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„From Medical Care to Citizenship:
Mapping the Healthcare Systems' Function of Inclusion for Refugees in Vienna, Austria"

verfasst von / submitted by

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Abstract

This thesis discusses the complex interplay between the universally recognised right to health and the increasingly restrictive asylum policies that prevail in Europe and globally. By addressing the implications of these conflicting logics for the lived experiences of refugees, it provides a nuanced and critical account of refugee health in a European high-income host country. The study builds upon ethnographic research on refugee health in Vienna, Austria. Between 2018 and 2020, data were collected through qualitative interviews with seven asylum seekers and recognised refugees, and observations before, during, and after their medical appointments, as well as during various other situations. Additionally, this thesis incorporates insights from qualitative interviews with care providers, representatives of political parties and other professionals, and from a literature synthesis and document analysis about relevant legal structures and institutions.

In the Austrian public healthcare system, refugees are granted access to the same facilities and services as other beneficiaries from the moment they file an asylum claim. Extending beyond the medical aspects of these entitlements, this thesis maps personal, social, and political dimensions of healthcare, specifically focusing on how it plays a role in creating, enacting, and contesting the inclusion or exclusion of refugees. The first part of the findings focuses on aspects of refugees' lives in Austria that shape and meet their health needs outside of institutionalised healthcare structures. Refugees face legal, practical, and discursive forms of exclusion due to the insecurity while waiting for an asylum decision, encounters with discrimination, and other asylum related factors. These challenges have a detrimental effect on their health. To compensate for them and restore their well-being, refugees engage in self-care practices, such as creating safe havens in public places associated with well-being, using mobile phones to feel connected with significant others, and engaging in religious practices.

The second part of the findings describes how refugees' experiences within the healthcare system counter their exclusion and enact societal inclusion for them. First, the lived solidarity of some medical professionals and other care providers, such as social workers, resists and compensates for injustices in the healthcare system, such as discrimination and lack of interpreter services. Second, healthcare creates a personal sense of belonging to society; examples include sitting together in the waiting room with other insured persons and using the personal electronic health card that refugees receive like everyone else in the healthcare system. Third, practices in medical institutions play an important role in refugees forming a relationship with the Austrian state and in shaping them as citizens.

These findings indicate a complex dynamic of simultaneous inclusion and exclusion experienced by refugees in Austria. They encounter exclusion in their everyday lives, which can manifest as health problems. However, concurrently, care practices in medical institutions facilitate their inclusion. This inclusive function of healthcare engenders a rethinking of the role of healthcare systems, which extends beyond merely delivering medical care. Ideally, public healthcare systems should foster equality and social cohesion through their fundamental function of providing equitable medical care and their role of including marginalised groups in society.

Abstract (German)

Die vorliegende Doktorarbeit diskutiert das komplexe Zusammenspiel zwischen dem allgemein anerkannten Recht auf Gesundheit und den immer restriktiveren Asylpolitiken, die in Europa und weltweit vorherrschen. Indem sie die Auswirkungen dieser widersprüchlichen Logiken auf die Lebenserfahrungen von geflüchteten Menschen thematisiert, liefert sie eine differenzierte und kritische Darstellung der Gesundheit Geflüchteter in einem wohlhabenden europäischen Aufnahmeland. Die Studie stützt sich auf ethnografische Forschung zur Gesundheit von geflüchteten Menschen in Wien, Österreich. Zwischen 2018 und 2020 wurden Daten durch qualitative Interviews mit sieben Asylsuchenden und anerkannten Geflüchteten gesammelt, sowie durch Beobachtungen vor, während und nach ihren Ärzt:innenbesuchen als auch in verschiedenen anderen Situationen. Zusätzlich stützt sich diese Arbeit auf Erkenntnisse aus qualitativen Interviews mit Gesundheitsfachkräften, Vertreter:innen politischer Parteien und anderen Fachleuten sowie aus einer Literatursynthese und Dokumentenanalyse zu relevanten rechtlichen Strukturen und Institutionen.

Im österreichischen öffentlichen Gesundheitssystem haben geflüchtete Menschen ab dem Zeitpunkt ihrer Asylantragstellung Zugang zu denselben Einrichtungen und Leistungen wie andere Begünstigte. Über die medizinischen Aspekte dieser Ansprüche hinausgehend, werden in dieser Doktorarbeit persönliche, soziale und politische Dimensionen des Gesundheitswesens aufgezeigt. Der Fokus liegt speziell darauf, wie das Gesundheitswesen die Inklusion und Exklusion von Geflüchteten schafft, umsetzt und anfechtet. Der erste Teil der Ergebnisse konzentriert sich auf Aspekte des Lebens von geflüchteten Menschen in Österreich, die ihre gesundheitlichen Bedürfnisse außerhalb der institutionalisierten Gesundheitsstrukturen formen und erfüllen. Geflüchtete erleben verschiedene Arten von Ausgrenzung, sei es rechtlich, praktisch oder diskursiv, die sich aus der Unsicherheit während des Wartens auf einen Asylbescheid, aus Diskriminierungserfahrungen und aus anderen asylbezogenen Umständen ergeben. Diese Herausforderungen wirken sich nachteilig auf ihre Gesundheit aus. Um sie zu kompensieren und ihr Wohlbefinden wiederherzustellen, praktizieren geflüchtete Menschen Selbstfürsorge. Beispielsweise schaffen sie sich sichere Orte in öffentlichen Plätzen, nutzen Mobiltelefone, um sich mit nahestehenden Menschen verbunden zu fühlen und üben religiöse Praktiken aus.

