

Research Summary

Inequalities and Multiple Discrimination in Access to Health – Austria

by

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Abstract: In the European Union context existing legislation on non-discrimination (Equality Directives of 2000 and various directives on equality of men and women) oblige Member States to eliminate inequalities of treatment on grounds of gender, age, race and ethnic origin, religion, disability and sexual orientation. While there is an increasing awareness and knowledge of how single equality grounds impact on (in-) equality in different societal domains, the intersection of different grounds remains little understood, particularly in the area of health care. This research brief provides the results of research conducted between 2009 and 2011 on multiple discrimination and inequalities in access to health in Austria.

Disclaimer

This document was commissioned as background material for the comparative report on 'Inequalities and multiple discrimination in access to and quality of healthcare' published by the European Union Agency for Fundamental Rights (FRA). The views expressed in this document do not necessarily reflect the views or the official position of the FRA. The document is made publicly available for information purposes only and does not constitute legal advice or legal opinion.

Research background and sources of information

The research for this project was carried out between December 2009 and November 2011. The Austrian case study for this project on which this research summary is based was implemented by the International Centre for Migration Policy Development (ICMPD) in cooperation with the Research Institute of the Red Cross. This document was last edited in February 2012 and released in March 2014.

All information contained in this research brief has been collected in the context of this project. The empirical observations derive from qualitative fieldwork with health users, health professionals and other experts conducted in the framework of this project. All legal, policy and statistical information on health outcomes and access to health derive from a background report compiled for this project, published as

Albert Kraler (ed.), Julia Edthofer, Edith Enzenhofer & Bernhard Perchinig (2014): Inequalities and Multiple Discrimination in Access to Health. National Background Report on Austria. Vienna: ICMPD.

For further information and links to other project related publications consult
<http://research.icmpd.org/1489.html>.

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Legal protection of the right to access healthcare

Article 35 of the Charter of Fundamental Rights of the European Union recognizes the right of every person to access healthcare under the respective national laws.

Evidence has shown that how healthy a person is and whether they have access to health care can strongly depend on the class, ethnicity, age, gender, disability, and migration status of that individual. Persons at the intersection of these lines can be particularly susceptible to discrimination on more than one ground, or what is known as multiple discrimination.

The European Union is committed to fighting discrimination on grounds of gender, age, race and ethnic origin, religion, disability and sexual orientation. However, EU-level protection from discrimination on each of these grounds does not currently apply to access to healthcare. Discrimination on multiple grounds is also not legally protected.

The study

Against this background, the European Union Agency for Fundamental Rights (FRA) has launched a study on inequality, and multiple and intersectional discrimination in access to health care in the EU. The project was coordinated by the Middlesex University (UK) and conducted together with partners in five countries (Austria, the Czech Republic, Italy, Sweden and the United Kingdom).

Aims and outcomes

The aim of the study was to inform policy measures in order to tackle multiple discrimination in access to healthcare. Specific objectives are:

- mapping law and policy developments
- identifying barriers to accessing health care experienced by healthcare users – mapping the ways health professionals address the needs of vulnerable groups.

Methodology

In the five countries studied, altogether 142 interviews were conducted with health professionals, policy makers and other stakeholders, and 172 interviews with health service users.

To find out about particular vulnerabilities of persons at the intersection of ethnic origin, age, and gender the study focused on **three groups of health service users**:

- 1) elderly migrants/minority members,
- 2) migrant/minority women with reproductive health needs, and
- 3) young migrant/minority adults with intellectual disabilities.

Results for Austria

In Austria the research was coordinated by the International Centre for Migration Policy Development and conducted together with the Research Institute of the Red Cross. Regarding particular user groups, the research in Austria focused on the two largest immigrant groups in Austria, persons with Turkish and with former-Yugoslavian immigrant background. Research was conducted in the cities of Vienna and Graz between February and July 2011. The table below gives an overview of the number of interviews conducted in Austria.

Table 1 Overview of interviews conducted in Austria

Interview category	Women	Men	Total number of interviews
Legal experts	3	1	4
Ombudspersons	2	2	4
Advocacy organizations	1	4	5
Health providers	3	9	12
Policy makers	1	0	1

User interviews	Women	Men	Ethnic/national background	Total number of interviews
Women with reproductive health needs	13	0	9 Turkey, 4 former Yugoslavia	13
Elderly migrants	7	6	5 Turkey, 8 former Yugoslavia	13
Young adults with intellectual disabilities	7	3	Second generation migrants: 5 with Turkish background, 2 former Yugoslavia, 2 Poland, 1 China/Vietnam	10

The health system and entitlements

Statutory health insurance and health provision

Austria's health system is based on statutory insurance with one of the various public health insurance funds, which cover about 99% of the population. Private health insurance only plays a rudimentary role: in 2006, 28% of the Austrian population held also a private supplementary insurance (e.g. for costs of treatment by doctors without a contract with one of the public health insurance funds or for imbursement of costs for complementary medical treatment procedures). The insurance funds are organised regionally and on the basis of major occupational groups (e.g. employees, self-employed persons, civil servants, farmers).

