Policies on Health Care for Undocumented Migrants in EU27

Country Report

Austria

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Preface

Undocumented migrants have gained increasing attention in the EU as a vulnerable group which is exposed to high health risks and which poses a challenge to public health. In general, undocumented migrants face considerable barriers in accessing services. The health of undocumented migrants is at great risk due to difficult living and working conditions, often characterised by uncertainty, exploitation and dependency. National regulations often severely restrict access to healthcare for undocumented migrants. At the same time, the right to healthcare has been recognised as a human right by various international instruments ratified by various European Countries (PICUM 2007; Pace 2007). This presents a paradox for healthcare providers; if they provide care, they may act against legal and financial regulations; if they don’t provide care, they violate human rights and exclude the most vulnerable persons. This paradox cannot be resolved at a practical level, but must be managed such that neither human rights nor national regulations are violated.

The EU Project, “Health Care in NowHereland”, works on the issue of improving healthcare services for undocumented migrants. Experts within research and the field identify and assess contextualised models of good practice within healthcare for undocumented migrants. This builds upon compilations of

- policies in the EU 27 at national level
- practices of healthcare for undocumented migrants at regional and local level
- experiences from NGOs and other advocacy groups from their work with undocumented migrants

As per its title, the project introduces the image of an invisible territory of NowHereland which is part of the European presence, “here and now”. How healthcare is organised in NowHereland, which policy frameworks influence healthcare provision and who the people are that live and act in this NowHereland are the central questions raised.

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<th>Healthcare in NowHereland: Improving services for undocumented migrants in the EU</th>
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Introduction

This report is written within the framework of the research project, NowHereland – Health Care in NowHereland – Improving Services for Undocumented Migrants in the EU, and one of its work packages. The focus of this work package – policy compilation – was to collect data on policy approaches regarding access to health care for undocumented migrants in the EU member states, to deliver 27 Country Reports and to offer a clustering of the states. A descriptive approach has been applied. In order to contextualise health care access, certain other themes are covered, such as the main characteristics of the various health systems, aspects of policies regarding undocumented migrants and the general context of migration.¹

The term used in this project is thus, “undocumented migrants”, which may be defined as third-country nationals without a required permit authorising them to regularly stay in the EU member states. The type of entry (e.g. legal or illegal border crossing) is thus not considered to be relevant. There are many routes to becoming undocumented; the category includes those who have been unsuccessful in the asylum procedures or violated the terms of their visas. The group does not include EU citizens from new member states, nor migrants who are within the asylum seeking process, unless they have exhausted the asylum process and are thus considered to be rejected asylum seekers.

All the reports draw upon various sources, including research reports, official reports and reports from non-governmental organisations. Statistical information was obtained from official websites and from secondary sources identified in the reports. As regards legislation, primary sources were consulted, together with the previously mentioned reports. One salient source of this project was information obtained via a questionnaire sent to recognised experts in the member states.²

The General Migration Context

Austria entered the EU in 1995 and is situated on the border of the Schengen Area, and is bordered by Switzerland, as well as Hungary, Slovakia and Slovenia, although these borders were of greater significance prior to these states becoming members of the EU in 2004.

¹ Information regarding the project and all 27 Country Reports can be found at http://www.nowhereland.info/. Here, an Introduction can also be found which outlines the theoretical framework and method as well as a clustering of the states.