Der zweite Teil der Ergebnisse beschreibt, wie die Erfahrungen von geflüchteten Menschen im Gesundheitssystem ihrer Exklusion entgegenwirken und gesellschaftliche Inklusion für sie bewirken. Erstens tritt die gelebte Solidarität einiger medizinischer Fachkräfte und anderer

Gesundheitsfachkräfte, wie Sozialarbeiter:innen, Ungerechtigkeiten im öffentlichen Gesundheitssystem entgegen und gleicht diese aus, wie beispielsweise Diskriminierung und fehlende Übersetzungsdienste. Zweitens schaffen Praktiken im Gesundheitswesen ein persönliches Gefühl der gesellschaftlichen Zugehörigkeit; Beispiele dafür sind das gemeinsame Sitzen im Wartezimmer mit anderen Versicherten und die Nutzung der persönlichen elektronischen Gesundheitskarte, die Geflüchtete wie alle anderen im Gesundheitssystem erhalten. Drittens spielen Praktiken in medizinischen Einrichtungen eine wichtige Rolle dabei, dass geflüchtete Menschen eine Beziehung zum österreichischen Staat aufbauen und formen diese als Staatsbürger:innen.

Diese Ergebnisse zeigen eine komplexe Dynamik gleichzeitiger Inklusion und Exklusion, die geflüchtete Menschen in Österreich erleben. Sie begegnen in ihrem alltäglichen Leben Ausgrenzung, die sich in gesundheitlichen Problemen manifestieren kann. Gleichzeitig jedoch stellen Praktiken in medizinischen Einrichtungen ihre Inklusion her. Diese inklusive Funktion der Praktiken im Gesundheitswesen führt zu einem Überdenken der Rolle der Gesundheitssysteme, die über die bloße Bereitstellung von medizinischer Versorgung hinausgeht. Idealerweise sollten öffentliche Gesundheitssysteme durch ihre grundlegende Funktion der Bereitstellung gerechter medizinischer Versorgung und ihrer Rolle bei der Einbindung von marginalisierten Gruppen in die Gesellschaft Gleichheit und sozialen Zusammenhalt fördern.

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Information about Co-Authorship

I am the sole author of this thesis, except for Chapter 7 titled *Lived solidarity by healthcare providers and other care providers*. This specific chapter is based on the co-authored article *Lived solidarity in the Austrian healthcare system*, published in *EASST Review* (Spahl & Prainsack, 2021).[1] For this thesis, I adapted the language in the collaborative sections and added extra content to further develop those parts. These sections within Chapter 7 were originally co-authored:

- Introduction
- Concretising Solidarity: Listening to Patients and Their History of Forced Migration
- Compensating Solidarity: Filling in for Structural Gaps
- Creating Solidarity: Improving the Healthcare System for Refugee Patients
- Motivations for Lived Solidarity
- Conclusion

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[1] This article was also published in German as a chapter within the edited volume *Solidarität im Gesundheitswesen: Strukturprinzip, Handlungsmaxime, Motor für Zusammenhalt?* (Hofmann & Spieker, 2022), presenting slight variations from its English counterpart (Spahl & Prainsack, 2022).

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List of Abbreviations

AKH	*Wiener Allgemeines Krankenhaus* (Vienna General Hospital)
BGBl.	*Bundesgesetzblatt* (Federal Law Gazette)
BFA	*Bundesamt für Fremdenwesen und Asyl* (Federal Office for Immigration and Asylum)
BZÖ	*Bündnis Zukunft Österreich* (Alliance for the Future of Austria)
CGT	Constructivist grounded theory
E-card	Electronic health card
ELGA	*Elektronische Gesundheitsakte* (Electronic health record)
EOHS	European Observatory on Health Systems and Policies
EU	European Union
FPÖ	*Freiheitliche Partei Österreichs* (Freedom Party of Austria)
GDP	Gross domestic product
GÖG	*Gesundheit Österreich GmbH* (Austrian Public Health Institute)
GVV	*Grundversorgungsvereinbarung* (Agreement on basic care)
KRP	Key research participant
NEOS	*Das Neue Österreich und Liberales Forum* (The New Austria and Liberal Forum)
NGO	Non-governmental organisation
NHS	National Health Service (publicly funded healthcare system in the UK)
OECD	Organisation for Economic Co-operation and Development
ÖGK	*Österreichische Gesundheitskasse* (established in 2020, Austrian-wide SHI fund that merged the regional SHI funds)
ÖVP	*Österreichische Volkspartei* (Austrian People's Party)
SHI	Social health insurance
SitA	Situational analysis
SPÖ	*Sozialdemokratische Partei Österreichs* (Social Democratic Party of Austria)
UK	United Kingdom of Great Britain and Northern Ireland
US	United States of America
WGKK	*Wiener Gebietskrankenkasse* (regional SHI fund in Vienna; merged into the nationwide fund ÖGK in 2020)