Conditions to access statutory insurance: legal residence is a precondition to take out health insurance. All persons in active employment, pensioners, unemployed persons receiving unemployment assistance, recipients of minimum social protection (since 2010, minimum social protection is a social assistance scheme that covers all persons who are not covered by un/employment-related benefits), and asylum seekers admitted to the "basic care system for foreigners in need for assistance and protection" are covered by statutory health

insurance. Health insurance also covers dependants of the beneficiary (spouses and children up to the age of 27). Persons who are not insured as a family member and who earn below a certain threshold, may opt into voluntary self-paid insurance for 52.78 EUR a month.

Groups at risk of exclusion from access to healthcare:

- Persons who are not covered by statutory insurance, such as temporary migrants (persons holding a visa or a stay permit “Aufenthaltserlaubnis”; e.g. seasonal workers, students, etc.);
- unemployed persons not eligible for unemployment benefits;
- irregular migrants and irregularly employed migrants;
- asylum seekers who have dropped out of the reception system are not covered by health insurance;
- in case of divorce, compulsory membership to a health insurance fund as a spouse ends and thus the divorced partners are at risk of losing insurance coverage;
- Generally, low income groups and individuals choosing not to sign up to voluntary self-paid health insurance.

Health care provision: The main providers of health services are medical practitioners in private practices and the hospital sector. Patients have free choice among the practitioners holding a contract with their respective health insurance fund. Specialised care can be accessed through referral by a practitioner or directly at a specialised outpatient hospital department.

Health entitlements

Statutory health insurance virtually covers all of medical aid and support, but the scope of the health basket differs according to type of insurance for different occupational groups, mainly with regard to dental and ophthalmologic treatment, benefits for the extramural sector, psychotherapy, physiotherapy, ergo-therapy, speech therapy, and in respect to rehabilitative care.

Some services are also accessible to persons without insurance coverage against proof of registered residence (legal residence is not required), including mother-child-card examinations, an annual health examination, or cancer screening. All school children are examined once a year by the respective school doctors irrespective of residence or insurance status. Persons without insurance have to pay the full costs of treatment. Hospitals are obliged to provide first aid in case of emergency (including giving birth) irrespective of the ability of the person to pay, although they will attempt to recover any costs from patients ex post.

Persons covered by statutory insurance enjoy free treatment by professionals contracted by health insurance fund (for certain insurance companies 20% of treatment costs are self-paid). If consulting a professional not contracted by the respective insurance fund, the patient has to pay the full costs, but these can be partially refunded.

Specific entitlements

Sexual and reproductive care:

- Mother-child-card (Mutter-Kind-Pass): offered to all pregnant women, irrespective of insurance status if they have a proof of registered residence and of eligibility by

health insurance fund (issued upon showing registration of residence) and includes five gynaecological examinations during pregnancy, HIV-testing, test of glucose tolerance, three ultrasonic examinations, as well as several medical examination of the child up to the age of five. Attendance is a precondition for receiving child care benefits.

- In-vitro fertilisation: 70% of the treatment costs are refunded for heterosexual couples.
- Abortions: permitted within first three months of pregnancy. The costs have to be covered by the woman.

Mental health care:

Provision of mental health care still focuses on treatment of persons in acute conditions by psychiatrists and treatment in institutionalised settings, while there is a lack of services provided by psychotherapists and psychologists in the extramural sector.

With regard to custodianship for persons without or with limited legal capacity, some 10% of persons who have been assigned a custodian belonged to the age group from 18 to 30. The majority of persons in custodianship live in institutional households.

Long term and rehabilitative care:

Access to rehabilitative care and cost-sharing is highly complex and mainly depends on the province and type of insurance fund of the patient. Persons in need of long term care can apply for long term care benefits by the federal state (all persons receiving a public pension) or the provinces (all persons not receiving a public pension, including family members). While the provisions by the federal state are independent of the type of residence status (only precondition: regular residence), there is generally no legal claim to long term care benefits under the provincial schemes (except for Tyrol, Lower Austria and Vorarlberg). The provincial long term care schemes moreover exclude third country nationals of countries not holding a bilateral social security agreement with Austria, third country national spouses and children of third country nationals, and third country nationals not accepted as asylum seekers. Both schemes however exclude persons earning below the insurance threshold without private insurance and persons without access to minimum social protection payments.

Persons with disabilities may apply for funding of personal assistants under this scheme. Costs for therapies and stays at spas are only partially refunded by the public health insurance schemes.

Policies for specific groups

Policies targeting vulnerable groups: Persons with chronic conditions (including disabilities), as well as persons with a low income and children are exempt from paying prescription charges for medication, which generally amount to 5.10 EUR per package up to an annual maximum of 2% of net income. Persons receiving minimum social protection are entitled to health insurance as of 2010.

Policies targeting migrants: There are no nationally coordinated health policies targeting migrants. Policies regarding language, interpretation, or intercultural competencies are left to the health providing institution.