² For the report at hand, the persons to acknowledge are: Agnes Handler and Birgit Metzler, Centre for Health and Migration, Danube University Krems.
The Republic of Austria has, over the last two centuries, experienced various forms of international migration, including immigration, emigration, and transit migration connected to internal population movements of the Habsburg Empire. There was also a salient migration bound mainly for Germany, Switzerland, Italy, and later, to an increasing extent, the Americas (Jandl and Kraler 2003). In the wake of the disappearance of the Habsburg Empire, Austria was part of the reshuffling and repatriation of people caused by the establishment of new states (with homogeneous claims). Between the two world wars, there was considerate emigration due to the economic situation (initially) and political reasons (the "Austro-fascist" regime of 1919 -1937). Between 1938 and 1941 (during the Nazi annexation), some 128 000 Jews were forced to leave Austria, whilst up until 1945 at least 64 459 Austrian Jews were murdered, both inside and outside death camps. At the end of World War II, some 1.4 million foreigners, including foreign workers, slave labourers, war refugees and ethnic Germans, emigrated to Austria, with 500 000 (mainly German) settling permanently (ibid.). During the Cold War, and due to the political crises in the communist countries in Eastern and Central Europe between 1945 and 1989, Austria was one of the main receiving and transit countries. This involved about two million people and in terms of sending countries, Hungary (1956), Czechoslovakia (1968) and Poland (1981) (ibid.)

Austria began to forge bilateral agreements to recruit temporary workers with southern and south eastern European states in the 1960s, which over time lead to significant numbers of workers and their families residing in Austria. In 1969, the number of foreign workers from Turkey and Yugoslavia stood at 76 500. By 1973, the numbers had almost tripled to 227 000 (ibid.). This recruitment was ended in response to the recession of the early 1970s (as in other European countries). Furthermore, a new law aiming at restricting access to employment was passed in 1975 - the Aliens Employment Act (ibid.). While active labour recruitment was stopped, other forms of migration, including family reunification, spontaneous labour migration and, by the late 1980s, irregular and asylum migration, became more important. The labour migration in the 1960s clearly had lasting effects on both the current composition of the foreign resident population in Austria and subsequent migration inflows (ibid.).

In the 1980s and 1990s, the recruitment of labour relied on informal channels as well as the large supply of labour resulting from the political and economical situation in Yugoslavia. During this period, the number of non-nationals in Austria doubled, from 344 000 in 1988 to 690 000 in 1993. The proportion of foreign workers rose from 5.4 percent to 9.1 percent. In 2001, 62.8 percent of the foreign resident population came from two recruitment regions: the former Yugoslavia and Turkey (ibid.).

During the 1990s there were a series of legislative reforms in respect of entry, residence, employment, and asylum, aiming at tightening regularisations on entry, emphasising integration and “successive consolidation of residence”, and the acquisition of citizenship
The inflow of foreign workers continued to increase, and in 1998 15,400 persons entered the country, compared to 29,600 in 2007.  

With respect to asylum migration, Austria played a role in this respect during the 1980s and 1990s (in the latter case, involving refugees from the former Yugoslavia granted "temporary protected status"). Due to the restrictions which were initiated, the number of asylum applications dropped steeply (4,744 in 1993), and remained low for the next four years. At the end of the 1990s, the number of new asylum applicants, increasingly from Asian and African countries, rose. In 2002, a record 36,990 asylum applications were lodged.

In 2008, Austria received 12,750 asylum applications, mainly from citizens of Russia (3,445), Serbia (1,700) and Afghanistan (1,345) (Eurostat 66/2009). The same year, 13,705 decisions were issued (in the first and second instance) and the rate of recognition was 62% (3,640 in the first instance) (Eurostat 175/2009).

**Total Population and Migrant Population**

By 1 January 2010, the population in Austria was 8,372,930 (Eurostat). In 2008 the foreign-born population was 835,000, which equalled 10% of the total population (Eurostat 94/2009). The main countries of origin of these foreigners were Serbia and Montenegro (132,600), Germany (119,800) and Turkey (109,200) (ibid.).

In the first quarter of 2008, approximately 1.427 million people with an immigrant background (1st and 2nd generation) lived in Austria, which equated to 17.3% of the population.

**Estimated Number of Undocumented Migrants**

As regards undocumented migrants in Austria, the numbers are estimated to be at a medium level by European standards. Estimates range between 40,000 and 100,000.

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4 Between 1992 and 1995, about 95,000 war refugees from Bosnia-Herzegovina received “temporary protected status” (Jandl and Kraler 2003).


migrants, corresponding to 0.9% of the population (Baldwin-Edwards & Kraler 2009:41). There are more exact and modest figures presented, which range from 18 439 to 54 064 (Kraler et al. 2008:35).