List of Translated Terms

Association	*Verein*
Agreement on basic care	*Grundversorgungsvereinbarung*, Art. 15a Federal Constitutional Law 2004
Aliens Police Act	*Fremdenpolizeigesetz*, Federal Law Gazette (Bundesgesetzblatt [BGBl.]) I Nr. 100/2005
Alliance for the Future of Austria	*Bündnis Zukunft Österreich*
Asylum Act	*Asylgesetz*, BGBl. I Nr. 100/2005
Asylum seekers	*Asylwerber:innen*
Austrian Agency for Health and Food Safety	*Österreichische Agentur für Gesundheit und Ernährungssicherheit GmbH*
Austrian Integration Fund	*Österreichischer Integrationsfond*
Austrian People's Party	*Österreichische Volkspartei*
Austrian Public Health Institute	*Gesundheit Österreich GmbH*
Basic care	*Grundversorgung*
Basic Care Act	*Grundversorgungsgesetz*, BGBl. Nr. 405/1991
Basic Social Assistance Act	*Sozialhilfe-Grundsatzgesetz*, BGBl. I Nr. 41/2019
Centres for developmental support	*Zentren für Entwicklungsförderung*
Community service worker	*Zivildiener:in*
Courses for orientation and on Austrian values	*Werte- und Orientierungskurse* (organised by the Austrian Integration Fund)
Elective physician	*Wahlärzt:in*
Electronic health record	*Elektronische Gesundheitsakte*
Federal Administrative Court	*Bundesverwaltungsgericht*
Federal Asylum Office	*Bundesasylamt*
Federal Constitutional Law	*Bundesverfassungsgesetz*, BGBl. I Nr. 194/1999
Federal Constitutional Law on the Accommodation and Allocation of Aliens in Need of Assistance and Protection	*Bundesverfassungsgesetz über die Unterbringung und Aufteilung von hilfs- und schutzbedürftigen Fremden*, BGBl. I Nr. 120/2015
Federal Equal Treatment Act	*Bundes-Gleichbehandlungsgesetz*, BGBl. Nr. 100/1993
Federal Health Agency	*Bundesgesundheitsagentur*
Federal Office for Immigration and Asylum	*Bundesamt für Fremdenwesen und Asyl*
Freedom Party of Austria	*Freiheitliche Partei Österreichs*
General Law on Social Security	*Allgemeines Sozialversicherungsgesetz*, BGBl. Nr. 189/1955
Health route	*Gesundheitsstraße*
Integration Act	*Integrationsgesetz*, BGBl I 2017/68
Initial interview	*Erstbefragung*

Intercultural Cooperation and Integration Unit at the Viennese Medical Chamber	*Referat Interkulturelle Zusammenarbeit und Integration*
Islam Act	*Islamgesetz*, BGBl. I Nr. 39/2015
Main Association of Austrian Social Security Institutions	*Hauptverband der österreichischen Sozialversicherungsträger*
Minimum social benefits	*Mindestsicherung*
Coordination platform for the psychosocial support of refugees and helpers	*Koordinationsplattform zur psychosozialen Unterstützung für Geflüchtete und Helfende*
Performance-based hospital funding	*Leistungsorientierte Krankenanstaltenfinanzierung*
Primary Care Act	*Primärversorgungsgesetz*, BGBl. I Nr. 131/2017
Public employment service	*Arbeitsmarktservice*
Reception centre	*Erstaufnahmestelle*
Recognised refugees	*Asylberechtigte*
Regional social health insurance fund in Vienna	*Wiener Gebietskrankenkasse* (WGKK; merged into the nationwide fund ÖGK in 2020)
Serial examination	*Reihenuntersuchung*
Social health insurance-accredited physician	*Kassenärzt:in*
Social Democratic Party of Austria	*Sozialdemokratische Partei Österreichs*
Social Insurance Transition Act	*Sozialversicherungs-Überleitungsgesetz*, BGBl. Nr. 97/1954
Subsidiary protection	*Subsidiäre Schutzberechtigung*
Residence permit for humanitarian reasons	*Aufenthaltstitel aus humanitären Gründen*
The New Austria and Liberal Forum	*Das Neue Österreich und Liberales Forum*
Tolerated stay	*Duldung*
Vienna Child and Youth Welfare Service	*Stadt Wien – Kinder- und Jugendhilfe (MA11)*
Vienna General Hospital	*Wiener Allgemeines Krankenhaus*
Vienna Social Fund	*Fond Soziales Wien*
Viennese Patient Ombudspersons' Office	*Wiener Pflege-, Patientinnen- und Patientenanwaltschaft*
Vienna Refugee Aid	*Wiener Flüchtlingshilfe* (department of the Vienna Social Fund that coordinates basic care for refugees)
Vienna Social Services	*Wiener Sozialdienste*
Vienna Umbrella Association of Social Institutions	*Dachverband Wiener Sozialeinrichtungen*
Welcome culture	*Willkommenskultur*

Preliminary Notes

In this thesis, the term refugee refers to persons who fled violence or persecution in their home countries. If a particular legal status is relevant, it is explicitly indicated, such as asylum seekers or recognised refugees. I conducted the majority of my empirical research in German, with a few exceptions. Three refugees had interpreters during interviews, and one refugee and I talked directly in French (see Chapter 3). The translations provided in this thesis are my own, and although I tried to stay close to the original formulations, I made adjustments to terms and phrases so that they would make sense in English. During the transformation of direct quotes to ensure grammatical correctness, I was always careful to not change their meaning. When I found it appropriate and significant, I included the original wording in parentheses and italics, particularly for nuanced or challenging-to-translate German terms. When introducing proper names, laws, or less familiar Austrian institutions for the first time, I provided their names in German in parentheses and italics. A list of these translated terms can be found above.