Policies regarding persons with disabilities:

As of 2011 there will be a free of charge telephone hotline for blind or visually-impaired persons providing instructions on medication usage and pharmacies (see <http://www.oebsv.at/home/129>). Persons with disabilities may apply for a so-called disability card ("*Behindertenausweis*") after a medical examination by an official practitioner that facilitates access to certain benefits (e.g. for public transport).

Table 2 Entitlements to access health care for migrants and asylum seekers in Austria

	Is this group entitled to access healthcare?	Please add relevant legal provision	Comments
Asylum seekers	Yes	Basic care system for foreigners in need for assistance and protection: Grundversorgungsvereinbarung, Art. 15a of the Federal Constitution	Groups at risk of exclusion: Asylum seekers who have been excluded from the basic care system, rejected asylum seekers who have gone underground.
Migrants with a permit to stay	Yes, if holding a health insurance contract	General Social Insurance Act (ASVG) and similar specific social security acts for other occupational groups	Family members and children up to the age of 27 are co-insured Groups at risk of being excluded: Temporary migrants, and TCN who are not family members and earn below a certain threshold; they may opt into voluntary, self-paid insurance

Potential exclusion of intersectional groups

Low-income groups, persons in need of long term care or with disabilities, and immigrants are amongst the groups specifically affected by health and structural inequalities and lower take-up of health services.

A study by Reinprecht (2009) showed that *elderly migrants* (75+) report health related problems far more often than non-migrants and show a considerably lower rate of taking up support services. The study attributed these differences to a lack of intercultural competencies of medical staff and institutions.

Third country nationals in need of long term care who are not pensioners are not entitled to claim provincial long-term care allowance payments, with the exception of permanent residents in the provinces of Tyrol, Vorarlberg, and Lower Austria. In case of social hardship access may be granted on a case-by-case basis. In addition, retirement homes are accessible to third country nationals only if holding a permanent residence permit; in some provinces access is even restricted to EU citizens.

Until 2010, persons receiving social assistance payments were not included into the provincial health insurance fund. Since September 2010, the system has been replaced by a system of minimum social protection which also includes health insurance. Third country

nationals are only eligible to minimum social protection if they have a status as recognised refugees or subsidiary protection, or if they hold a permanent residence permit.

Generally, there is a lack of transparency regarding waiting lists for elective surgery, which are administered separately by each hospital and may reach up to 255 days. There are indications that *persons with a private insurance* contract receive appointments for elective surgery much faster than publicly insured patients.

Relevant anti-discrimination legislation

The EU antidiscrimination acquis has been fully implemented into Austrian national law since 2007. The Austrian constitution prohibits discrimination or disadvantages on the basis of birth, sex, social status, class, religion, disability, race, language, colour, descent or national or ethnic origin. Foreigners may be treated differently than Austrians in areas permitted by law; unequal treatment of groups of foreigners is prohibited except where explicitly permitted (e.g. treatment of EU vs. TCN). Constitutional regulations only apply to services provided under public law.

Anti-discrimination legislation is extremely complex and consists of several federal and provincial acts, which separately regulate the areas falling under federal (federal administration) or provincial legislative competence (e.g. regional hospitals).

Federal and provincial regulations both cover direct and indirect discrimination, harassment and victimisation. The protected grounds of discrimination in the area of health are generally broader in the provinces than at the federal level and (except for Lower Austria) encompass at least gender, ethnic affiliation, disability and age. Anti-discrimination on the ground of disability is regulated by a separate law (see Table 3).

This leads to a highly complex situation and, as a result, this research shows that complainants are often unclear whether they should turn to the provincial or federal equal treatment bodies in a concrete situation.

With regard to cases of *multiple discrimination*, the distinction between disability and other grounds makes it difficult to deal with cases involving disability as “multiple” discrimination, as it will tend to be treated on single grounds. If multiple discrimination is found to have occurred, it has to be taken into due consideration when calculating the amount of compensation for personal damages.

So far, the numbers of discrimination cases related to the health sector known to the equal treatment bodies indicate that the use and awareness of the discrimination legal framework is fairly limited as regards health. As a corollary, special complaint mechanisms within the health system remain by far the most important institutions.

Table 3 Grounds of discrimination covered by national legislation

Relevant piece of legislation	Grounds covered	Sectors covered
Equal Treatment Act (Gleichbehandlungsgesetz of 2005, last amended in 2008)	Gender, ethnic affiliation, religion or belief, age, sexual orientation	Applies to services under private law (e.g. medical practices) Employment: covers all grounds Goods and services available to the public including health: covers gender and ethnic affiliation
Federal-Equal Treatment Act – (Bundes-Gleichbehandlungsgesetz of	Gender, ethnic affiliation, religion or belief, age, sexual orientation	Applies to employment in the federal administration including staff of hospitals

Relevant piece of legislation	Grounds covered	Sectors covered
2004)		under federal competence for example.
Act on the Employment of Persons with Disabilities, (Behinderten-einstellungsgesetz of 1970, last amended in 2005)	Disability	Employment and occupation including the concept of reasonable accommodation
Federal Disability Equality Act, (Behindertengleichstellungsgesetz of 2005)	Disability	Regulates non-employment areas: Access to and supply of goods and services, which are available to the public, including housing and publicly available health services.