**Categories of Undocumented Migrants**

There are no, or insufficient, quantitative indicators or estimates regarding different pathways into an irregular stay in Austria (Kraler et al. 2008:59). Due to this lack of information, it is also not meaningful to pin down categories of undocumented migrants. However, the asylum process does play a role in the “production” of undocumented migrants (Baldwin-Edwards & Kraler 2009:41). In addition, one possible pathway into legality is the asylum application process, as it is likely that a certain share of asylum applicants have been staying illegally in the country prior to submitting their asylum claims (Kraler et al. 2008).

**Policies Regarding Undocumented Migrants**

**Regularization Practice, its Logic and Target Groups**

Austria has never implemented an explicit programme to regularise irregular stay migrants. According to available reports, there is no comprehensive policy approach to legalise or regularise undocumented migrants and applied procedures are based on selective and individual regulations, issued for humanitarian reasons. (Kraler et al. 2008; Baldwin-Edwards & Kraler 2009; see also Clandestino Policy Brief Austria 2009:3f).

**Internal Control: Accommodation, Labour, Social Security and Education**

An undocumented migrant cannot sign a contract of accommodation. Likewise, an undocumented migrant cannot access employment, or the related social security (IOM 2005:28). As regards schooling, a child who is undocumented can go to school, in accordance with the Constitution and the School Organisation Act (Schulpflichtgesetz) (European Commission 2004:33). In terms of those acts, all public schools are "universally accessible without discrimination on grounds of birth, gender, race, social status, class, language or religion." However, for registration purposes, every child needs to provide confirmation of residence (IOM 2005:29). This prerequisite might imply that education is in fact not available in practice.

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(11-03-2010).
Main Characteristics of the Health System

Financing, Services and Providers

Health care provision is primarily a public task in Austria, which is regulated by social law. The main legislative competencies are given to the Federal Ministry of Health, Family and Youth (Karl-Trummer et al. 2009). Nine federal states are responsible for the enactment of legislation and its implementation, as well as for financing and the provision of inpatient care (ibid. with reference to BMGF 2005). The financing of the health care system is pluralistic, in accordance with the constitution and social insurance laws. In terms of financing, a social health insurance system provides approximately half of the total health care expenditure (Hofmarcher and Rack 2006). The insurance is mandatory and based on membership of an occupational group or place of residence and involves the beneficiaries’ dependants as well. The General Social Security Act (ASVG) is applicable to around 80% of the population (mainly wage earners). To this figure must be added the so-called marginal employees (with income below a ceiling), who can choose to pay voluntary social insurance contributions. In 2007 the statutory health insurance scheme covered 99% of the population (Karl-Trummer et al. 2009). Contributions are tied to income levels and are progressive, divided between employer and employee and collected by 21 insurance funds. However, as resources are subject to re-allocation there is in effect a single national pool for social insurance contributions (Hofmarcher and Rack 2006). In addition to contributions, funding stems from taxes (30% from VAT), from private insurances (8%) (for faster access and "special class" accommodation) and out-of-pocket payments (17%). Health insurance funds can offer additional voluntary benefits or exemptions from cost sharing (Hofmarcher and Rack 2006).

Members of the statutory health insurance scheme have a legal entitlement to a wide range of benefits. These include outpatient medical treatment, dental treatment (not fixed dentures), psychotherapy, physiotherapy, ergo therapy and speech therapy, medicines and therapeutic aids, medical nursing care, rehabilitation, hospital treatment and stays at spas (Hofmarcher and Rack 2006). Cost sharing applies to most health services but low-income pensioners, children, and people with chronic illnesses are exempt from prescription charges (approximately 12% of the population) (ibid.).

Persons not covered by insurance are expected to pay the full cost of medical treatment. In this context it is also relevant that in terms of the Austrian Federal Hospitals Act, hospitals are obliged to provide first aid in case of emergencies, regardless of any ability to pay (KAKuG 2008). If a patient is unable to pay or cannot be identified, hospitals are obliged to cover the expenses (IOM 2005).