In presenting direct quotes. I use square brackets when I add words, while parentheses signify that I provide additional information or clarifications on what is said. To denote an ellipsis, I use three dots with no additional punctuation to signify a continuing sentence and four dots to indicate that a new sentence begins. This applies to quotes from my empirical work and from the literature. Italics within a quote from the literature indicate words emphasised by the author. I format direct quotes with an indent, as I do for descriptions from my observations. Whether the indented text is direct speech from interviewees or my descriptions of situations I observed is clear from the context and from source’s name, which distinguishes between “interview” and “observation”.

Parts of my empirical findings and arguments were published in articles in *Bioethics* (Spahl, 2023) and *EASST Review* (Spahl & Prainsack, 2021), a book chapter (Spahl & Prainsack, 2022) in *Solidarität im Gesundheitswesen: Strukturprinzip, Handlungsmaxime, Motor für Zusammenhalt* (Hofmann & Spieker, 2022; my own translation from German: “Solidarity in the healthcare system: Structural principle, maxim for action, motor for cohesion”) and a blog entry for Eurac Research (Spahl, 2022). Footnotes mark the presence of pre-published parts within chapters or sections.

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Chapter 1: Introduction

1.1 Introduction

I wrote this thesis based on the premise that the fulfilment of health needs is part of a dignified life and that high-income countries should have policies that guarantee that these needs are met for all people living in their territories, including refugees.[2] The subsequent chapters discuss the complex interplay between the imperative to provide people seeking protection with the best possible healthcare in a safe medical and general environment, rooted in the principle of human dignity, and the increasingly stringent and often severe asylum policies that prevail in Europe and globally. By addressing the implications of these conflicting logics for the lived experiences of refugees, I provide a multifaceted account of refugee health in a European high-income host country.

This thesis addresses the following questions: How do the health needs of refugees emerge as they navigate the health system and the asylum system? How are these met (or not met)? To answer these questions, I combined ethnographic methods, qualitative interviews, and document analysis on refugee health in Vienna, Austria. At the heart of the project was in-depth ethnographic fieldwork with seven asylum seekers (*Asylwerber:innen*) and recognised refugees (*Asylberechtigte*) between 2018 and 2020. I interviewed these persons at several points in time and conducted observations when accompanying them to medical appointments. I also gained insights during other interactions between them and myself. Moreover, I conducted qualitative interviews with care providers, including doctors and social workers, as well as representatives of political parties and other professionals, as well as a literature- and document-based analysis of relevant legal frameworks.

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[2] Unless I indicate otherwise, the term "refugee" in this thesis refers to people who fled violence or persecution in their home countries. The focus of my doctoral work was on asylum seekers and recognised refugees. However, my understanding of the term "refugee" also encompasses a wider range of legal statuses, such as undocumented persons and persons facing deportation. Due to the distinct and more exclusionary legal frameworks that place these persons in a particularly precarious situation (Ataç et al., 2020; Rosenberger et al., 2018; Stiller & Humer, 2020), I chose not to include an analysis of their situation in the scope of this thesis.

In the Austrian public healthcare system, refugees are granted access to the same facilities and services as other beneficiaries from the moment they file an asylum claim (Bachner et al., 2018; Knapp, 2019). Extending beyond the medical aspects of these entitlements, this thesis maps personal, social, and political dimensions of healthcare, specifically focusing on how medical care plays a role in creating, enacting, and contesting the inclusion or exclusion of refugees. As the title of this thesis – *From medical care to citizenship: Mapping the healthcare systems' function of inclusion for refugees in Vienna, Austria* – suggests, I explored how medical care is related to citizenship. In this thesis, citizenship is not defined by possessing a country's passport; instead, it is conceptualised as a social right that is established through the entitlement to welfare state benefits (Baldi & Goodman, 2015; Joppke, 2007) and as a relational and lived practice (Pols, 2016). The analysis of the (non-)fulfilment of refugees' health needs thereby serves as the lens for observing how boundaries around national communities are drawn (Anderson, 2006 [1983]).

In the following sections, I first detail how I came to spend six years studying refugee health in Austria for this thesis. Second, I introduce my epistemological assumptions as rooted in interpretive and critical policy studies, in addition to my understanding of studying the "political" in refugee health. Third, I present this thesis' research questions, before describing my doctoral work's underlying understanding of health as a dynamic practice encompassing bodily, psychological, and social aspects, extending beyond narrow biomedical approaches to health. Fifth, I give an overview of the Austrian context, delineating the asylum system and the healthcare system, and elucidating how both systems adhere to distinct logics of exclusion and inclusion within the broader scope of refugee experiences. Sixth, I discuss the absence of refugees in health policymaking. Finally, an overview of the subsequent chapters is provided.