Main barriers to access healthcare

Access to health care is limited through multiple barriers based on gender, age, or disability, as well as other characteristics such as class, education, national origin or migration background, or a combination of all. Social inequalities and poverty, along with discrimination, marginalisation and social exclusion, or straining life conditions affect both, the health of migrants and their access to health provisions, in particular regarding disabled or older persons, or persons with insecure residence.

Table 4a Unmet need for medical examination or treatment (% answering 'yes')

	Female	Male	Total	Sample size
Native born	2.12	2.35	2.23	9,508
Foreign born	3.22	5.17	4.13	1,535

Source: EU SILC 2009

Table 4b Main reason for unmet need for medical examination or treatment (in%)

	Native born	Foreign born
Could not afford to (too expensive)	7.7	23.1
Waiting list	3.9	2.5
Could not take time because of work, care for children or for others	9.9	12.8
Too far to travel/no means of transportation	2.9	0
Fear of doctor/hospitals/examination/ treatment	8.2	12.5
Wanted to wait and see if problem got better on its own	20.7	23.2
Didn't know any good doctor or specialist	1.5	0
Other reasons	45.2	25.8
Sample Size	255	59

Source: EU SILC 2009

Although the Austrian population shows an generally high insurance coverage, some groups face structural barriers to access the health system. Stakeholders in this research highlighted that asylum seekers stand out as a particular marginal group, who may be excluded from the regular health system and from provisions and allowances for specific groups, such as allowances for disabled children. Also young adults with intellectual

disability who are not eligible to employment-related benefits are at risk of losing health insurance coverage without further notice when they complete education and are thus deregistered from co-insurance with their parents, or when they fail to prolong their application to minimum social protection.

Language and communication

From the perspectives of providers and users, language and communication issues are a major barrier to access health care. A lack of language proficiency and a lack of interpreter services particularly is an issue for newcomers and first generation immigrants. The research showed that communication is also an issue for persons with specific communication needs such as older persons (e.g. speaking slower, bigger letters), persons with low educational levels, or impaired persons such as the hearing impaired or persons with intellectual disability. Users highlighted that apart from a lack of multilingual information and services, a lack of time and unwillingness of doctors to use slow and easy language are particular impediments in the communication with health professionals. Contacts with specialists and inpatient hospital stays were considered specifically problematic. Language and communication issues turned out to be relevant in all parts of the medical sector but are particularly crucial with respect to highly language-bound psycho-social provisions (e.g. psychotherapy) and diagnoses and treatment of complex medical problems (e.g. infertility, intellectual disability).

Our research shows that language and communication barriers lead to a lack of information on entitlements and service provision, lower trust in health services, a lower take up of specialised, preventative and rehabilitative health services, serious limitations to informed consent, and to wrong diagnosis and treatment. Persons with low educational background and a low socioeconomic status are specifically affected. In this context, stakeholders and health providers referred to a 'middle class bias'.

Persons with no or little proficiency in the national language and particularly older migrants tend to avoid contacts with specialised health services, may reject rehabilitative health offers (stays at spas) because they fear that they will not be able to communicate, delay treatment, or do not seek help at all. Moreover, the adequacy and efficiency of treatment is limited because patients are hesitant or not able in the given time to ask questions about the treatment or feedback treatment effects to the medical professionals.

Regarding **interpreter services**, stakeholders and health providers criticised that these, if existing at all, are not always available when needed. Moreover, in rural areas such services are often not available at all. Using informal interpretation by relatives and friends or ad-hoc interpretation by hospital staff (including non-medical personnel) seems to be very widespread, but is considered ethically and professionally problematic by health providers and other experts interviewed for this study. Interpretation specifically represented a problem at specialist appointments, inpatient treatment, or when giving birth at hospital, as the use of informal interpretation strategies is limited in these cases. Due to the lack of formal interpreter services, access to information and services for persons without social networks (e.g. divorced women, older persons, irregular migrants) is thus additionally limited. Among health providers, there is mostly – but not always – a critical awareness about using unqualified persons such as cleaning staff or children as interpreters.

With regard to **access to information**, several users also remarked that they sensed a lack of willingness by health providers to deal with and adequately inform non-German speaking patients. Moreover, they felt that the Austrian health system requires a great deal of self-initiative on the side of patients (e.g. information is not provided automatically, but has to be sought proactively by the users), which is problematic especially for newcomers, persons

with low education, and persons in need of multiple support such as families with disabled children.

