as so-called “guest workers”. This fact finds its reflection in higher life expectancy and lower decease rates. Current data allow for calculating the effect of deceases abroad: Thus, the advance of foreign-born individuals decreases.<sup>222</sup>

With respect to causes of death, some facts stand out: In age corrected analysis, the mortality due to coronary diseases is about a quarter lower for men with migration background compared to the majority of society. For women with migration background, mortality due to both coronary diseases and cancer is about a fifth lower than for the majority of women in society. Only few causes of death affect people with migration background more often than the majority society: For example, death due to stomach cancer occurs more frequently in women with migration background, but less often in men with migration background.<sup>223</sup>

## 11.2. Fertility Rates and Infant Mortality

In the year 2009, with respect to the fertility the overall Austrian average was 1.39 children per woman. Austrian-born women gave birth to 1.27 children in average, foreign-born women to 1.84 children (Turkish women: 2.41 children, women from Ex-Yugoslavia: 1.87 children). It is remarkable that women with migration background who have obtained the Austrian citizenship have lower fertility (1.52 children) compared to women with migration background and foreign citizenship (1.98 children).

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<sup>222</sup> Österreichischer Integrationsfonds (2010) *Statistisches Jahrbuch Migration und Integration. Daten und Fakten*, available at:

[http://www.integrationsfonds.at/publikationen/zahlen\\_und\\_fakten/statistisches\\_jahrbuch\\_2010/](http://www.integrationsfonds.at/publikationen/zahlen_und_fakten/statistisches_jahrbuch_2010/)  
/ (3. 4. 2011)

<sup>223</sup> Österreichischer Integrationsfonds (2010) *Statistisches Jahrbuch Migration und Integration. Daten und Fakten*, available at:

[http://www.integrationsfonds.at/publikationen/zahlen\\_und\\_fakten/statistisches\\_jahrbuch\\_2010/](http://www.integrationsfonds.at/publikationen/zahlen_und_fakten/statistisches_jahrbuch_2010/)  
/ (3. 4. 2011)

In 2009, the *birth rate* of the population with foreign citizenship was 12.5 per thousand. This is clearly higher than the birth rate the in the majority of the population (8.7 per thousand). The birth rates for citizens of countries of the former Yugoslavia (10.6 per thousand) and EC and EEA-countries (11.3 per thousand) are lower than for Turkish and other citizens (14.9 per thousand resp. 17.3 per thousand).<sup>224</sup>

In the year 2009, the overall *peri-natal mortality* in Austria was 5.6 per thousand. However, for women with Turkish background (7.5 per thousand) and those from third countries (6.5 per thousand) it was significantly higher. For women from the former Yugoslavia (2.9 per thousand) on the contrary, peri-natal mortality was below the average. The same is true for women from other EC and EEA-countries.

The overall *stillbirth rate* in Austria in 2009 was 3.8 per thousand. The risk was clearly lower for women appertaining to the majority of society (3.2 per thousand) than for foreign-born women (4.9 per thousand). Women from the former Yugoslavia had the highest stillbirth rates (5.6 per thousand), mothers with Turkish or third country background had stillbirth rates of 5.0 per thousand.

## 11.3. General Health Condition (Self Assessment)

In general, *subjective health* is likely to decrease with age. A detailed analysis of the data from the Austrian Health Survey shows that in all age groups more respondents without migration background estimate their subjective health as good or very good compared to respondents with Turkish background or from the former Yugoslavia. Particularly notable is the low proportion of migrant women in the middle age group rating their health as good or very good. The finding could be interpreted as a premature aging of migrant women compared with women from the majority society. In the highest age group, the worst health status is reported by men with migration background (Table 2).

**Table 2: Self Reported Subjective Health: Good or Very Good**

Age	No migration background		Migr. background (Ex-Yu / T)	
	Male	Female	Male	Female
15 to 34	94.9%	93.0%	87.7%	81.0%
35 to 54	83.4%	83.2%	74.8%	54.9%
55+	56.1%	52.5%	30.1%	48.6%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

<sup>224</sup> Österreichischer Integrationsfonds (2010) *Statistisches Jahrbuch Migration und Integration. Daten und Fakten*, available at: [http://www.integrationsfonds.at/publikationen/zahlen\\_und\\_fakten/statistisches\\_jahrbuch\\_2010/](http://www.integrationsfonds.at/publikationen/zahlen_und_fakten/statistisches_jahrbuch_2010/) (3. 4. 2011)

Young women with Turkish or Ex-Yugoslavian background report less often chronic health issues than the majority of women in society (Table 3). However, in the middle age group, migrant women are clearly more affected than women without migrant background. In age, the groups align, with migrant women being more affected than men.

**Table 3: Self Reported Chronic Health Issues**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	17.9%	21.6%	17.1%	11.2%
35 to 54	32.2%	33.9%	20.1%	45.0%
55+	56.0%	60.5%	61.5%	68.3%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

Only a marginal proportion of respondents in young age feel *seriously restricted by any health issue*. In the middle age group it can be noticed that a remarkable proportion of women with Turkish background or from the former Yugoslavia report serious problems. In the highest age group, men with migration background are the most seriously restricted group (Table 4).

**Table 4: Self Reported Restriction by Health Issue: Seriously Restricted**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	2.2%	1.4%	1.2%	1.3%
35 to 54	6.9%	5.2%	4.1%	13.5%
55+	16.5%	20.4%	37.4%	27.0%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

Persons from the selected migrant groups report having suffered from *considerable pain* more frequently than members of the majority population. Age is a major determinant of these differences, as considerable pain increases with age.

These results show that the intersection of *age, gender, and migration background* lead to a distinct pattern of pain prevalence (Table 5). The high pain prevalence experience among older males with migration background might be interpreted as an effect of the hard labour carried out by so called “guest-workers”, which shows its harmful consequences in age, particularly when taking into account the results about pains of the musculoskeletal system mentioned below.

**Table 5: Considerable Pain during the last 12 Months**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	20.6%	26.3%	31.7%	34.0%
35 to 54	36.3%	38.7%	35.7%	50.4%
55+	47.5%	55.0%	68.7%	50.2%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

*Migraine and frequent headaches* in general are clearly related to gender (see Annex, Table 31), but also to migration background. Women with Turkish and Ex-Yugoslavian backgrounds face a higher risk of suffering from these diseases than women from the majority of society. For men with migration background, in the older age group an age effect can be observed that otherwise is unusual for these kinds of symptoms.

Between men with and without migration background, differences of pain prevalence can be particularly found with respect to pain of the *legs including knees, shoulders, cervical spine, back pain*, and pain of the *arms and the elbow*. Older male migrants also suffer more often from pain of the *lumbar spine* and the *hips and feet*. Women with Turkish and Ex-Yugoslavian background suffer more often than non-migrants from *migraine and frequent head ache, stomach and abdominal pain*, pain of the *cervical spine, legs including knees*, and of the *arms and the elbow*. Pain of the *shoulder, back and thoracic spine*, and the *hands and fingers* affects migrant women of the middle age group more than women of the majority society (see Annex, Table 32 to Table 40).

## 11.4. Morbidity and Specific Health Conditions

In the following chapters, recent Austrian data on a selection of specific health conditions will be presented. The selection is guided both by the relevance and prevalence of health issues and the focus on the specific target groups older people, women in reproductive age, and young adults with mental health problems, all groups particularly considering people with migration background.

### 11.4.1. Cardiovascular and Circulatory Diseases

In general, cardiovascular and circulatory diseases are likely to increase by age. This is particularly the case for hypertension where the data show a dramatic increase in the age group of 55 and more years. However, the data show that for Women with a Turkish or Ex-Yugoslavian migration background, such an increase of prevalence rates can already be found in the middle age group (35 to 54 years), this indicating a complex

inter-dependency of gender and age in people with migration background. In the highest age group however, the prevalence rates for people with and without migrations background are similar (Table 6).

**Table 6: Self Reported Life Time Prevalence of Hypertension**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	3.5%	3.2%	7.3%	6.2%
35 to 54	16.4%	10.5%	12.1%	36.6%
55+	43.2%	47.1%	41.1%	44.4%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

Myocardial infarction, apoplectic strokes and cerebral haemorrhages are more likely to happen in higher age (see Annex, Table 41 and Table 42). Projected data does not allow drawing reliable conclusions on the effect of the migration background.

In this context an alarming finding should be mentioned: A study on distribution of cardiac pacemakers in Tirol in the years 1999 to 2001 indicated a remarkable under-supply for the following groups: women, patients with migration background and in consequence especially women with migration (and particularly Turkish) background. A projection of figures shows a ratio of 4.4 pacemakers for 10.000 male and female Austrians per year, 1 pacemakers for 10,000 male and female Non-Austrians per year, and 0,6 pacemakers for 10,000 male and female Turkish citizens per year.<sup>225</sup>

#### 11.4.2. Diseases of the Musculoskeletal System and Connective Tissue

Arthrosis, arthritis, and rheumatism are clearly related with age, and additionally, there is a gender effect to the disadvantage of women. Among women with Turkish or Ex-Yugoslavian background there is a sharp increase of prevalence rates that can already be noticed in the middle age group. In the highest age group, the differences between migrant and non-migrant females disappear, whereas the difference between men with and without migration background increases (Table 7).

<sup>225</sup> Cited in International Organization for Migration (2003) Soziale Exklusion und Gesundheit von MigrantInnen in Österreich. European network for co-operation and exchanges on social exclusion and health issues for migrants - Austria, France, Greece, Portugal, Spain. National Report Austria. Available at [http://kompass.humanrights.ch/cms/upload/pdf/oe/gesundheit\\_migrantinnen.pdf](http://kompass.humanrights.ch/cms/upload/pdf/oe/gesundheit_migrantinnen.pdf) (14.6.2011), p. 34

**Table 7: Self Reported Life Time Prevalence of Arthrosis, Arthritis, and Rheumatism**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	2.7%	1.4%	.7%	1.9%
35 to 54	9.8%	10.6%	9.5%	19.1%
55+	28.5%	44.0%	34.5%	44.1%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

Problems with the column are already present in a remarkable proportion of younger respondents and further increasing by age. The overall results show that people with migration background throughout all age groups are more often affected by dorsal issues than those without migration background. There is a particularly high difference in men ages 55 and more which can be interpreted as a result of straining working conditions of former guest workers. For women, a noticeable difference between migrants and non-migrants can be found in the middle age group (Table 8).