1.2 Why Conduct Research on Refugee Health? A Personal Answer

In 2015, hundreds of thousands of refugees from Syria, Afghanistan, Iraq, and other countries were passing through Austria on their way to seek a better future in Germany and other Western European countries. As a resident of Vienna, where many arrived, this had a profound impact on me. During that year, Austria was one of the European countries with the highest per capita asylum applications, with 88,340 persons applying for asylum in a country with a population of 8.5 million. At the time, I felt that a monumental historical event was unfolding and held an optimistic belief that humanity and a genuine commitment to immigration would prevail, welcoming these people in need with open arms. During that period, in Austria – as in other

European countries – the so-called "welcome culture" (*Willkommenskultur*)[3] was practised. Austrians provided food for those passing through, donated clothing to those staying in the country, and actively assisted in accommodating the newcomers. However, this atmosphere began to change as the attitudes of many, as well as the public and political discourse, shifted towards a more exclusionary stance against refugees. Upon later reflection, my optimism proved to be unfounded, given the adoption of progressively cynical and inhumane measures aimed at preventing people from entering Europe.

In addition to my personal involvement in refugee support, I wanted to gain a deeper understanding of the experiences of refugees and how Austria and other destination countries governed these people seeking protection. In 2015, I was pursuing a Master's degree in socio-ecological economics and policy at the Vienna University of Economics and Business. During this time, along with my fellow students Yannick Brandt, Cornelia Hörtner, and Nora Laufer, I carried out a group project focusing on refugees living in Austrian rural areas. Moreover, I was actively involved in gathering data for a survey study, which involved interviewing asylum seekers residing in accommodations in Vienna in 2015 (for the study results, see, for example, Buber-Ennser et al., 2016; Kohlenberger et al., 2019). I decided on the topic for my master's thesis with the aim of further exploring how refugees are cared for. At that time, Turkey was hosting approximately three million refugees, making it the country with the largest refugee population globally. Legal provisions in Turkey entitled refugees to comprehensive medical care within the public healthcare system. To understand how this healthcare was delivered in terms of practice, I conducted fieldwork on this topic in Ankara during the first half of 2016 (see Spahl, 2018; Spahl & Österle, 2019).

After six months in Ankara, during which I had gained a comprehensive understanding of the situation, built valuable connections, and had improved my proficiency in the Turkish language, I hoped to continue working in Turkey. However, a shift in the political climate occurred in the aftermath of the military coup in the summer of 2016. Fieldwork in Turkey became subject to stringent state regulations, making it nearly impossible to conduct empirical research on refugees without violating legal constraints. Nevertheless, I could not let go of the topic of refugee health. I applied for a pre-doctoral position advertised by Barbara Prainsack at the Centre for the Study

[3] In 2015, Germany and Austria embodied the welcome culture phenomenon: in response to the rise in asylum applications, civil society initiatives formed to show support for those arriving (Trauner & Turton, 2017).

of Contemporary Solidarity, Department of Political Science, University of Vienna, with a research proposal focused on studying the topic in Austria. In March 2018, with this position acquired, I commenced my doctoral research.

Throughout my scientific work on refugee health, spanning from 2015 to the present, my personal motivation for studying this topic has evolved and deepened. Initially, I felt compelled to engage with the urgent humanitarian situation simply due to the presence of people who needed help. My deeper involvement in the realm of health for my Master's thesis led me to develop an academic enthusiasm for this area of study. I began to view health as a valuable lens for critically examining how people are governed, supported, and excluded in various ways. Upon further exploring these aspects during my early years of doctoral research, I felt a particular affinity for biopolitical perspectives (Fassin, 2018; Foucault, 1994 [1963], 2003, 2009; Lupton, 1995; Mbembe, 2019; Rose, 2001; see Chapter 2).

In parallel with this evolving theoretical interest, my perspective on and concern for the research topic became more personal. Allow me to share an experience from my fieldwork in Vienna that helps illustrate this:

> On a spring day in May 2020, Sabah invited me to dinner in her new apartment. As I rang the doorbell of the newly constructed apartment in Vienna, two of her newly adult sons greeted me. They were busy with the final preparations for that day's *iftar*[4] and were setting the table with Syrian dishes. Shortly thereafter, Sabah, her husband Osman, and their younger daughter arrived, all in high spirits, warmly welcoming me for the evening. After the meal, we settled into comfortable chairs and a sofa in the living room, and Osman began to recount their life in Syria. With excitement and enthusiasm in his eyes, he shared stories of grand celebrations, dances, and the abundance of friends who used to visit each other. At one point, his expression darkened, and he remarked on how drastically their new life in Vienna differed from that. It was not that they did not find moments of joy or form new connections and friends. However, there was an underlying tone of bitterness in his voice as he expressed that crucial elements of their previous life were missing. He longed for his close family, his old friends, and his work, and he carried a profound sense of sorrow for the loss of their family home in Syria. (visit at Sabah's home)

As Osman spoke, his emotional transition from euphoria about the past to bitterness about the present, as well as the change in his facial expressions that revealed loss and pain, strongly reminded me of my own grandfather. Along with his wife and children, my grandfather had fled

[4] *Iftar* is the evening meal during the holy month of Ramadan that Muslims eat to break their fast.

from Poland to Germany in the early 1980s.[5] When he talked about his life in Poland, his mouth and eyes would hold the same radiant joy Osman showed. Similarly, his expression would shift to emptiness or bitter anger over the loss of those previous connections and his new situation in Germany, where he was no longer a school principal but a courier and always struggled to find the right words when he wanted to express something in German.