Everything is important. There is a lack of information, people are always working hard and therefore have only little time to get the information needed. If there's a lack of knowledge in regard to the language then people won't be able to find the information they need or they won't be interested enough in the matter. Of course, also the people's financial position is of great importance, for example if there's no balanced diet or good clothing provided for people get sick more often than usual. People don't take enough care of themselves, they move on until they reach the point of no return. (*Woman from Croatia, 60-69 years old, retired*)

Financial barriers

In Austria, financial barriers mainly affect access to services that are not or only partially covered by the health insurance funds and are thus not affordable for a great deal of patients in need. In particular this related to access to psychotherapy (particularly important for traumatised asylum seekers/refugees, elderly persons, and young adults with intellectual disability), other specialised offers (e.g. specific therapies for disabled children, in-vitro fertilisation, dental treatments), but also medication costs for persons who are not exempted from prescription charges. In particular older persons who live on a small monthly pension faced limitations to access medical supports or more generally, to afford a healthy lifestyle. At a structural level, some stakeholders pointed out that **expenditure cuts** in the health sector (e.g. current reductions in the disability and long term care sector) and lack of resources often affect disadvantaged social groups more than others. Moreover, fear of unemployment may prevent migrants from going on sick leave.

I just had problems with psychotherapy – but really, we need this ... we need it. Without [the therapy] I cannot do any longer. This is so important, I don't know. If I had not found this therapy, or a neuro-psychiatrist, I would have been dead for a long time already, or in psychiatry – believe me.

Woman from Serbia, 50-59 years old, unemployed

Supply gaps

According to experts, the Austrian health system specifically lacks interpreter services and native language mental health provisions. With respect to provisions for persons with disability, lack of barrier-free and inclusive health provisions and a lack of training of health staff with regard to dealing with persons with intellectual disabilities were reported. For rural areas experts noticed a general supply gap in all these respects.

A lack of specialised services in native language, and in particular of multilingual psychotherapy services especially affects older persons and young adults with intellectual disability who frequently suffer from mental health problems due to traumatic migration experiences, loneliness, or deprivation. Moreover, few psychotherapists are specialised on teenagers and above that, on young persons with intellectual disability.

There is also a lack of female gynaecologists who offer native language services and hold a contract with a health insurance company.

Experiences of discrimination

Awareness of discrimination

Awareness on discrimination among health providers differed remarkably. Providers reported subtle incidents of discrimination such as being treated disrespectfully or impolitely or facing longer waiting times. Those who were aware of discrimination, in general also were aware of multiple discrimination and general structural inequalities. Awareness among health users depended on the knowledge of the system as well as on language proficiency (co related to length of stay in the country and educational background). Both groups generally welcomed the good quality and fairness of the Austrian health system, although having heard of or having experienced discrimination or perceiving structural inequalities in access to health care.

Representatives of advocacy groups were aware of many and partly very severe cases of discrimination. According to advocacy groups, legal experts and representatives of ombuds bodies most of the cases they were aware of have a multiple discrimination component. Reported cases referred to **refusal of treatment** due to lack of German language skills, **dismissive treatment** of women with headscarf, **sexual harassment** in health facilities, committed by both staff and fellow patients, **verbal racist insults**, forced **sterilisation** of disabled women, **over-medication** of intellectually disabled and mentally challenged patients, and lethal cases of **maltreatment with suspicion of a discrimination component**. Cases related to discriminatory regulations and guidelines include major blood donating institutions which have **racist regulations** discriminating African persons and their spouses and partners and **regulations discriminating homosexual persons**.

With regard to intellectual disability, there are indications of structural discrimination: migrant teenagers seem to be categorised as having an intellectual disability or learning difficulties more easily due to language difficulties and negative stereotyping. There were indications in the research that young persons with intellectual disability and migrant background have more difficulties in accessing social protection schemes (e.g. regarding the length of period for which minimum social protection is granted).

With respect to **multiple discrimination**, an expert of the disability sector stresses that all clients would benefit from a multiple discrimination approach as it would encourage closer investigation of each individual case. A multiple discrimination approach would also decrease stigmatisation of certain groups, such as disabled persons.

Experiences of discrimination

Generally health users remarked that experiences of discrimination occur more often in the employment field or in the public compared to the health sector. Reported cases of discrimination were often attributed to structural problems in the health system in general, or attributed to the personality of a single doctor or nurse. Perceived reasons for discrimination were ethnicity (e.g. having a foreign-sounding name), language (including lack of communication and information), appearance (e.g. wearing a headscarf, looking foreign), but also social inequalities as well as a power imbalance in the doctor-patient relationship, which might even be strengthened if adding a gender component.

In the following the main types of reported cases of discrimination are listed:

Refusal of treatment: Reported cases range from neglect of patients due to lack of time and communication problems (e.g. not giving blood transfusion until the patient broke down),

rejection of follow-up treatment for dentures obtained abroad, to failure to diagnose pregnancy due to time pressure and language problems.

Dignity and respect: Many health users reported of disrespectful, harsh, unfriendly and undignified treatment by health professionals and in particular by nurses or administrative hospital personnel (e.g. receptionists). In relation to delivery and post-natal care at hospitals incidents with nurses and midwives were reported, as well as disrespectful treatment by staff at reception desks. Young adults with disability may face infantilizing and disrespectful treatment by health professionals. Specific problems were reported by older persons with regard to examinations required to evaluate applications for invalidity pension or early retirement by staff of health insurance funds who would blame patients to lie and simulate health problems.