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In the welfare system, pensions are covered by generous schemes, related to the final salaries. Unemployment is also covered by generous schemes (Questionnaire Austria).

The organisational structure of the Austrian health care system is defined by an interaction between public, private non-profit and private for-profit players (Hofmarcher and Rack 2006:32). Patients have free choice of outpatient provider and there is no gate keeping by general practitioners (Thomson et al. 2009:113). Health care is mainly provided by the public health service, via both outpatient and inpatient care at hospitals. Hospital services are provided in both public, private non-profit and private hospitals. Services such as nursing care and rehabilitation are also publicly financed and partially publicly provided. Outpatient care is provided mostly by self-employed physicians in private practice, outpatient clinics and hospital outpatient departments (Hofmarcher and Rack 2006).

**Basis of Entitlement**

In Austria, the basis of entitlement to health care is affiliation to insurance. However, to be included in the insurance system, legal residency is required.

**Special Requirement for Migrants**

Regular migrants are included in the social health insurance.

Migrants who have a recognised status based on humanitarian reasons, including refugees and asylum seekers, are entitled to receive health care, and their services are covered by health insurance. Asylum seekers who have been admitted to the federal care system are included in social health insurance if they are resident in Austria and are not already subject to mandatory insurance, in accordance with certain other legal provisions in the health insurance system. The federal care system has now been replaced by the “basic care system for foreigners in need of assistance and protection”, based on an agreement in terms of the Federal Constitution Article 15a between the Federal Government and the Länder (Hofmarcher and Rack 2006).

**Difference Sensitivity**

There are adaptive structures to migrants in health care involving mediation/translation services, translated informational material, health services adapted to migrant specificities (for example, meals in hospitals) as well as the integration of such in education for healthcare providers.⁹

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⁹For examples, see [http://mighealth.net/at/index.php/Hauptseite topic 5](http://mighealth.net/at/index.php/Hauptseite topic 5), (11-03-2010).
Health Care for Undocumented Migrants

**Relevant Laws and Regulations**

There is no specific regulation governing health care provision for undocumented migrants. In this context, some laws are relevant as they do not distinguish between patients in terms of legal status. These include:

The Austrian Federal Hospitals Act, in terms of which every hospital is obliged to provide first aid in case of emergencies (KAKuG/Bundesgesetz über Krankenanstalten und Kuranstalten StF: BGBl. Nr. 1/1957, §§ 22 (4)). This applies also to women giving birth. This legislation also provides that persons whose lives are in danger (due to mental or physical conditions) or risk serious damage to their health and are therefore in need of immediate treatment, and women who are about to give birth, may not be refused. 10

Further legislation, namely the Aids Gesetz BGBl.Nr. 728/1993 as well as Tuberkulosegesetz StF: BGBl. Nr. 127/1968, regulate medical testing and access to treatment.

**Access to Different Types of Health Care**

Undocumented migrants are excluded from the insurance system and from the state-funded scheme for uninsured persons. However, undocumented migrants access first aid, in cases of emergency, at federal hospitals (in terms of the KAKuG 2008). In general, opportunities to receive medical treatment beyond emergency care (primary and secondary care) without being insured or being able to pay directly, are highly limited. Nevertheless, in some cases and at the health professional’s discretion, a window of opportunity exists for undocumented migrants to receive treatment beyond an actual case of emergency. In practice, a medical professional can ‘turn a blind eye’ by applying a wider definition of “emergency”; providing services despite knowing that they will not be paid for and/or accepting false identities. Care offered beyond this opportunity mostly depends on sporadic agreements with doctors who offer medical treatment at reduced costs, or organisations who offer specific services free of charge (e.g. gynaecological examinations and child birth) (see below) (Karl-Trummer et al. 2009; see also PICUM 2007).