My realisation of the striking similarity between Osman's and my grandfather's changing emotions and expressions made my research more personal to me. Even though the historical context was entirely different, I began to comprehend my research within a broader framework of recurring lives marked by uprooting and challenging arrivals. I felt a shared, universal experience – that of violently losing your home forever. This realisation shaped my own understanding of care and solidarity in this research project. These encompass adequate medical treatment but also broader forms of care that enable refugees to arrive at a destination country and start anew.

> Arrival here is not a question of patronisingly welcoming helpless victims, but a question of enabling a good act, and that means solidaristic as well as caring coexistence in the postcolonial present. (Kubaczek & Mokre, 2021, p. 13; my own translation from German)

In my personal politics I oppose advocating for the "integration" of incoming refugees because in political discourse this term often implies the superiority of the host country's people and culture while unfairly placing the entire responsibility for building a new life on migrants (Münch, 2018). Furthermore, I want to stress the importance of being sensitive about recreating differences when researching refugees while acknowledging the need to name injustices. Despite the term "refugee" being a constructed category that overlooks essential personal characteristics, it has significant implications for people's lives (Anthias, 2013). In my research, this means avoiding reducing participants solely to their refugee status while recognising the effects it has on their lives. To achieve justice, it is crucial to acknowledge differences and, in doing so, risk recreating them (Dhawan & Varela, 2018), a paradox that also gained attention in social studies of health (DelVecchio Good & Hannah, 2015; Epstein, 2007). Naming and addressing these differences are essential for promoting equal opportunities for a healthy life for all. The interpretive and critical

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[5] In *Wir Strebermigranten* (my own translation: *We Overachiever Migrants*), a novel by Emilia Smechowski (2017), the author provides a thoughtful and informative account of the arrival and experiences of Polish migrants in Germany. Drawing from her personal migration history and incorporating historical and political insights, she offers a sensitive and comprehensive portrayal of this community's life in Germany.

practice-based approach to studying policies, which I adopted for my doctoral work, aligns well with these personal politics, as elaborated in the subsequent sections.

1.3 Epistemological Background and Methodology

This thesis follows an interpretive and critical approach to studying policies. Using ethnographic methods, it places a specific focus on practices. After describing this approach in depth, this section addresses the distinction between "politics" and "the political", positioning this thesis as a study of the political of refugee health.

1.3.1 An Interpretive and Critical Practice-Based Approach to Studying Policies

Epistemologically, this thesis aligns with interpretive approaches. Since the middle of the 20th century, the "interpretive turn" has reshaped the epistemological foundation of research in cultural studies and the social sciences. In contrast to the previously dominant positivist inquiry, interpretive research is "not an experimental science in search of law but an interpretive one in search of meaning" (Geertz, 1973, p. 5). This approach embodies a double hermeneutic, in which social scientists interpret the interpretations made by research participants (Della Porta & Keating, 2008). Furthermore, building on feminist theory, it acknowledges that scientific knowledge is situated within the personal, political, historical, cultural, and value context of the researcher (Haraway, 1988).

In the realm of political science, the interpretive turn gained momentum in the 1990s, often labelled as "interpretive policy analysis" (Münch, 2016; Yanow, 1996). Its proponents distinguished themselves from instrumental policy research, which seeks "objective" and "effective" solutions to "solve" policy problems. In a

> In a conventional understanding of public policy, governments are seen to be *reacting* to fixed and identifiable "problems" that are exogenous (outside) the policy process. Hence, the focus of analysis is limited to competing ways of "solving" policy problems. The terms in which specific policy problems are understood are left unexamined. (Bacchi, 2009, p. 1)

Interpretive policy analysis emphasises that the framing of policy problems and the policies formulated in response to them are value-laden practices that are far from neutral, similar to the scientific knowledge production about them. Instead of focusing on policymaking utility,

interpretive policy analysis addresses the meaning of policies. Analyses in this vein are "situation-specific, rather than entailing general laws or universal principles" (Yanow, 2007, p. 110).

Methodologically, adopting an interpretive approach entails broadening the research scope beyond conventional policy analysis methods, such as thematic document analysis of laws, party manifestos, and other legal texts. It involves analysing "the totality of what policy entails in the real world" (Wagenaar et al., 2017, p. 4), encompassing both intended and unintended consequences, the associated moral claims, the effect on people, and the institutions and organisations engaged in drafting and implementing these policies. The analytical focus is on "meanings in action" (Bevir & Waring, 2018; Wagenaar, 2011). In the study of health policies, an interpretive approach "focuses on the social construction of health policies through the ability of individuals for meaningful action, and highlights the meanings that inform the actions of the individuals involved in all kind of healthcare practices" (Bevir & Waring, 2018, p. 6).