**Table 8: Self Reported Life Time Prevalence of Dorsal Issues**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	18.9%	19.3%	22.5%	27.9%
35 to 54	38.6%	38.5%	39.8%	48.5%
55+	50.3%	52.7%	66.5%	53.9%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

Osteoporosis affects mainly women in higher age. Data analysis shows that older women with migration background report remarkably lower rates of osteoporosis than those without migration background (Table 9) which might be an effect of under-detection.

**Table 9: Self Reported Life Time Prevalence of Osteoporosis**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	0.1%	0.1%	0.0%	0.0%
35 to 54	1.2%	3.2%	1.4%	2.9%
55+	4.5%	24.1%	4.8%	12.2%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

### 11.4.3. Tumours and Cancer

Both men and women with Turkish and Ex-Yugoslavian backgrounds report suffering from *gastric and intestinal ulcer* more often than the majority population (Table 10). However, the reported cancer rates are lower in migrants. However, this finding should be interpreted with care as it might be an effect of data projection. It should be further investigated whether the cancer prevalence in migrants is in fact lower or whether there is an under-detection of cancer in the migrant population (Table 10).

**Table 10: Self Reported Life Time Prevalence of Gastric and Intestinal Ulcer**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	2.0%	2.0%	2.9%	2.7%
35 to 54	6.0%	4.9%	11.6%	8.3%
55+	14.1%	9.3%	18.8%	14.8%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

**Table 11: Self Reported Life Time Prevalence of Cancer**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	0.6%	0.3%	0.0%	0.5%
35 to 54	2.4%	3.0%	0.2%	1.1%
55+	6.5%	8.2%	4.7%	4.3%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

#### 11.4.4. Diabetes

The diabetes risk increases with age. It is worthwhile noticing that for women with a Turkish or Ex-Yugoslavian background, a sharp increase of the diabetes prevalence can already be observed in the middle age group (Table 12).

**Table 12: Self Reported Life Time Prevalence of Diabetes**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	0.4%	0.8%	1.8%	1.9%
35 to 54	2.0%	1.6%	3.6%	11.5%
55+	14.9%	14.6%	12.1%	19.9%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

To further investigate the reasons for the comparably high rate of diabetes in migrant females of the middle age groups, it would be advisable to consider the social context of this disease.

For diabetes, the Statistics Austria report “Socio-demographic and Socio-economic Determinants of Health”<sup>226</sup> provides complex logistic regression models for both *genders* including *age* and various indicators for social inequalities such as *income, type of work, current occupational status, education, migration background*. In this model, not the migration background but rather other forms of social inequalities prove to be relevant risk factors.

For women, all included indicators for social inequalities except education show significant effects, for males the current occupational status turns out to be a major

<sup>226</sup> Statistik Austria (2008) *Sozio-demographische und sozio-ökonomische Determinanten von Gesundheit 2006 / 2007*



predictor. Interestingly, the income – but also migration background – only shows significant effects for women.<sup>227</sup>

Following these findings in their complexity, preventive strategies should focus on multiple social risk factors.

### 11.4.5. Disability

Some basic information on the prevalence of disabilities can be taken from the “Austrian Report on Disabled Persons”.<sup>228</sup> According to projected Micro-Census data of the year 2007 and 2008, 20.5 per cent of the respondents living in private households are affected by permanent impairment. However, this figure includes very heterogeneous issues and covers persons with sensual impairment, restriction of mobility, mental health problems, and other chronic and impairing health issues.

The most prevalent form of impairment are permanent *mobility restrictions* (13.0 per cent). 3.9 per cent of the population are affected by *visual* and 2.5 per cent by *hearing impairment*. 2.5 per cent of the Austrian population suffer *mental health problems* and psychological distress, 1.0 per cent report to have *intellectual and learning difficulties*, 0.8 per cent are impaired by *speaking difficulties*.

In general, *permanent impairment* is highly age related. This is true for both genders. According to EU-SILC Data, women are a particularly vulnerable group due to their longevity. Women aged 60+ are often affected by visual impairment, hearing impairment, and mobility restrictions, but also mental health problems.

7.0 per cent of the Austrian population (and about a third of all people with permanent impairment) are affected by *multiple impairment*. Again, multiple forms of impairment are more common in women of high age. As all women participating in the survey live at home and a considerable amount of them alone, this figure indicates an increasing demand for appropriate health offers.<sup>229</sup>

As the “Austrian Report on Disabled Persons” does not disaggregate the data by migration background, this information will be added on basis of the Austrian Health Survey. The questionnaire contains a range of question on various physical impairments which allow for calculating a selection of respective indicators.

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<sup>227</sup> Statistik Austria (2008) *Sozio-demographische und sozio-ökonomische Determinanten von Gesundheit 2006 / 2007*, p. 100f

<sup>228</sup> Bundesministerium für Arbeit, Soziales und Konsumentenschutz (2009) *Behindertenbericht 2008. Bericht der Bundesregierung über die Lage von Menschen mit Behinderungen in Österreich*

<sup>229</sup> Bundesministerium für Arbeit, Soziales und Konsumentenschutz (2009) *Behindertenbericht 2008. Bericht der Bundesregierung über die Lage von Menschen mit Behinderungen in Österreich*, p. 10f

All results show the above mentioned age and age-gender effect (higher vulnerability of older women) which will not further be commented on.

Interestingly, younger respondents with Turkish or Ex-Yugoslavian background seem to report less *visual impairment* in comparison to respondents from the majority society. In older age, however, the advantage of migrants disappears (Table 13).

**Table 13: Self Reported Visual Impairment**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	17.7%	27.7%	5.7%	11.9%
35 to 54	19.5%	25.2%	9.3%	24.7%
55+	26.0%	39.5%	28.6%	38.2%

*Indicator for visual impairment: capability of seeing a face from 4 metres distance without any visual aid*

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

*Hearing impairment* is hardly present in the young and middle age group, but it dramatically increases in the group from 55 years on. Respondents with migration background report less often on hearing impairment (Table 17).

**Table 14: Self Reported Hearing Impairment**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	0.9%	1.8%	1.5%	0.6%
35 to 54	3.2%	3.1%	2.9%	0.8%
55+	14.6%	14.3%	10.7%	6.1%

*Indicator for hearing impairment: capability of following a conversation of some conversation partners without any hearing aid*

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

It can be observed that *restriction of mobility* already increases in the middle age group women with Turkish and Ex-Yugoslavian background. This gives reason to the assumption that particularly in this context age should be seen a social rather than a merely biological category, reflecting straining living conditions (Table 15).

**Table 15: Self Reported Restriction of Mobility**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	0.4%	0.4%	0.4%	0.9%
35 to 54	1.6%	1.2%	1.4%	6.3%
55+	10.9%	19.5%	10.3%	16.3%

*Indicator for restriction of mobility: being capable of walking 500 metres without any aid*

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

*Physical impairment* affects young men and women hardly ever, regardless of their migration status. In the middle age group, there is a sharp increase in physical impairment to be observed for women with migration background. In the highest age group (55 years and more), a clear difference between men with and without migration background can be observed. These findings might indicate the effects of hard labour work and straining living conditions (Table 16).

**Table 16: Self Reported Physical Impairment**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	0.7%	1.1%	0.7%	1.6%
35 to 54	6.1%	6.0%	7.9%	17.6%
55+	24.9%	34.8%	36.0%	39.6%

*Indicator for physical impairment: capability of bending or kneeling down without difficulties*

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

#### 11.4.6. Mental Health

According to Micro-Census data, 2.5 per cent of the Austrian population suffer from permanent mental health issues (such as depression, chronic anxiety, or psychosomatic diseases).

Generally, mental health problems are to be seen as multi-causal health issues. Thus, intersections of gender, age, and migration background play an important role. Throughout all age groups, women are more often affected than men. Age has a strong

effect on the prevalence of mental health issues, which is even more relevant in women than in men.<sup>230</sup>

In the mental health literature and in experts' consultation, mental health is regularly pointed out as crucial issue with respect to the health situation of the population with migration background. For migrants – and especially for migrant women – it is stressed that they are often affected by psycho-social distress, above all in older age.<sup>231</sup> Traumatization, insecurity with respect to precarious residence status, poverty, discrimination and the experience of racist incidents can have harming effects on mental wellbeing and raise new challenges for health providers.<sup>232</sup> It should be critically mentioned, however, that the Austrian Report on Psychiatric Diseases<sup>233</sup> does not mention the issue at all.