The first thing he said was that he wanted to obtain a driving license. Then the doctor told him that people with Down syndrome cannot do this, that in fact nobody is doing this and that nobody with Down syndrome is driving a car. Thereupon his face turned red and he got angry and entered a state of mind in which he could have killed somebody. Then the doctor got up and by patting him on the back he said that they would talk about this again but that for now the time was up. Then D told him (slowly) "Don't TOUCH me". (*Mother of a young man with Trisomy 21 reporting about an incident with his neuropsychiatrist*)

(Sexual) harassment: Several cases were reported when the patient felt degraded or intimidated, such as being blamed for simulating a health problem in order to receive social benefits, being shouted at and treated like a child ('I told you not to enter!', 'Don't cry! You can cry at home!', 'You are only allowed to sit down until I tell you!'), as well as xenophobic insults such as being affronted for not speaking German ('You are in Austria!'), or being directly confronted with negative and xenophobic stereotypes about the own ethnic community.

Especially Muslim women often felt that medical professionals treated them in inappropriate and tactless ways. Respondents felt embarrassed being treated by male doctors and nurses, for example being asked totally inappropriate questions about one's religion during treatment (e.g. directly after giving birth), being forced to shake hands by male doctors, or being forced to undress in front of male doctors and being refused to be examined by a female colleague.

Malpractice: Malpractice cases involved incidents at dentists who pulled or treated the healthy tooth instead of the ill one, failures to diagnose serious health problems such as cancer or inward injuries with possible life-threatening consequences, over-medication of young adults with intellectual disability, or serious medical malpractice which was tried to cover up and brought serious damage to the health of the affected patient. The latter case was the only case we found that was brought to the Patients' Ombud.

Specific challenges of particular groups – results from the fieldwork

Migrant women with reproductive health needs

Access to a number of pre- and post-natal health examinations has been mainstreamed within the Mother-Child-Card scheme. Migrant women may face problems when giving birth at hospital due to a lack of interpreter services. In addition, there is a need for more systematic and targeted information on additional services, such as birth-preparation courses or available options for post-natal home support by midwives.

Specific intersecting issues relate to Muslim women and to women with disabilities. The research indicates that women with disabilities (both physically and intellectually) often lack rights to self-determination in relation to their sexual and reproductive life. Gynaecological check-ups and contraception are often a taboo among the families of young women with disabilities. Experts mentioned cases of intended forced sterilisation or contraception as very critical issues in this context.

Discrimination of Muslim women seems to be widespread in the Austrian health sector and is an issue that negatively impacts on reproductive health of women. Also the lack of female (and multilingual) gynaecologists with public insurance contract is an issue which has to receive utmost attention. No current official data could be obtained by the Austrian Medical Chamber, but according to other figures,[please check with background report] there is only roughly a dozen of female gynaecologists with public insurance contracts in Vienna, and in some provinces there are no female gynaecologists available at all.

Elderly migrants

First generation migrants, former so-called 'guestworkers', due to their migration and labour history have specific health needs. Cardiovascular diseases, chronic health problems due to hard manual work, and mental health problems such as depression are specifically frequent. Yet, the Austrian health system is ill-prepared for accommodating the increasingly diverse old population. Regulations on access to long-term care provisions, in particular rehabilitative care, entitlements to receive care allowance benefits and access to retirement homes to large parts exclude the non-national elderly population.

In old age, health problems that were frequently neglected in younger years due to a lack of entitlements, lack of awareness, or insecure working conditions accumulate. Studies show that elderly migrants (75+) have a worse health than the non-migrant population and show a lower take up of health and support services. In old age also social problems accumulate. Living on a small monthly pension, elderly migrants face difficulties to afford medication or other care devices. Moreover, due to a lack of access to health provisions in younger years older migrants may lack an officially documented medical history, which may lead to difficulties in obtaining early retirement or invalidity pension due to health reasons.

Young adult migrants with intellectual disabilities

Young adults with intellectual disabilities are in need of inclusive health provisions that include general and specialist care, but also psychosocial counselling [parents]. However, there is a clear lack of specialised health provisions and a lack of inclusive health provisions and of specifically trained staff.

Moreover, migrant families of children with intellectual disability may lack targeted support and advice in accessing information on required examinations, health provisions and related entitlements (e.g. higher family allowances) in the best interest of their children [yes]. Access to health services of young persons with disabilities strongly depends on the ability of their families or carers to look for information and communicate needs (related to language, education, socioeconomic status). The research also shows that young migrants with intellectual disability face considerable disadvantages

in obtaining an appropriate diagnosis and treatment.