Furthermore, some interpretive approaches to policy analysis explicitly aim at performing critical analyses; They foreground how policies articulate interests, values, and norms and how scientific knowledge can selectively highlight certain aspects while silencing others (Wagenaar, 2011). An emphasis on power structures has been advanced under the banner "critical interpretive policy analysis", which "indicates an emancipatory interest in its critique of contemporary techno-empirical policy analysis" (Fischer et al., 2015, p. 9). It aims to leverage the insights of the interpretive paradigm about situated scientific knowledge to imagine and enact alternative power structures that combat inequities and domination. In this vein, I understand my doctoral work as productive for facilitating a more equal world, as is also underscored by the interpretive and critical method I employed for analysis, situational analysis (SitA) (see Chapter 4):

> The interpretive turn … often assumes researchers have the responsibility to produce knowledge that can make better worlds, specifically antiracist, antisexist, and anticolonial worlds. If knowledge is to be productive instead of merely representative, we must be responsible to the kinds of worlds our knowledge practices enable and facilitate. (Clarke et al., 2018, p. 11)

The ethnographic fieldwork that this thesis is based on is particularly suitable for facilitating an interpretive and critical analysis of health policies. Ethnography is especially valuable for comprehending the interrelationships between personal experiences of illness and health-related practices at the micro level and the social, political, economic, and cultural conditions that influence these experiences and practices at the macro level. For instance, ethnographic research is a powerful tool for researching the unintended consequences of health policies, as even well-

intentioned efforts can inadvertently contribute to marginalisation and worsen inequalities (Holmes & Castañeda, 2014).

Despite ethnography's capacity to contextualise "individual experiences and micro-observations in the broader perspective of power and inequality structures" (Dubois, 2015, p. 478), it remains relatively niche in the realm of interpretive policy analysis and political science (Dubois, 2009, 2015; Schatz, 2009). There are limited examples of ethnographic studies within IPA, and the existing ones focus on traditional political arenas such as international summits and parliaments (Münch, 2016) and public management (Cappellaro, 2017). In contrast, anthropology has a more established tradition of studying policies using ethnographic methods:

> From our perspective, policies are not simply external, generalised or constraining forces, nor are they confined to texts. Rather, they are productive, performative and continually contested. A policy finds expression through sequences of events; it creates new social and semantic spaces, new sets of relations, new political subjects and new webs of meaning. … we see policies as windows onto political processes in which actors, agents, concepts and technologies interact in different sites, creating or consolidating new rationalities of governance and regimes of knowledge and power. (Shore & Wright, 2011, pp. 1–2)

In the anthropology of policies, emphasis is put on how lived experiences, practices, and discourses shape and continually redefine the meanings of policies. This focus on the contested and unforeseen meanings of policies was a significant source of inspiration for this study.[6]

1.3.2 Studying "The Political" of Refugee Health

This thesis does not address health policymaking in the traditional sense. Its focus is neither on legal texts and guidelines related to refugee health nor how health policymakers *do* refugee health in their concrete practices (Freeman et al., 2011). Instead, this thesis diverges from political science understandings.

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[6] In traditional anthropological ethnographic studies, researchers typically completely immerse themselves in the field and live alongside the research participants. In contrast, political science ethnographic studies are better characterised by "ethnographic sensibility", "an approach that is different from a full-fledged ethnography but which is underpinned by a commitment to taking seriously the meaning of practices and forms beyond the immediate domain of policy making" (Prainsack & Wahlberg, 2013). In this approach, researchers complement standard policy study tools, such as document analysis and expert interviews, with time-limited, often informal participatory observation.

> Health to a political scientist, in common with more widely held views, most often means only one thing: health care; and usually, only one minor aspect of health care: the health care system. .... Health, in its broader sense, is therefore apolitical and should only be the concern of disciplines such as sociology, public health or medicine. In this way specified aspects of health, namely health care issues, are politically defined as political while all other aspects are not. (Bambra et al., 2005, p. 191)

This quotation highlights political science's neglect of several aspects of health. The fallacy that the aspects of health other than healthcare are outside the research purview of political scientists reflects the more general distinction between "politics" and "the political". The prevailing political discourse and political scientists typically define politics as a state's political system. This comprises a country's constitutional institutions, including the parliament, the government, and the administration. More recently, these traditional perspectives have also encompassed collective actors, such as parties, trade unions, and social movements (Sauer, 2006).

When I refer to the political, I diverge from this relatively limited interpretation of politics. Drawing from the differentiation between politics and the political in political theory (Arendt, 1998 [1958]; Mouffe, 2000; Rancière, 2004), Foucault's (2003 [1975–1976], 2009 [1977–1978]; see Chapter 2) work on power dynamics, and feminist perspectives, this thesis defines the political as power relations manifesting and evolving in everyday life. This encompasses mundane aspects, such as the living situation in asylum accommodations, medical encounters, and the use of public transportation to reach a hospital appointment.

> Political inquiry, within such an alternative framework, is concerned with process; more specifically, with the (uneven) distribution of power, wealth and resources. As such it may occur in any institutional and social environment, however mundane, however parochial. (Hay, 2002, p. 73)

Political theory makes a distinction between politics and the political. In his influential differentiation of these terms, Rancière (2004) used politics to refer to the practices, strategies, and institutions that shape the exercise of power within a society, often serving to maintain existing hierarchies and perpetuate inequalities. In contrast, the political pertains to the potential for people in a society to engage and participate in the public sphere. It opens up opportunities to challenge and contest the prevailing distribution of power and reshape social dynamics. Similarly, Arendt (1998 [1958]) conceptualised the political as essential for nurturing shared responsibility and active participation in society. Mouffe (2000), through her concept of agonistic pluralism, emphasised the productive role of conflict inherent in a vibrant democracy (the political), in contrast to the structures that accommodate these conflicts (politics) (Mouffe, 2000).