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10 The original text reads as follows: “unabweisbar im Sinne des Abs. 2 sind Personen zu betrachten, deren geistiger oder körperlicher Zustand wegen Lebensgefahr oder wegen Gefahr einer sonst nicht vermeidbaren schweren Gesundheitsschädigung sofortige Anstaltsbehandlung erfordert, sowie jedenfalls Frauen, wenn die Entbindung unmittelbar bevorsteht. Ferner sind Personen, die auf Grund besonderer Vorschriften von einer Behörde eingewiesen werden, als unabweisbar anzusehen.” (italics not in original).
Costs of Care

Being uninsured, undocumented migrants are obliged to pay the full cost of treatment when seeking health care (IOM 2005:27), including emergency care. In principle, the patient is invoiced after treatment. Unpaid bills may have consequences for undocumented migrants who manage to regularise, as these debts must then be paid (PICUM 2007:15).

In cases where the patient cannot be identified, hospitals are obliged to cover the expenses out of their own budgets (IOM 2005:27).

There are nongovernmental organisations which might help undocumented migrants to pay the costs of health care (Questionnaire Austria). Some non governmental organisations either act as intermediaries, asking for a cancellation or reduction of the fees, or establish lists of individual health care providers willing to assist undocumented migrants free of charge (PICUM 2007:15).

Specific Entitlements

With respect to the entitlement to health care for undocumented migrants, there is one specifically identified group, namely women in labour (giving birth). This is in terms of the Austrian Federal Hospitals Act (KAKuG/Bundesgesetz über Krankenanstalten und Kuranstalten StF: BGBl. Nr. 1/1957, § 22 (4)).

The specific laws regarding infectious diseases such as tuberculosis and HIV/Aids do not make a distinction on the grounds of residency and require health care providers to inform the competent authorities about all new cases. The Tuberculosis Act of 1968 stipulates that people suffering from infectious tuberculosis are entitled to receive medical treatment and that the authorities are obliged to provide subsidised health care.

As regards HIV/Aids, tests are free of charge but there is no subsidised access to treatment for undocumented migrants.

Regional and Local Variations

There are no local or regional variations in entitlements to care in terms of legislation.

Obstacles to Implementation

This topic is not relevant.
**Obligation to Report**

In accordance with the rules governing professional confidentiality, there is no obligation on staff to report a patient to the police or other authorities (Questionnaire Austria).  

**Providers and Actors**

* Providers of Health Care

Given the limited entitlement to health care, providers are to be found among the general hospital emergency units. There are, however, also some established organisations, namely nongovernmental and local and international non profit religious organisations which provide services for people that have fallen out of the health and social insurance system (Karl-Trummer et al. 2009; see also PICUM, 2007).

Krankenhaus der Barmherzigen Brüder (Brothers of Mercy Hospital) has become one of the most important contact points for undocumented migrants in Vienna (PICUM 2007; Karl-Trummer et al. 2009). In addition, the hospital DRG (Diagnosis-Related-Groups), funded by the provincial health fund and additionally financed by donations is salient. Examples of non governmental organisations providing healthcare to undocumented migrants in Vienna include AMBER-MED (a joint project of the refugee service of The Diakonie Austria and the Austrian Red Cross), Hemayat and Aidshilfe. Other examples of non governmental organisations providing healthcare for UDM in Graz include Marienambulanz (with Caritas Austria as the responsible body), Omega and Zebra. Some of the NGOs (including AMBER-MED and Marienambulanz) are supported by a large network of medical specialists and institutes (Questionnaire Austria).

The providers of health care outside the mainstream system are mainly found in the main cities (Vienna and Graz). Some are coordinated, e.g. Krankenhaus der Bamerzigen Brüeder and AMBER MED in Vienna. AMBER refers patients with special needs or serious cases to the KBB, which refers ambulant patients to AMBER.

* Advocacy Groups and Campaigns on Rights

There are no particular advocacy groups or campaigns championing the rights of undocumented migrants (Questionnaire Austria).

* Political Agenda

Undocumented migration is not a salient topic on the agenda during public debates (Kraler et al. 2008).

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International Contacts

Actors in the field of health care for undocumented migrants in Austria do not have international contacts.

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