The Statistics Austria report “Socio-demographic and Socio-economic Determinants of Health” provides complex empiric analysis (logistic regression) on that issue. The results show that even if accounting for other socio-economic influence factors, migration background remains an important factor, which points to migration related distress. But in this context the important role of social inequalities has to be stressed: The current occupational status proves to be the most salient predictor both for women and men, with effects much stronger for men than for women. Simplifying, it can be said that being out of the labour process increases the risk of chronic anxiety and depression. Low income and for women also simple manual work could be identified as other important influence factors on mental health.<sup>234</sup>

On basis of the Austrian Health Survey, data on *chronic anxiety and depression* can be disaggregated by age, gender, and migration background. The results show that in the middle age group, women with Turkish and Ex-Yugoslavian background are

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<sup>230</sup> Bundesministerium für Arbeit, Soziales und Konsumentenschutz (2009) *Behindertenbericht 2008. Bericht der Bundesregierung über die Lage von Menschen mit Behinderungen in Österreich*, p. 11

<sup>231</sup> Stadt Wien (2004a) *Wiener Gesundheitsbericht*

<sup>232</sup> See for example R. Kronsteiner (2009) ‘Migrationsprozess – Trauma – Gesundheit. Theoretische Grundlagen der psychosozialen Versorgung von MigrantInnen’, in: Six-Hohenbalken, M. & Tošić, J. (eds) *Anthropologie der Migration. Theoretische Grundlagen und interdisziplinäre Aspekte*. Vienna: Facultas, pp. 322-342; K. Ottomeyer & W. Renner (2008) ‘Die doppelte Befremdung: Diagnostik und wirksame Psychotherapie bei traumatisierten Flüchtlingen’, in: Golsabahi, S. & Heise, T. (2008) *Von Gemeinsamkeiten und Unterschieden*, Berlin: VWB Verlag, pp. 165-175; H. J. Assion (2005) ‘Migration und psychische Krankheit’, in: H.-J. Assion (ed.): *Migration und seelische Gesundheit*. Heidelberg: Springer, pp. 133-144; H. Fronek (1994) *Psychiatrische Belastungen und Bewältigungen des Langzeitexils. Am Beispiel von in Wien lebenden Exilchilenen mit extremtraumatischer Erfahrung*. Vienna: unpublished Thesis, University of Vienna

<sup>233</sup> H. Katschnig, P. Denk, P. & M. Scherer (2004): *Österreichischer Psychiatriebericht 2004. Analysen und Daten zur psychiatrischen und psychosozialen Versorgung der österreichischen Bevölkerung*. Vienna: Ludwig Boltzmann Institute for Social Psychiatry

<sup>234</sup> Statistik Austria (2008) *Sozio-demographische und sozio-ökonomische Determinanten von Gesundheit 2006 / 2007*, p. 102f

considerably more often affected by chronic anxiety and depression than those without migration background. In the higher age group, both men and women with migration background are more often affected than the majority society. The considerable differences of about 15 per cent show clearly that there is an issue to be addressed with respect to the health situation of the migrant population in Austria (Table 17).

**Table 17: Chronic Anxiety and Depression**

Age	No migration background		Migr. background (Ex-Yu / T)	
	Male	Female	Male	Female
15 to 34	2.4%	4.2%	2.3%	4.1%
35 to 54	5.7%	10.0%	4.2%	24.1%
55+	10.1%	14.8%	24.9%	31.7%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

## 11.5. Health Related Life Style

Two selected indicators for health related lifestyles will be presented in this chapter. In general, the relation between socio-economic status and health behaviour resp. lifestyles and risky *health behaviour* or a lack of preventive health care is mentioned in the Austrian Health Report(s).<sup>235</sup>

Data from the Austrian Health Survey shows that extensive tobacco consumption is more common in younger and middle age groups. Generally, men smoke more often than women and people with migration background more often than the majority society. Consequently, male migrants are described as a hardly reachable risk group with respect to extensive tobacco consumption.<sup>236</sup> However, complex logistic regression analysis points out other factors, such as the kind of work (particularly manual work), unemployment or permanent incapability of working, and low education play a more important role than the migration background itself.<sup>237</sup>

<sup>235</sup> See for example Stadt Wien (2004a) *Wiener Gesundheitsbericht*, p. 363ff

<sup>236</sup> Stadt Wien (2004a) *Wiener Gesundheitsbericht*

<sup>237</sup> Statistik Austria (2008) *Sozio-demographische und sozio-ökonomische Determinanten von Gesundheit 2006 / 2007*, p. 95ff

**Table 18: Daily Smoking**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	31,2%	27,0%	47,7%	33,0%
35 to 54	30,2%	24,1%	46,2%	32,2%
55+	14,7%	8,2%	33,8%	16,8%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

Adipositas ("obesity", defined by a Body Mass Index of 30 and more) increases with age. Based on the data at hand, particularly women with Turkish or Ex-Yugoslavian background can be identified as risk group.

However, complex logistic analysis shows a much more complex picture for women's obesity. Particularly the current occupational status has a strong effect: Women who are permanently incapable of working or unemployed face a much higher risk of obesity than employed women. Also, the type of (former) employment, education, and the income level play an important role: Women who have only accomplished compulsory education and women in the lowest, but also in the second highest income class face an increased risk of obesity. Migration background is a rather weak factor compared to the influences caused by social inequality. Anyway, the results should be interpreted with caution, because the total model has rather weak properties.<sup>238</sup>

<sup>238</sup> Statistik Austria (2008) *Sozio-demographische und sozio-ökonomische Determinanten von Gesundheit 2006 / 2007*, p. 98f

**Table 19: Adipositas (Obesity)**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	5,0%	4,9%	11,2%	9,0%
35 to 54	12,7%	10,6%	19,8%	27,1%
55+	16,9%	19,2%	24,2%	40,8%

*Definition of Adipositas: Body Mass Index of 30 and more*

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

## 12. Inequalities in Access to Health Care

Even if the public health literature stresses the social dimension of health and access to health care, only recently some representative data is available that allows for disaggregating access to health by social inequalities such as the migration background. The following chapter is based on data of the Austrian Health Survey, supplemented by other information sources.

### 12.1. Access to GPs / Primary Health Care

It is regularly stated in the literature that people with migrant background tend to use primary health care more often and specialist health care less often than the majority society.<sup>239</sup> The available and current data sheds a more detailed light on these findings.

The Statistics Austria health survey contains the question whether the respondent has seen a *general practitioner* (GP) in the last year. The need for a GP in general increases with age, and with one exception – migrants in the highest age group – women tend to see their GP more often than men. In the young and middle age groups, women with Turkish or Ex-Yugoslavian background clearly see the GP more often than the other groups. This effect decreases by age (Table 20).

<sup>239</sup> Österreichischer Integrationsfonds (2010) *Statistisches Jahrbuch Migration und Integration. Daten und Fakten*, available at: [http://www.integrationsfonds.at/publikationen/zahlen\\_und\\_fakten/statistisches\\_jahrbuch\\_2010/](http://www.integrationsfonds.at/publikationen/zahlen_und_fakten/statistisches_jahrbuch_2010/) (3. 4. 2011)

**Table 20: Access to General Practitioner in the Last Year**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	68.2%	75.6%	67.8%	84.1%
35 to 54	73.3%	77.3%	72.8%	84.1%
55+	87.3%	91.2%	94.7%	91.6%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

With respect to the usage of *outpatient departments and emergency units*, the descriptive analysis of empirical data contradicts the frequently cited perception that migrants use outpatient departments more often than the majority society. Analysis provides no evidence of a systematic over- or under-usage of this type of medical service by migrants. Instead, the picture is more complex and should be interpreted with care due to the use of projected data. Only in the highest age group, men with migration background report having visited an outpatient departments or emergency unit more often than the other groups (Table 21).

**Table 21: Access to Outpatient Departments or Emergency Units in the Last Year**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	21.3%	18.8%	15.2%	16.6%
35 to 54	17.8%	16.9%	7.0%	20.7%
55+	17.8%	20.2%	28.3%	22.9%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

## 12.2. Access to Secondary / Specialist Health Care

### 12.2.1. Access to Gynaecologists

Women with migration background have a lower uptake of gynaecological health care than women without migration background. The data of the Austrian Health Survey gives evidence that particularly in reproductive age, women of Turkish or Ex-Yugoslavian background see a *gynaecologist* less often than women from the majority society. In the highest age group, however, the picture changes: women with migration background see a gynaecologist more often than women without migration background (Table 22).



**Table 22: Access to Gynaecologists in the Last Year**

Age	No migration background	Migration background (Ex-Yu / T)
15 to 34	68.5%	57.5%
35 to 54	69.0%	53.9%
55+	36.1%	41.5%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

Both lack of information on the side of socially marginalised groups in general and lack of awareness of gynaecological health service providers for cultural and migration related issues might be responsible for the alarmingly low up-take of gynaecological services by migrant women. Another possible reason could be the low number of gynaecologist contracted by the public health insurance (KassenärztInnen).

For women without any insurance coverage, gynaecological treatment is offered by two institutions: AMBER-MED, situated in Vienna (a joint project of the refugee service of Diakonie Austria and the Austrian Red Cross), and Marienambulanz, situated in Graz (jointly financed by the Federal Ministry for Health, Family and Youth, the province of Styria, the Municipal Health Authority of Graz, and the Caritas).

### 12.2.2. Access to Dental Care

In the literature, dental health is regularly pointed out as a crucial public health issue. In older publications, the issue has been linked to lower socio-economic status, but recently, there is a shift to discuss dental health with respect to migration background and to focus on this particular target group.<sup>240</sup>

With respect to migration background, the data of the Austrian Health Survey show that there is a dramatic under-usage of *dental care services* by migrants of Turkish or Ex-Yugoslavian background. This is most evident among women from the middle age group, where nearly a 30 per cent gap is found. The picture changes in the age group of 55 years and more, where the different groups align on a rather low up-take level (Table 23).

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<sup>240</sup> See for example Österreichisches Bundesinstitut für Gesundheitswesen (2009) p. 34ff, (2010) p. 60

**Table 23: Access to Dentist in the Last Year**

Age	No migration background		Migr. background (Ex-Yu / T)	
	Male	Female	Male	Female
15 to 34	65.3%	72.6%	47.7%	62.8%
35 to 54	65.5%	75.0%	45.1%	47.2%
55+	50.9%	45.7%	46.5%	46.2%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

Social inequalities rather than cultural assumptions could be conclusive context explanations for the alarming under-representation of migrants. One possible reason for these findings might be the – sometimes remarkable – expenses for patient's contribution, which incur for some types of dental treatment such as anaesthesia for minor interventions or dental prosthesis such as bridges, implants etc.<sup>241</sup>

### 12.2.3. Access to Internal Specialists

In the highest age group, persons with Turkish and Ex-Yugoslavian background see an *internal specialist* more often than those without migration background. The same is true for women in the middle age group, but not for migrant men which are under-represented. The pattern might resemble the pattern of conditions as for example cardiovascular diseases or diabetes (Table 24).