Over-medication of young adults seems to be wide-spread, especially with regard to young persons [again, who says this? The reserach]. In this context, the lack of psychotherapeutic treatment provided by the mainstream system is a crucial issue. Young adults with intellectual disabilities are socially and economically marginalised, and thus cannot afford covering therapy out of their own pocket. Psychotherapy as well as social counselling would however be specifically needed at the transition from teenage- to adulthood to promote leading a self-determined life.

Experiences with using complaints mechanisms

Following the complex legal anti-discrimination framework, also the institutional anti-discrimination framework is highly complex. **Major complaint bodies** are the following: the Patients Ombuds Body (*PatientInnenanwaltschaft*) which mainly deals with medical complaint cases, the Arbitration Board of the Federal Social Welfare Office (*Schlichtungsstelle des Bundessozialamtes*) which is responsible for all cases involving disability, the Disability Ombud (*Behindertenanwaltschaft*), and the Equal Treatment Commission (*Gleichbehandlungskommission*) which deals with cases related to gender or ethnicity regulated under federal law, as well as the Complaint Board of the Austrian Medical Chamber (*Beschwerdestelle der Ärztekammer*).

According to the legal experts, there are generally **very few complaint cases** and **hardly any court cases** on discrimination and more particular, in the health sector there are no cases. In the scope of the Disability Ombuds Body, up to now only one case has resulted in a court case after a failed arbitration. The litigation association (Klagsverband) knows about 8 disability related cases, however, mostly not health related.

According to representatives of the complaint bodies, in health-related discrimination cases both, clients and the representatives of the complaint bodies strongly favour **low threshold intervention** (phone call, letter of complaint) or **out-of-court settlements** such as **arbitration procedures**. According to the legal experts, out-of-court settlements provide a better chance that the conflict partners find a common and constructive solution. The **arbitration procedure** of the Federal Social Welfare Office is considered an effective tool and an example of good practice by the interviewed legal experts and stakeholders. According to the Disability Ombudsman, from 1,200 complaints per year, only 1% is health-related, and less than 5% of the cases result in a formal arbitration procedure.

Experiences with using complaint mechanisms

According to the expert's experience, as well as according to health users, patients rarely **engage in complaint procedures** due to fear of negative consequences, lack of knowledge, and lack of transparency of the complaint mechanisms. The **complex mandate structure and lack of consistency of legal regulations (e.g. due to different provincial rules)**, both on the horizontal (discrimination grounds) and vertical level (policy levels), limit the access of clients to complaint structures and are even challenging for experts. Research with health users showed in addition, that awareness of discrimination and related entitlements is low, which would be a precondition for making use of the complaints system. Also health providers often have a very limited knowledge of complaint bodies.

Younger persons, second generation migrants, persons with good German skills and with higher education were better informed about complaint mechanisms and also more willing to make use of them. Only one interviewee who had experienced serious damage to his health due to medical malpractice filed a formal complaint and turned to the Patients Ombud (see textbox). Informal strategies, such as changing the doctor, talking about the incident to friends and relatives, or complaining directly in the situation were much more frequent reactions to discriminatory behaviour.

Among the **reasons for not complaining** were low awareness on entitlements and competent bodies, anticipated low success chances due to low language proficiency, fear that the complaint would not be taken seriously and doctors would always be in the right, too much time and emotional stress involved in filing a complaint, as well as lack of money for paying a lawyer.

It's troublesome and it means a lot of work. One has to pay attention to the complaint etc. and this means a lot of work. Anyway, the German language is another obstacle. I prefer to keep a low profile. We are in a foreign country and the language is not our language.
(Woman with Kurdish background, aged between 40 and 49)

Accessibility of the complaint system

Legal experts and stakeholders stated that a serious limitation of the legal complaint options is the fact that in Austria **compensation sums in case of discrimination are usually very low** (a few hundred Euros), and there remains the **litigation risk**. There is a clear lack of affordable support and counselling during court proceedings, which is currently offered by few institutions (such as the Litigation Association which offers legal representation for free). Counselling organizations assess the risks related to a court proceeding and sometimes also discourage clients from going to court for their own good.

Another limitation on the legal level is lack of effective legal measures: Austrian law allows suing for compensation but there is **no legal provision for omission or elimination**. Among the recommendations by health users to improve awareness and use of the complaints system included promoting centres that offer counselling and information on health and discrimination in multiple languages, or offer psychological support to victims of discrimination.

There are different expert opinions on the fact that different discrimination grounds are addressed by different institutions. This constellation might be a barrier with respect to accessibility on the one hand, but on the other hand a range of highly specialised complaint services might serve the individual needs of the clients. For health users this means however, that they need a **qualified referral** in order to find the responsible body. In cases of persons with intellectual disability or with specific communication needs (e.g. need for interpreters or sign interpreters) it has to be ensured that the referral process is accompanied in an adequate way.