<sup>241</sup> Österreichischer Integrationsfonds (2010) *Statistisches Jahrbuch Migration und Integration. Daten und Fakten*, available at: ["http://www.integrationsfonds.at/publikationen/zahlen\\_und\\_fakten/statistisches\\_jahrbuch\\_2010/](http://www.integrationsfonds.at/publikationen/zahlen_und_fakten/statistisches_jahrbuch_2010/) (3. 4. 2011)

**Table 24: Access to Internal Specialist in the Last Year**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	5.4%	8.0%	7.0%	3.7%
35 to 54	12.6%	13.5%	6.3%	24.8%
55+	26.9%	25.1%	34.0%	38.0%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

#### 12.2.4. Access to Orthopaedic Specialists

Bearing in mind the fact that a remarkable proportion of people with Turkish or Ex-Yugoslavian background suffers from back pain and the musculoskeletal system, the access to *orthopaedic specialist* might be of particular interest. It can be seen, that in the age group 55+, both male and female migrants see the orthopaedic specialist much more often than members of the majority society, for men there is even a gap of 23 per cent. For women, such a difference between migrants and non-migrants can already be found in the middle age group (Table 25). Thus, the service uptake reflects the health needs.

**Table 25: Access to Orthopaedic Specialist in the Last Year**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	7.1%	5.4%	4.2%	6.4%
35 to 54	8.8%	11.4%	7.9%	17.8%
55+	12.2%	18.3%	35.2%	32.7%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

#### 12.2.5. Access to Mental Health Care

Data on the access mental health care has not been included in the Austrian Health Survey.

The Austrian Women's Health Report mentions language barriers and the lack of interpreters as the most important problems, particularly for asylum seekers. Intercultural ambulances, which are located in the Psychiatric Hospital Wagner Jauregg and in the outpatients department for Psychiatry and Psychotherapy of the General

Hospital Vienna, are mentioned as good practices.<sup>242</sup> Another outpatients department with multi-lingual and inter-cultural service is available at the Sigmund Freud Privat Universität Wien.

Facilities dedicated to the treatment patients without health insurance, such as AMBER (Vienna) or Marienambulanz (Graz) are also very important contact points for migrants with mental health issues.

## 12.3. Access to Check-ups / Screenings / Preventive Offers

### 12.3.1. Access to Immunisation

Inhabitants with Turkish or Ex-Yugoslavian background more often lack complete *immunisation* compared to the majority society. For selected vaccinations, even differences of up to 40% between people with and without migration background can be found. In general, older people are more likely of not having sufficient immunisation. In the group of older migrants, this leads to a dramatic under-protection with respect to e.g. Polio or Diphtheria (see Annex, Table 43 to Table 46).

### 12.3.2. Access to Preventive Medical Screenings

Preventive medical screenings are – not exclusively, but particularly relevant – for population in middle and higher age. Data from the Austrian Health Survey indicate a disadvantage of the migrant population.

Parts of the Austrian population with Turkish or Ex-Yugoslavian background have a remarkably lower up-take of preventive medical services compared to majority society. This is the case both for general preventive screenings and for specific cancer prevention exams. With respect to *general preventive screenings*, differences are found in all age groups, but they are particularly remarkable in the middle age group (Table 26).

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<sup>242</sup> Bundesministerium für Gesundheit (2011) *Österreichischer Frauengesundheitsbericht 2010 / 2011* BIZEPS 2010: Krank, behindert, ungehindert.... In Wien, p. 359

**Table 26: Uptake of Preventive Medical Screening**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	30.8%	32.1%	17.2%	24.3%
35 to 54	61.0%	59.4%	23.5%	32.2%
55+	59.9%	55.5%	34.6%	29.9%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

Respondents aged 40 and above have been asked about the up-take of cancer prevention offers. With regards to *preventive colonoscopy*, particularly older men with Turkish and Ex-Yugoslavian background are under-represented (Table 27).

**Table 27: Uptake of Preventive Colonoscopy**

	No migration background		Migr. background (Ex-Yu / T)	
Age	Male	Female	Male	Female
Minimum age 40 to 54	15.2%	14.1%	4.6%	9.9%
55+	40.5%	36.7%	17.8%	25.2%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

Also the uptake of the *PSA test* for prevention of prostate cancer is lower among migrant men aged 40 or more. Particularly in the age group 35 to 54, this preventive test is hardly ever used by men with Turkish or Ex-Yugoslavian background (Table 28).

**Table 28: Uptake of PSA Test**

Age	No migration background	Migr. background (Ex-Yu / T)
Minimum age 40 to 54	32.5%	6.0%
55+	69.0%	51.7%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

In accordance with the findings about lower uptake of gynaecological services, women with migration background have lower access to gynaecological prevention.

Women aged 40 years and more have been asked whether they have had a *mammography* which is recommended. Women with Turkish or Ex-Yugoslavian background are clearly under-represented with respect to the uptake up this type of cancer prevention offer (Table 29).

**Table 29: Uptake of Mammography**

Age	No migration background	Migr. background (Ex-Yu / T)
Minimum age 40 to 54	64.3%	48.8%
55+	81.5%	64.1%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

With respect to the *pap smear test* for the prevention of cervical cancer, there are remarkable differences between women with and without migration background as well. This is particularly the case in the middle age group. Whereas nearly all women of the majority society report on having had a pap smear test, this is only the case for about six out of ten women with Turkish or Ex-Yugoslavian background (Table 30).

**Table 30: Uptake of Pap Smear Test**

Age	No migration background	Migr. background (Ex-Yu / T)
15 to 34	73.2%	47.9%
35 to 54	94.5%	58.8%
55+	81.9%	60.0%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

## 12.4. Provisions for Specific Women's Health Issues

For about two decades now, there is a rising awareness about the health needs of women, which for example is reflected by the introduction of gender specific health reporting. Increasingly, awareness for the health needs of women with migration background is to be noticed.

Women with migration background are considered as important target group of Women's Health programmes. They are explicitly addressed in the "Wiener Programm für Frauengesundheit" [Viennese Program for Women's Health], which has been installed in 1999 and generally encompasses the following topics: reproductive health (focus: post-natal depression) and prevention (focus: breast cancer), psychic health, addiction prevention, physical and psychic violence against women and children and support of women within the health system.<sup>243</sup> The programme focuses on female migrants' health and encompasses special offers and programmes such as

<sup>243</sup> Stadt Wien (2006) *Wiener Frauengesundheitsbericht*, p. 48

mammographic screenings, cardiovascular health support, and psycho-social support for migrant women.<sup>244</sup> Furthermore, a study regarding access to health care and living conditions of female disabled migrants is announced, which is not available yet.<sup>245 246</sup>

In the following, provisions for some specific women's health issues will be briefly mentioned which might be relevant for some women with migration background. However, even if these paragraphs address very sensitive issues which require suitable treatment and prevention strategies, the heterogeneous group of migrant women should not be reduced to these issues.

The Vienna Report on Women's Health<sup>247</sup> contains a section on violence which focuses on domestic violence and encompasses the topics FGM and forced marriages and so-called "traditional violence" as well as human trafficking. Most attention is dedicated to *FGM*, which is described as issue of increasing interest in the last years, leading to the establishment of special programmes and specific research. In 2005, the Vienna Program for Women's Health together with the "Fonds Gesundes Österreich" [Fund Healthy Austria] and the Municipal Department for Diversity and Integration founded a counselling centre for victims of FGM, contemporaneously, information brochures in various languages were disseminated, and information days were organised.<sup>248</sup> Furthermore, a study on FGM in Austria was conducted (see: BMGF 2006c).

Migrant women who are working as sex workers are also stressed as a specific health risk group as there are high ratios of infections with sexually transmitted diseases amongst this group.<sup>249</sup> These women are particularly vulnerable because of their likeliness to work illegalised and thus unregistered, which restricts their access to health services. Thus, they are subject to structural discrimination due to their lack of information and legal barriers regarding the access to health services and legal employment.

### 12.5. Reproductive Health (Pregnancy, Birth and after-birth Care)

The above mentioned findings on inequalities regarding the access to gynaecologists answer most of the questions on this issue. Most of the regular reproductive health provisions (such as check-ups in the frame of the "mother-child-card", see below,

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<sup>244</sup> Stadt Wien (2006) *Wiener Frauengesundheitsbericht*, p. 67

<sup>245</sup> The mentioned study "Studie zur Lebenssituation von behinderten Frauen und Mädchen mit Migrationserfahrung" should have been carried out by "Initiative Minderheiten" but is not published yet.

<sup>246</sup> Stadt Wien (2006) *Wiener Frauengesundheitsbericht*, p. 375

<sup>247</sup> Stadt Wien (2006) *Wiener Frauengesundheitsbericht*

<sup>248</sup> Stadt Wien (2006) *Wiener Frauengesundheitsbericht*, p. 393f

<sup>249</sup> Stadt Wien (2006) *Wiener Frauengesundheitsbericht*, p. 403ff

contraceptives on prescription, regular check-ups with focus on cancer prevention) are provided by gynaecologists. Others which require specialised facilities available in hospitals (such as screening of fetal organs by ultrasonics) are possible only by referral of gynaecologists. Thus, women who do not consult the gynaecologist – among them women with migration background – can not benefit from these provisions.

Pre-natal examinations in the context of the “mother-child-card” (“Mutter-Kind-Pass”) are available to all pregnant women with registered residence in Austria, independently of their insurance-status. The “mother-child-card” covers five gynaecological examinations of the mother during pregnancy, three ultrasonic examinations of the baby, general blood testing, HIV-testing, a check-up for gestational diabetes and several medical examinations of the child up to the age of five.