A malpractice case brought to the Patient Ombud

I went to the hospital. The welcome I received there seemed kind of exaggerated to me. When they had read the letter of my specialist doctor the situation changed completely. Suddenly people weren't nice to me any longer. One of the nurses asked me to wait. After some minutes she finally returned with some documents. Then she told me the following: "If your doctor doesn't have to do any better things then give her these documents to read." With all these documents in hands I went again to my doctor. But she told that those weren't the documents she had asked for and until today I wasn't able to get them. [...] Only then I found out that I had been treated inadequately at the hospital. The specialist told me: "Mr S, do you know that the hospital did not treat you right?" Until then I did not know about this!

In my case it's not for the money. I only want to know the truth. I have to know what really happened! I don't want any money but I want the doctors' excuse and that they finally come to admit their mistake! I only want justice to be done, I don't want any money. Everybody can make a mistake, mistakes also happened to me when I was at work but you should be ready to admit them.

Man from Bosnia, aged between 50 and 59, incapacitated due to medical malpractice

GOOD PRACTICE EXAMPLES

Provisions for patients with intellectual disabilities

The *Down Syndrome Outpatients Department* at a Viennese public hospital (Rudolfsstiftung) supports children, adolescents, and adults with Down syndrome and their families. The ambulance is the only one in Austria and at the moment it provides services for about 400 patients. The service is well-known and encompasses multi-professional clearing and medical, psychological, and social support. One third of the users have a migration background. In Vienna, the *Krankenhaus der Barmherzigen Brüder* is known for offering health care and further developing guidelines and standards for the treatment of patients with intellectual disabilities. The offers are designed in a way suitable for the needs of this clientele and include dental health care.

Provisions for the hearing impaired

The *Outpatients Department for the Hearing Impaired* is a specialised medical centre and a major contact point for the community of the hearing impaired. Outpatients department for the hearing impaired are available in Graz, Linz, Vienna, and Salzburg.

Provisions for socially marginalised individuals

In Graz, *Marienambulanz* is an outpatient department specialised on medical provision for patients without health insurance and also frequented by asylum seekers and other groups of poor persons (e.g. the homeless). The department has good reputation due to the broad language competence of the staff, psycho-social provisions, and provisions suitable provisions (e.g. dental care, gynaecological care) for excluded social groups. In Vienna, *AMBER Med* is dedicated to the same target groups and is also frequently mentioned as example for good practice in the health sector for the above mentioned reasons.

Multi-lingual mental health provisions

Multi-lingual psychotherapeutic treatment is available at the *Outpatients Department for Transcultural Psychiatry and Migration Related Disorders* at the General Hospital Vienna on a project-basis and at the *Sigmund Freud Privat Universität Wien*. *ZEBRA* (Graz), and *HEMAYAT* (Vienna) are specialised counselling and psychotherapy centres who have a great focus on the treatment of extremely traumatised persons such as refugees (victims of torture, violation etc.). *PEREGRINA* (Vienna) offers free psychotherapy in native language.

All three centres have very good reputation and extensive networks with other health institutions and NGOs, but have very limited resources available. ZEBRA is considered an important contact point for the provision of qualified interpreters in Graz and thus fills an important gap. ZEBRA has participated in the development of a curriculum for community interpreting services in the health centre.

Community based and outreach approaches

In Graz, the *Social Medical Centre Liebenau* successfully addresses otherwise hard-to-reach groups such as Turkish Housewives or migrants from the African community. The initiative “*Pro Health*” is dedicated to addressing the African community located in Graz. In Vienna, the community based approach of *FEM Süd* is to be mentioned as good practice that clearly enhanced the access to health care for communities such as the Turkish community, but also the Chinese, African, and Arab community. Another example is the Vienna based counselling centre “*Miteinander Lernen – Birlikte Ögrenelim*” which provides psycho-social support and psychotherapy for the Turkish community in Vienna and is a well known institution.

Anti-racism support and counselling centres

The Vienna based anti-discrimination NGO *ZARA – Zivilcourage und Anti-Rassismus-Arbeit* (Civil Courage and Anti-Racism Work) and in Graz, the anti racism support centre of *Helping Hands* are major institutions where to place complaints related to racism and discrimination and where to obtain support.

Programmes for newcomers

The city of Vienna in the *Start Vienna Coaching* offers information on relevant areas of daily life to newcomers from third countries. Information on the health system is provided in several languages in a separate module, and discussion groups for pregnant women are organised in native language.

About ICMPD

The International Centre for Migration Policy Development (ICMPD), established in 1993 by Austria and Switzerland, is an international organisation working in migration-related fields. Although ICMPD has a European base, it carries out its activities throughout the world, including in Europe, Africa, Central Asia and the Middle East. Through its six Competence Centres, ICMPD provides its 15 Member States and numerous partners with in-depth knowledge and expertise in dealing with the phenomenon of migration. It does so by applying a holistic 3-pillar approach: research, capacity building and migration dialogues.

ICMPD's Research Unit aims to further knowledge on migration-related issues, to facilitate cooperation and synergy within and beyond the research community and to respond to an increased demand for a more policy-relevant research. It has built up a reputation for research on international migration trends, patterns and policies in the wider European context based on comparative analysis. This work is policy-orientated and empirical with an interdisciplinary and international approach.