In case of medical emergency, Austrian hospitals are obliged to provide the necessary medical treatment, independently of insurance status. This applies also to women giving birth. However, the expenditures for obstetric care have to be taken by the woman herself (which under extremely unfavourable conditions might be conducted by levy of execution). In individual cases, individual solutions for cost absorption can be negotiated.<sup>250</sup>

## 12.6. Provisions for Older People

Information on access to health with respect to older people can be retrieved from previous chapters which have been systematically disaggregated by age.

With respect to older people, data on access to orthopaedic specialists and internal specialists might provide valuable insights. As well, information on selected preventive health screenings which are recommended for people from the age of 40 onwards is relevant for this age group. This information is presented above in the respective chapters.

The report Healthy Ageing Profile<sup>251</sup> contains figures on the availability of long term care homes and palliative care, but not in relation to the demand in this area. Data is not disaggregated by any category. Furthermore, no systematic evaluation is obtainable with respect to the needs of different social groups or possible referral barriers.

In Austria, health promotion for older people is strongly promoted and receives attention in health policy. In the years 2003 to 2005, the health promotion project “Aktives Altern” (“Active Ageing”) aimed at strengthening participation and improving

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<sup>250</sup> This information was provided by the Federal Ministry for Health, AMBER and Marienambulanz

<sup>251</sup> Stadt Wien (2007), *Altern in Gesundheit – Vienna Healthy Ageing Profile*



the health and living conditions of inhabitants aged 55 and more. Activities encompassed the activation of older people's resources, the improvement of social and health infrastructure and its accessibility, and networking between institutions.<sup>252</sup>

Reactions of health policy to demographic change increasingly have to consider the situation of the migrant population. In this context, health inequalities arise at the intersection of migration background and age.<sup>253</sup> Those migrant workers who came to Austria in the 70es now enter higher age. As a consequence, various sources and experts stress the necessity to provide care infrastructure for older migrants and to ensure their access to health and social services.<sup>254</sup> Specific health issues and needs that might affect older migrants, such as physical decline, functional impairment, early retirement and the resulting poverty risk, mental health problems, bad housing conditions, etc. have to be addressed.<sup>255</sup>

Suitable health policies for older migrants require structural changes in the health sector. This includes low threshold approaches and promoting intercultural competences within the health system. The Viennese Healthy Ageing Profile mentions the previously existing lack of intercultural competence in health and geriatric nursing facilities as important barrier for old people with migration background.

Good practices encompass information services for migrants with a special focus on information distributors with migration background, the employment of health and care personnel with migration background and various language competences, special health care offers and services for older migrants which are adapted to diverse needs and lifestyles, such as native-language counselling services for older migrants, and a senior's meeting point ("Seniorentreff") for older migrants.<sup>256</sup>

The Viennese Healthy Ageing Profile mentions other specific barriers regarding the access to social and health care for *older migrants*. It focuses on legal aspects and stresses that a considerable number of older migrants is affected by legal barriers, due to the fact that care allowances are bound to legal residence and pension entitlement, or to the Austrian citizenship.<sup>257</sup> Besides that, there are situations where health providers

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<sup>252</sup> C. Reinprecht and K. Kienzl-Plochberger (2005a) *Aktiv ins Alter. Publikumsbericht. Ergebnisse und Perspektiven. Anregungen für die Gesundheitsförderung älterer Menschen in der Großstadt*, p. 2

<sup>253</sup> C. Reinprecht (2006) *Nach der Gastarbeit. Prekäres Altern in der Einwanderungsgesellschaft*, Vienna: Braumüller, p. 169

<sup>254</sup> For elaborated discussion see Kremla 2005, Reinprecht and Unterwurzacher 2006, for more practice related information Reinprecht and Kienzl-Plochberger 2005a and 2005b.

<sup>255</sup> M. Kremla (2005) *Interkulturelle Altenpflege in Wien: Angebote und Veränderungsbedarf aus der Sicht von ZuwanderInnen und Trägereinrichtungen*, Vienna, p. 67, C.

C. Reinprecht (2006) *Nach der Gastarbeit. Prekäres Altern in der Einwanderungsgesellschaft*, Vienna: Braumüller, p. 170ff

<sup>256</sup> C. Reinprecht & A. Unterwurzacher (2006) *Lebenslagen und Lebensqualität von MigrantInnen der 1. und 2. Generation in Wien. Sonderauswertung des Datensatzes „Leben und Lebensqualität in Wien II“*

<sup>257</sup> Stadt Wien (2007) *Altern in Gesundheit – Vienna Healthy Ageing Profile*, p. 52

might be less willing to offer suitable intervention to older migrants despite their formal entitlement with reference to their origin.<sup>258</sup>

On the other hand, lack of information about health and care provisions has to be mentioned as a barrier. Using the comprehensive Austrian social system requires detailed information and orientation about existing provisions, responsible institutions, and entitlements. This in combination with communication difficulties and fear of impolite or disrespectful treatment at public authorities limits the access to appropriate health and social care in high age<sup>259</sup>. A study on care needs of older migrants <sup>260</sup> mentions cases in which migrants do have entitlements to health provisions, but are wrongly informed about them, assuming that they do not meet the formal requirements. Such constellations can constitute relevant barriers for older migrants with respect to access to health and social services.

### 12.7. Provisions for People with Intellectual Disability

The demand for provisions dedicated to patients with intellectual disabilities can not easily be estimated, as no valid data is available. Micro-Census data suggest that about one per cent of the population suffer some form of intellectual challenge. However, small sample sizes and the fact that this survey only covers persons living in private households – thus excluding disabled persons living in care institutions, supervised residential groups, and others – limit the information content of these figures.<sup>261</sup>

Very few information is available on suitable provisions for patients with intellectual impairment in Austria. A study on relatives of patients with intellectual disabilities who are referred to hospital highlights some aspects<sup>262</sup>.

Communication and collaboration between health staff and relatives are mentioned as key issues. As patients with reduced cognitive and communicative skills have difficulties to understand diagnosis and medical interventions, or to communicate their needs and preferences, good communication and close co-operation with the relatives are of highest importance. An extensive intake interview is suggested in order to improve the

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<sup>258</sup> C. Reinprecht (2006) *Nach der Gastarbeit. Prekäres Altern in der Einwanderungsgesellschaft*, Vienna: Braumüller, p. 204

<sup>259</sup> C. Reinprecht (2006) *Nach der Gastarbeit. Prekäres Altern in der Einwanderungsgesellschaft*, Vienna: Braumüller

<sup>260</sup> M. Kremla (2005) *Interkulturelle Altenpflege in Wien: Angebote und Veränderungsbedarf aus der Sicht von ZuwanderInnen und Trägereinrichtungen*, p. 62f

<sup>261</sup> See B. Leitner (2008) *Menschen mit Beeinträchtigungen. Ergebnisse der Mikrozensus-Zusatzfragen im 4. Quartal 2007*, Statistische Nachrichten 12/2008, Statistik Austria

<sup>262</sup> B. A. Grassegger-Igler (2010) *Menschen mit geistiger Behinderung im Allgemeinkrankenhaus – Erfahrungen aus Sicht der Angehörigen*, Vienna: unpublished Thesis, University of Vienna

suitable treatment of the patient.<sup>263</sup> Relatives need to be actively informed about treatment, interventions, and progress of the patient.<sup>264</sup>

A respectful and appreciative treatment of the patient is required. However, the interview partners of the study reported quite different experiences with the hospital staff. Good and supportive experience, but also insecurities, concerns, negative attitudes, fear of contact, or lack of interest were mentioned.<sup>265</sup> Relatives see lack of experience and deficits in professional training of the health staff as the underlying causes for difficulties and suggest introducing this topic in health providers' curricula, similar to the issue of dementia which already has been recognised as important topic.<sup>266</sup>

Communication with the patient should be respectful and address him or her directly rather than addressing the accompanying relative. They should be treated as adults and not as children.<sup>267</sup> But also relatives claim more respect as some of them made experiences of stigmatisation and lack of respect.<sup>268</sup> Sometimes, this stigmatisation takes the form of unintended hurtful commentaries. Relatives – particularly if they feel treated unfair by the health staff – rather do not mention this need for equal treatment in front of them.

Despite the various specific needs of the patient, the relatives claim to be treated as normal people. Relatives of Patients with disability know that they need different forms of support in order to meet the needs of the person they are responsible for. At the same time, they claim equal treatment and want to be seen as normal people. This is in accordance with the equality principle that difference requires different action.<sup>269</sup>

In the study, disrespectful treatment by fellow patients is regularly mentioned and calls for suitable intervention by the hospital staff.<sup>270</sup>

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<sup>263</sup> B. A. Grassegger-Igler (2010) *Menschen mit geistiger Behinderung im Allgemeinkrankenhaus – Erfahrungen aus Sicht der Angehörigen*, Vienna: unpublished Thesis, University of Vienna, p. 81

<sup>264</sup> B. A. Grassegger-Igler (2010) *Menschen mit geistiger Behinderung im Allgemeinkrankenhaus – Erfahrungen aus Sicht der Angehörigen*, Vienna: unpublished Thesis, University of Vienna, p. 69ff

<sup>265</sup> B. A. Grassegger-Igler (2010) *Menschen mit geistiger Behinderung im Allgemeinkrankenhaus – Erfahrungen aus Sicht der Angehörigen*, Vienna: unpublished Thesis, University of Vienna, p. 92

<sup>266</sup> B. A. Grassegger-Igler (2010) *Menschen mit geistiger Behinderung im Allgemeinkrankenhaus – Erfahrungen aus Sicht der Angehörigen*, Vienna: unpublished Thesis, University of Vienna, p. 93

<sup>267</sup> B. A. Grassegger-Igler (2010) *Menschen mit geistiger Behinderung im Allgemeinkrankenhaus – Erfahrungen aus Sicht der Angehörigen*, Vienna: unpublished Thesis, University of Vienna, p. 88f

<sup>268</sup> B. A. Grassegger-Igler (2010) *Menschen mit geistiger Behinderung im Allgemeinkrankenhaus – Erfahrungen aus Sicht der Angehörigen*, Vienna: unpublished Thesis, University of Vienna, p. 69ff

<sup>269</sup> B. A. Grassegger-Igler (2010) *Menschen mit geistiger Behinderung im Allgemeinkrankenhaus – Erfahrungen aus Sicht der Angehörigen*, Vienna: unpublished Thesis, University of Vienna, p. 104ff

<sup>270</sup> B. A. Grassegger-Igler (2010) *Menschen mit geistiger Behinderung im Allgemeinkrankenhaus – Erfahrungen aus Sicht der Angehörigen*, Vienna: unpublished Thesis, University of Vienna, p. 85ff

As some patients with intellectual disabilities need more or less constant care or supervision, the health staff faces challenges, but particularly the accompanying relatives face a high level of stress and pressure.<sup>271</sup> Particularly mothers report to be confronted very high performance expectations.

Sometimes, intellectually disabled patients are accepted in hospital only under the condition that a relative gets taken in as well. These relatives often perceive their forced presence in hospital far more straining than the care activities they provide.<sup>272</sup> In general, the interviewed relatives reported to be willing to support the hospital staff by assisting with care activities, but the want awareness for their situation. Additional supporting offers for care givers are needed.

A project run by the „Krankenhauses Barmherzige Brüder Wien“ aims at adapting health provisions to the needs of patients with intellectual disabilities.<sup>273</sup> In case of hospitalisation of an intellectually challenged person, one person is appointed as co-ordinator. There is close co-operation with the patient's relatives. Intellectually disabled persons are treated with priority; medical intervention is done with as little delay as possible in order to keep the hospitalisation as short as possible and to relieve both the patient and the carers. Patients of the barrier free dental care department are given the chance to receive treatment without appointment and without waiting time; dental intervention is conducted under anaesthetic.<sup>274</sup>

An information leaflet has been developed in order to provide a guideline for doctors, care staff, legal representatives, and relatives of intellectually disabled patients<sup>275</sup> and to promote collaboration between these groups. The hospital “Krankenhaus der Barmherzigen Brüder Wien“ aims at strengthening its position as contact point and health provider for people with disabilities.

## 12.8. Dignity and Respect in Treatment / Users Satisfaction

For Austria, no comprehensive data on user's satisfaction is available. For Vienna, a study mentions that about eight out of ten inhabitants rate the communal health system

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<sup>271</sup> B. A. Grassegger-Igler (2010) *Menschen mit geistiger Behinderung im Allgemeinkrankenhaus – Erfahrungen aus Sicht der Angehörigen*, Vienna: unpublished Thesis, University of Vienna, p. 89ff

<sup>272</sup> B. A. Grassegger-Igler (2010) *Menschen mit geistiger Behinderung im Allgemeinkrankenhaus – Erfahrungen aus Sicht der Angehörigen*, Vienna: unpublished Thesis, University of Vienna, p. 102

<sup>273</sup> For more details see Krankenhaus der Barmherzigen Brüder Wien (2008) *Versorgung und Betreuung von Menschen mit geistiger und mehrfacher Behinderung im Krankenhaus. Ein Leitfaden für Ärzte, Pflegepersonen, gesetzliche Vertreter und Angehörige*, Vienna

<sup>274</sup> B. A. Grassegger-Igler (2010) *Menschen mit geistiger Behinderung im Allgemeinkrankenhaus – Erfahrungen aus Sicht der Angehörigen*, Vienna: unpublished Thesis, University of Vienna, p. 90, p. 108

<sup>275</sup> B. A. Grassegger-Igler (2010) *Menschen mit geistiger Behinderung im Allgemeinkrankenhaus – Erfahrungen aus Sicht der Angehörigen*, Vienna: unpublished Thesis, University of Vienna, p. 108

in Vienna as good or very good. Nearly all other respondents have a neutral opinion. The satisfaction with care homes for the elderly is high as well. However, in publically available material, this information is not further disaggregated. Other sources, however, give evidence for the fact that people with migration background appreciate the Austrian health system and the high level of social security compared to the countries of origin.<sup>276</sup> On the other hand, the Vienna Health Report stresses that people with migration background – and especially people with a Turkish background – report negative and discriminatory experiences during their treatment in health and social care centres.<sup>277</sup>

With respect to information on health provisions it is stressed that women in general are better informed about social and health care provisions than men. Inhabitants with Turkish or Ex-Yugoslavian background are less informed than the majority society.<sup>278</sup> In this context it is important to see the responsibility not only at the side of the migrants, but to motivate Austrian social and health care providers to make their offers accessible and to spread information in a way, which is suitable for the intended target group. It is a fact that information leaflets on health issues are produced in various languages, but however, it seems that this information does not always reach the target audience.<sup>279</sup> An example of good practice regarding the access to migrant communities is the Frauengesundheitszentrum FEM Süd [Women's Health Centre FEM Süd] located in the hospital "KaiserFranz-Josef Spital", which disseminates information in sites that are regularly frequented by migrant communities such as cultural centres, mosques and parks.<sup>280</sup>

Health providers and training institutions for health staff reacted to current challenges for the health system. They increasingly introduce training modules on intercultural competence in order to raise awareness in meeting the health needs of patients with diverse backgrounds, to ensure suitable treatment, and to combat discrimination. However, improving access to health care for socially marginalised groups such as migrants still faces serious challenges. As cited in various sources<sup>281</sup>, discrimination or

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<sup>276</sup> C. Reinprecht (2006) *Nach der Gastarbeit. Prekäres Altern in der Einwanderungsgesellschaft*, Vienna: Braumüller

E. Enzenhofer, D. Braakmann, C. Kein & I. Spicker (2009) *SALOMON Next Step. Bedrohungswahrnehmung von MigrantInnen. Eine Studie im Rahmen der österreichischen Sicherheitsforschung*

<sup>277</sup> Stadt Wien (2004a) *Wiener Gesundheitsbericht*, p.454

<sup>278</sup> Stadtentwicklung Wien (2009) 68f

<sup>279</sup> H. Amesberger, K. Auer & B. Halbmayer (2001) *Zugewanderte Patienten im Wiener Gesundheitssystem*, Vienna: Institute for Conflict Research

<sup>280</sup> This information was provided by a staff member of FEM Süd.

<sup>281</sup> See for example C. Reinprecht (2006) *Nach der Gastarbeit. Prekäres Altern in der Einwanderungsgesellschaft*, Vienna: Braumüller, p. 206; H. Amesberger, K. Auer & B. Halbmayer (2001) *Zugewanderte Patienten im Wiener Gesundheitssystem*, Vienna: Institute for Conflict Research, p. 34ff, p. 67ff; Stadt Wien (2006) *Wiener Frauengesundheitsbericht*, p. 454.

disrespectful treatment can be found among health providers and other public authorities. This might keep migrants from using existing social and health provisions. The illustration of health-related racist incidents in the Raxen Reports contains reports on the discrimination of persons with Muslim – mostly Turkish – and Ex-Yugoslavian background. Another finding concerned the racist labelling of persons with African background as potentially HIV-positive.

Language and communication issues are known as major barriers to an adequate treatment of patients with migration background. Such problems are not always exclusively language related – other contextual factors should be considered such as socio-economic living conditions, education, perception of health and illness, or the health staff's lack of time.<sup>282</sup> In consequence, the blame for communication failures should not be put on the migrant's side only.<sup>283</sup> Communication difficulties are a major barrier to adequate treatment as they can lead to wrong diagnosis, unnecessary medicalisation, disrespectful interaction between patient and health provider, loss of trust on the patient's side, and low compliance. Some forms of intervention, e.g. in the mental health sector, are simply impossible without succeeding communication.<sup>284</sup>

Possible strategies for overcoming communication barriers are among others interpreter services, cultural mediators, the employment of multi-lingual staff, or native-language services and institutions. Such options are increasingly used by health providers.<sup>285</sup> However, there can be structural barriers at the political level which impede such improvement in the health sector. The Raxen Report mentioned a particular project aiming at improving intercultural communication via the use of telephone interpreters. This project got politicised by the Austrian Freedom party and in consequence impeded by the hospitals' CEO.<sup>286</sup>

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<sup>282</sup> H. Amesberger, K. Auer & B. Halbmayer (2001) *Zugewanderte Patienten im Wiener Gesundheitssystem*, Vienna: Institute for Conflict Research, p. 34f

<sup>283</sup> H. Amesberger, K. Auer & B. Halbmayer (2001) *Zugewanderte Patienten im Wiener Gesundheitssystem*, Vienna: Institute for Conflict Research, p. 70

<sup>284</sup> H. Amesberger, K. Auer & B. Halbmayer (2001) *Zugewanderte Patienten im Wiener Gesundheitssystem*, Vienna: Institute for Conflict Research, p. 70, p. 75

<sup>285</sup> H. Amesberger, K. Auer & B. Halbmayer (2001) *Zugewanderte Patienten im Wiener Gesundheitssystem*, Vienna: Institute for Conflict Research, p. 70ff, for the risks of community interpreting in the health sector p. 76ff

<sup>286</sup> FRA (2009) and (2010) *RAXEN Report. Health Care*

## Conclusions

The following conclusion will summarise the overview of the Austrian health system and the antidiscrimination framework, the availability and quality of data and major findings of the inter-sectoral data analysis.

### **The Austrian health system**

The Austrian health system is based on compulsory insurance in public health insurance fund. There exist 22 public health insurance fund, which cover around 99% of the population. Whereas employment was the dominant key to access to health insurance in the first half of the 20<sup>th</sup> century, the coverage of the health insurance system was expanded to i.a. family members, unemployed persons, peasants and employees since 1945. Coverage increased from some 60% of the population in 1946 to some 86% in 1980 and today has de facto universal coverage (99%).<sup>287</sup> Furthermore, public hospitals are obliged to treat any person independently of the insurance status in a case of emergency. Today the main groups excluded from health care are generally low income groups, and in particular those not signed into self-paid health insurance and not eligible for unemployment benefits or the recently introduced minimum social protection payment scheme. Irregular migrants, including informally employed citizens from new EU Member States relying on health insurance and health services in their country of origin and asylum seekers who have dropped out of the reception system are particularly vulnerable.<sup>288</sup> In terms of coverage, therefore, Austria's health system does not differ fundamentally from universal, tax base systems such as the UK or mixed systems based on both health insurance and taxes such as Sweden. The main difference to these systems thus is of structural nature, which however has important implications not only for the financing of the health care system and the way chronic funding issues are tackled, but also for the organisation of the health care system and health policy making.

Despite of the broad health coverage of the population and the principle of equality of treatment enshrined in the laws governing the area of health, differences in the range of medical treatment available stay to be an area of concern. As a rule of thumb, the smaller health fund tend to fund a broader range of medical services and refund a higher percentage of the costs of fixed dentures or other medical appliances than the large provincial health fund insuring the vast majority of the population.

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<sup>287</sup> H. Gottweis / E.Braumandl (1996) 'Gesundheitspolitik', in: H. Dachs, P. Gerlich, H. Gottweis, H. Kramer, V. Lauber, W. C. Müller & E. Tálos (eds.) *Politik in Österreich. Das Handbuch*, Vienna: Manz, pp.753-767

<sup>288</sup> See for a study on the situation in 2003 M. Fuchs, G. Schmied & N. Oberzaucher N. (2003) *Quantitative und qualitative Erfassung und Analyse der nicht-krankenversicherten Personen in Österreich*. Wien: Bundesministerium für Gesundheit und Frauen

Recent years have seen an improvement in access of risk groups to the health care system and preventive health schemes. The replacement of the provincial social assistance schemes by a federal minimum social protection payment scheme including membership in the respective provincial health insurance scheme has included the largest group of previously excluded persons into compulsory health insurance, and access to the annual health screening scheme and the “mother-child-pass” programme including regular medical screening of pregnant women and their children has been opened to persons without insurance and thus virtually covers the total population. As access to the minimum social protection payment scheme is restricted to EU and EEA citizens with an employment history in Austria and third country nationals holding a permanent resident title, asylum seekers, legally resident third country nationals with a temporary residence permit and no health insurance and irregular immigrants do not have access to these basic benefit provisions.

Furthermore, the issue of cultural diversity and institutional adaptation only has been taken up reluctantly by the health-care providers. In particular in the field of long term care for elderly migrants there seems to be a lack of sensibility to issues of cultural diversity. A lack of equal access to health is also reported by the main organisations active on support of people with disabilities.

### **Non-Discrimination and access to remedies**

Austria has a long tradition regarding gender equality legislation. The first gender equality bill dealing with the area of employment, particularly with the issue of equal pay, came into force on February 23, 1979, and the first specialised body dealing with gender equality, the Equal Treatment Authority, was founded in 1991. Although Austria signed and ratified the ECHR and the ICERD in the 1970s and discrimination due to ethnic origin, skin colour or disability became an issue of public debate since the late 1980s, Austria did not develop a concise system of legal protection against discrimination on other grounds than gender until the non-discrimination directives forced Austria to do so.

The development of an Austrian Antidiscrimination Act came only gained momentum after the Directive 2000/43/EG and the Directive 2000/78/EG came into force in 2000. These Directives and the Directive 2002//3/EG were the reason for an amendment of the existing Equal Treatment Act, which had concentrated on the area of gender equality. In 2004, a comprehensive reform implementing the EU-antidiscrimination acquis entered into force. Whereas the areas of age, gender, race, religion and belief and sexual orientation were covered in two Equal Treatment Acts, the area of disability was regulated by three separate bills. The implementation of the EU-acquis reproduced the existing difference in the level of protection. Apart from three provincial equal treatment acts, which extended the protection against discrimination based on disability, religion and belief and sexual orientation to access to social security, health, education and goods



and service, the federal legislation shied back from equalising the levels of protection of the different grounds. Discrimination based on disability, religion and belief, sexual orientation and disability is only protected with regard to the labour market and labour relations, but not with regard to access to goods and services. In January 2011, the equalisation of the levels of protection to be introduced by an amendment of the Equal Treatment Act failed to reach a majority in parliament.

The health sector does not play a prominent role in debates on equality and discrimination. These debates concentrate on the areas of employment, housing and access to goods and services, particularly access to restaurants, bars and clubs. Multiple discrimination is getting growing attention by the Equal Treatment Commission, in particular with regard to discrimination based on gender and race in employment, housing, and access to goods and services. Academic research in this field is virtually inexistent. In addition, the notion of multiple discrimination, however, remains little known and understood outside expert circles, and is virtually unknown in the health sector.

For the area of health the most relevant complaint bodies are the provincial health ombudsmen and to a presumably lesser extent, the provincial arbitration bodies of the Austrian Medical Chamber. Due to its federal structure and complex constitutional provisions defining the areas of competence of the federal state and of the provinces, in the health sector federal and/or provincial acts may apply and may be implemented by federal or provincial specialised bodies, depending on the character of the case.

Due to the fragmented legal framework and the weak institutional powers of the specialised bodies, which are not allowed to award compensation, the antidiscrimination framework does not offer a promising path to redress in cases of discrimination in the health sector. Complaints are mainly directed to the health ombudsmen set up by the health insurance schemes and the province, which handle the cases according to medical paradigms and do not take notice of discrimination issues. Thus the health sectors does not seem well prepared to handle cases of discrimination properly.

### **Availability and quality of data**

In general, both the available statistical data on health issues and the Austrian health reporting are satisfying with respect to the availability of data. However, it is to be said that it is still difficult to obtain representative data on certain issues, such as disability, access to health care, or users' satisfaction. The Statistics Austria Health Survey which was conducted in the years 2006 and 2007 certainly fills some of these gaps; however, some further data collection would be helpful in order to further investigate health related issues.

Data collected by Statistics Austria routinely allows for disaggregation by gender, age, and migration background (as a combination of country of birth and citizenship, available for various ethnic groups), and meanwhile also other surveys follow this approach. However, in health reporting the authors do not always make use of this option.

Even if some reports provide their information by categories such as gender, age, or migrant background, a consistent intersectional analysis in general is lacking. The Statistics Austria Report on “Socio-demographic and Socio-economic Determinants of Health”<sup>289</sup> is an exception as it considers age, gender, and migration background and includes simultaneously other influencing factors such as income, education, occupational status, unemployment. Such a linked analysis, however, is only provided with respect to few selected health indicators.

An isolated analysis of risk factors can lead to a culturalisation and ethnisation of health issues. There is a risk of considering ethnicity or migration background as a risk factor where in fact other underlying factors of social inequality such as poverty, unemployment or the legal residence status might be equally – or even more – influencing the findings. This risk is even increased when not a systematic consideration of migration background in all analysis takes place, but when migrants are only mentioned in the context of specific health issues (e.g. tuberculosis, HIV, sexually transmitted diseases, dental health problems, obesity, etc.). The fact that some social groups are more often affected by certain health issues as others must certainly not be ignored. But there should be increasing awareness for sensitive and balanced health reporting in order to avoid constructing migrants as exclusively “deviant” social groups with “exotic” diseases and behaviour. Rather, a multi-causal analysis of such morbidity patterns would be advisable in order to identify social structures that negatively influence health status rather than singling out social risk groups.

Review of the Austrian health reporting showed that there are inconsistent definitions of both migration background and social inequalities. The overall category “migrants” is sometimes defined by citizenship, sometimes by a combination of citizenship, sometimes it includes asylum seekers and sometimes not. Austrian born members of the second generation are nearly never included. Social inequalities are defined by “income status”, “educational status”, and “occupational status”, some reports also differentiate between “horizontal inequalities” and “vertical inequalities, some reports refer to social inequalities without any specifications. The category “*social class*” is never mentioned, although it is implicitly referred to. Concluding, it would be necessary to

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<sup>289</sup> Statistik Austria (2008) *Sozio-demographische und sozio-ökonomische Determinanten von Gesundheit 2006 / 2007*

clear the terminology, for example with recourse to definitions developed within special reports on migration, in order to allow comparison of data<sup>290</sup>.

### Major health inequalities

The systematic descriptive analysis of the available data, mainly drawn from the Austrian Health Survey, gives empirical evidence for the fact that with respect to both health status and access to health care, complex patterns by the categories gender, age, and migration background can be found. This stresses the importance of an inter-sectoral analysis and discussions of the findings.

There is clear evidence for the fact that persons – and here again particularly women – with migration background face higher health risks. As most of the health risks increase by age, older men and women with migration background might be considered as specific risk groups.

Both men and women with Turkish and Ex-Yugoslavian background are more often than members of the majority society affected by diseases of the musculoskeletal system, mobility restrictions, and ulcer. Men, but also women with migration background, smoke more often than members of the majority society.

Older migrant men particularly suffer from dorsal and back pain, as well as pain of legs and knees. In consequence, they feel more often seriously restricted by chronic health issues. This clearly reflects the long term effects of the physically hard work done by members of the so called “guest-workers” generation.<sup>291</sup>

Older women with migration background are more often than majority women affected by chronic diseases such as myocardial infarction and strokes, diabetes, obesity, depression and chronic anxiety, migraine and frequent headache, and back pain.

In addition it has to be stressed that an increase of some age related health issues such as dorsal and back pain, mobility restrictions, depression and chronic anxiety, hypertension, diabetes, and obesity already can be found in the middle age group of women with migration background. Thus, age should be considered as a social issue rather than a merely biological fact.

The analysis of the Austrian Health Survey data shows a dramatically lower uptake of health offers by people with migration background. This is most evident with respect to dental and gynaecological care, but also other forms of special care (e.g. internal specialists), immunisation, or preventive medical screening.

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<sup>290</sup> H. Fassmann et al. (2007) 2. *Österreichischer Migrations- und Integrationsbericht*, Vienna: Drava

<sup>291</sup> Reinprecht, C. (2006) *Nach der Gastarbeit. Prekäres Altern in der Einwanderungsgesellschaft*, Vienna: Braumüller

It should be mentioned, that the results in this report are of merely descriptive nature and can only be satisfactorily explained by further complex causal analysis. Such analysis should particularly take into account a wide range of socio-demographic and socio-economic determinants which describe the living situations of the people involved. An isolated analysis by the category “ethnicity” – or, as it has been discussed here, “migration background” – might overlook more relevant underlying factors of discrimination and social inequality, such as poverty, access to employment, or others and bear the risk of a culturalisation and ethnisizing of health issues. Complex causal analysis, as it is partially available in the Statistics Austria Report on “Socio-demographic and Socio-economic Determinants of Health”<sup>292</sup>, can be seen as good practice, and research in this direction should further be advanced. With respect to access to health offers, an analysis of possible barriers and exclusion mechanisms should be included. Thus, a systematic inter-sectoral approach and the combination of qualitative and quantitative approaches might contribute to diminishing discrimination both in health reporting and intervention.

### **The health system and health entitlements**

According to the review of the European Observatory on Health Systems and Policies of the Austrian health system in 2006, almost all the indicators of the health status of the population have improved significantly since 1990. Altogether, life expectancy and most of the documented health indicators had improved markedly in the past 15 years. The level of satisfaction of the population with the health care system continued to be high in an international comparison.<sup>293</sup>

According to the report, the stakeholders in the Austrian health care system “had succeeded – characteristically by means of cooperative agreements and planning – in ensuring almost universal health care provision with a comprehensive benefit catalogue, in spite of considerable increases in expenditure and continuing cost containment measures.”<sup>294</sup> Waiting times for medical treatment “could be viewed as short in comparison to other countries, although there had been no precise evaluation of this”. However, the supply structure “would be characterized by inequalities between the provinces and also between urban and rural areas.”<sup>295</sup> Sectoral fragmentation – understood by Hofmarcher and Rack as the lack of coordination between planning and funding for outpatient care, which falls into the remit of the health insurance fund, and inpatient care, which is managed by the provincial governments, according to the study

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<sup>292</sup> Statistik Austria (2008) *Sozio-demographische und sozio-ökonomische Determinanten von Gesundheit 2006 / 2007*

<sup>293</sup> M. M. Hofmarcher & H. M. Rack (2006) ‘Austria. Health System Review, *Health Systems in Transition*, Vol.8, No.3, p. 18

<sup>294</sup> M. M. Hofmarcher & H. M. Rack (2006) ‘Austria. Health System Review, *Health Systems in Transition*, Vol.8, No.3, p. 18

<sup>295</sup> M. M. Hofmarcher, H. M. Rack (2006) ‘Austria. Health System Review, *Health Systems in Transition*, Vol.8, No.3, p. 19

cited above would create a bias towards hospital care and would be a long standing weakness of the Austrian health care system. In particular, it had not been possible “to structure the supply chain in a more needs-orientated way across these administrative and financial barriers at the sectoral borders, especially between outpatient and inpatient care or acute and long-term care.”<sup>296</sup> One expression of the lack of coordination and integration of different parts of the health system is the incomplete differentiation of primary and secondary care, another – and related one – are deficiencies in referral mechanisms, e.g. from general practitioners to specialists, or from one particular specialist to another, or from primary or secondary care to social care or rehabilitative care services. Finally, the recurrent financial crises of the health system has made economic considerations increasingly important, which health providers have to balance with intrinsic health considerations. There are several implications of the increasing importance of economic considerations: more intense scrutiny of the necessity of particular forms of treatment, notably elective treatment and rehabilitative care as well as other health related entitlements (e.g. sick-leave, invalidity insurance); shorter time allotted to individual patients, notably in specialist care, reduction of the number of hospital beds, reduction of number of the average number of days spent in hospitals and increased pressure on hospitals to discharge patients early.<sup>297</sup>

As a result of these structural features of Austria’s health system and despite the generally high level of health care entitlements access to adequate health care may thus be uneven, while in certain cases, for example in case of treatment requiring approval from public health fund there may be a disincentive to seek care. In addition, while health providers have become increasingly sensitive to specific needs of migrants, notably culturally sensitive forms of treatment, addressing language related needs and addressing the need to provide intercultural training to staff, amongst others, the structural constraints of the health care system to some extent run counter to these efforts and may act as a barrier to seeking health care altogether or may have adverse effects notably on specialist and hospital treatment in regard to which patients’ ability to make an informed choice much more limited.

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<sup>296</sup> M. M. Hofmarcher, H. M. Rack (2006) ‘Austria. Health System Review’, *Health Systems in Transition*, Vol.8, No.3, p. 19

<sup>297</sup> However, since hospitals also generate incomes from patients’ stay in hospitals, there is also an incentive to keep patients in hospital care, notably when there are many vacant beds.

## Annex: Tables

**Table 31: Self Reported Life Time Prevalence of Migraine and Frequent Headache**

	No migration background		Migration background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	8.8%	23.6%	13.7%	34.0%
35 to 54	11.5%	28.6%	13.3%	37.6%
55+	11.4%	22.3%	26.1%	37.1%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

**Table 32: Considerable Pain of Stomach and Abdominal Pain for more than 3 Months**

	No migration background		Migration background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	0.2%	1.4%	0.0%	0.0%
35 to 54	0.5%	1.5%	3.9%	6.7%
55+	1.6%	1.9%	4.3%	11.7%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

**Table 33: Considerable Headache and Migraine for more than 3 Months**

	No migration background		Migration background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	1.2%	3.9%	3.8%	13.1%
35 to 54	2.2%	5.4%	0.8%	17.3%
55+	3.0%	4.1%	5.4%	12.5%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

**Table 34: Considerable Pain of the Cervical Spine for more than 3 Months**

	No migration background		Migration background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	0.8%	2.0%	3.7%	1.4%
35 to 54	3.3%	5.8%	3.9%	12.7%
55+	5.6%	9.1%	13.1%	13.4%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

**Table 35: Considerable Pain of the Shoulders for more than 3 Months**

	No migration background		Migration background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	0.8%	1.3%	1.1%	.6%
35 to 54	3.8%	3.7%	3.0%	11.9%
55+	5.9%	7.7%	23.6%	7.4%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

**Table 36: Considerable Pain of the Arms and Elbows for more than 3 Months**

	No migration background		Migration background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	0.1%	0.3%	0.9%	0.5%
35 to 54	1.4%	1.8%	2.9%	9.8%
55+	3.0%	5.2%	11.4%	9.3%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

**Table 37: Considerable Pain of the Back and Thoracic Spine for more than 3 Months**

	No migration background		Migration background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	0.6%	1.5%	1.1%	0.6%
35 to 54	2.8%	2.9%	6.0%	10.7%
55+	4.7%	7.1%	2.5%	6.3%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations,  
Valid %*

**Table 38: Considerable Pain of the Lumbar Spine for more than 3 Months**

	No migration background		Migration background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	2.6%	3.7%	6.8%	4.4%
35 to 54	9.0%	9.0%	8.6%	14.6%
55+	15.0%	18.8%	25.2%	19.6%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations,  
Valid %*

**Table 39: Considerable Pain of the Hips for more than 3 Months**

	No migration background		Migration background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	0.1%	0.5%	0.0%	0.0%
35 to 54	1.6%	2.0%	1.7%	7.2%
55+	5.7%	7.6%	10.4%	5.4%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations,  
Valid %*



**Table 40: Considerable Pain of the Leg and Knee for more than 3 Months**

	No migration background		Migration background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	1.2%	1.4%	1.2%	0.6%
35 to 54	4.4%	3.4%	7.7%	9.6%
55+	10.1%	14.6%	34.3%	21.5%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

**Table 41: Self Reported Life Time Prevalence of Myocardial Infarction**

	No migration background		Migration background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	0.0%	0.0%	0.0%	1.8%
35 to 54	1.0%	0.2%	0.9%	1.7%
55+	7.9%	3.5%	8.4%	8.8%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

**Table 42: Self Reported Life Time Prevalence of Apoplectic Stroke and Cerebral Haemorrhage**

	No migration background		Migration background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	0.0%	0.2%	0.0%	0.5%
35 to 54	0.7%	1.0%	0.0%	1.4%
55+	6.7%	5.0%	1.7%	7.4%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

**Table 43: Tetanus Immunisation**

	No migration background		Migration background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	88.4%	82.0%	53.3%	47.4%
35 to 54	79.6%	74.5%	43.9%	40.4%
55+	63.2%	52.2%	38.0%	26.8%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

**Table 44: Diphtheria Immunisation**

	No migration background		Migration background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	72.3%	69.9%	30.4%	34.1%
35 to 54	58.8%	59.2%	23.5%	25.9%
55+	40.2%	31.5%	24.6%	12.2%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

**Table 45: Polio Immunisation**

	No migration background		Migration background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	75.9%	72.9%	31.8%	30.4%
35 to 54	58.6%	61.4%	17.6%	21.9%
55+	38.0%	33.0%	13.5%	16.0%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations, Valid %*

**Table 46: FSME Immunisation**

	No migration background		Migration background (Ex-Yu / T)	
Age	Male	Female	Male	Female
15 to 34	81.1%	81.5%	31.4%	46.0%
35 to 54	72.3%	75.9%	21.6%	26.9%
55+	66.0%	63.7%	23.5%	32.9%

*Source: Austrian Health Survey 2006 / 2007 data set, projected data, own calculations,  
Valid %*

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## **Background Report**

# **Inequalities and Multiple Discrimination in Access to Healthcare in Austria**

**International Centre for Migration Policy Development, 2014**

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