While Foucault did not explicitly discuss the concepts of the political and politics, his work provides valuable insights into how power dynamics shape the terrain of political and social engagement. Foucault's notion of biopolitics extends beyond political rule in the classical sense of a sovereign and the conventional sense of politics. It draws attention to modes of governance that operate through subjectification and shape aspects of lives that are typically seen as personal and external to traditional politics (Foucault, 2003 [1975–1976], 2009 [1977–1978]; see Chapter 2). From another perspective, the intertwining of personal and political matters has been advanced to fight against oppression and to empower marginalised groups. Feminist scholars and activists famously claimed that "the personal is political", emphasising the need to recognise the everyday practices of women and minorities as inherently political.[7] Methodologically,

> ethnographic studies open to inquiry areas of political activity that are not necessarily recognized as political, because they occur outside of "normal" political channels and on terms that are not explicitly or even intentionally political. (Brodkin, 2017, p. 131)

Ethnography is particularly well suited for understanding the political dimensions of everyday life within mundane settings, such as asylum accommodations and healthcare facilities (Katz, 2004). Using ethnography, this thesis studies the political at unexpected places, such as public transportation used for accessing a hospital, and in everyday practices, such as taking a walk.

1.4 Research Questions

Owing to my interest in a European welfare state's healthcare system's capability to ensure that everyone living there receives the care they need, the primary aim of my doctoral work was to map the health needs of refugees in Vienna, Austria, and to examine how these health needs are addressed within the existing legal frameworks and in practice. Beyond legal entitlements, I was interested in practical barriers to receiving medical services, such as language and cultural barriers, unacknowledged trauma, and the challenges associated with resettling in a new country. My research was guided by the following research questions:

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[7] Note that my remarks on how I understand the political only provide a very brief overview of the underlying theoretical debates. For example, feminist theory engaged in a discourse regarding Arendt's understanding of "the political", with criticisms that she undervalued the personal realm at the expense of women (Benhabib, 1993). I evoke the distinction between politics and the political to differentiate my understanding of "the political" from a conventional understanding of politics, which continues to be the prevailing perspective in the field of political science.

- *Main research question:* What are the health needs of refugees in Vienna, Austria, as experienced by them? How are these health needs addressed (or not) within the delivery practices of medical providers, as well as the legal frameworks?
- *Sub-question 1:* What health entitlements do refugees in Vienna have according to legal frameworks?
- *Sub-question 2:* What are the health needs of refugees in Vienna, and how are these addressed?
- *Sub-question 3:* How do actual public healthcare services differ from formal provisions as mandated by law?
- *Sub-question 4:* What are the factors that support and impede the fulfilment of refugees' health needs?

I chose the term "health needs" to emphasise the experience of health problems as opposed to existing legal entitlements. When designing my doctoral project, I also had the following aims:

- Make a theoretical contribution to scholarship on the social rights of refugees in citizenship studies
- Make a theoretical contribution to scholarship on solidarity in healthcare, especially in the context of migration
- Develop policy recommendations on how policies pertaining to refugees' healthcare access can be improved and how refugees' healthcare needs can be met more effectively

Based on my expectations about making a theoretical contribution to citizenship studies (Ataç & Rosenberger, 2013; Baldi & Goodman, 2015; Joppke, 2007; Morris, 2002) and the literature on solidarity and health (Gould, 2018; Prainsack & Buyx, 2017; West-Oram, 2018a; West-Oram & Buyx, 2017), I formulated an additional research question:

- *Additional research question:* How are persons who are not part of the "we" in terms of a narrow understanding of citizenship being thought and acted into being?

Citizenship and solidarity were the sensitising concepts for my research. In grounded theory approaches to data analysis (Charmaz, 2006; Clarke et al., 2018; see Chapter 4), sensitising concepts serve as guiding frameworks through which researchers explore a particular phenomenon. They are not rigid structures for analysis but provide flexible frameworks for analysing and interpreting empirical data. As I embarked on fieldwork and data analysis, I began to expand these frameworks based on inductive insights from the data and by incorporating other relevant concepts.

Early in my fieldwork, particularly after conducting first interviews with refugees, I realised the profound impact of their broader life situations on their health. Accordingly, I adjusted the focus of my research, reformulating my main research question as follows:

- *New main research question:* How do the health needs of refugees emerge as they navigate the health system and the asylum system? Moreover, how are these met (or not met)?

The tension between an inclusive healthcare system and an exclusionary asylum system discussed in earlier sections in this chapter began to shape how I thought about my research. This led me to incorporate the terms "the health system" and "the asylum system" into my research question.

In my new main research question, I adopted the term "health system" to go beyond the analysis of medical services provided within the healthcare system. When I refer to "the healthcare system", I am addressing institutionalised medical care in healthcare facilities such as hospitals, doctor's practices, and pharmacies. Throughout this thesis, I focus on healthcare services that are provided to persons in Austria through their SHI coverage, essentially focusing on the Austrian public healthcare system. In contrast, the health system presents a more comprehensive perspective. It not only encompasses institutionalised medical care but also considers broader factors affecting health and well-being, such as social, economic, environmental, and cultural determinants. The term "health system" emphasises the treatment of disease as well as preventive measures and the promotion of overall health. Within this broad health system perspective, healthcare practices comprise more than just the medical services currently offered within the healthcare system. Consequently, I revised the second part of my main research question – leaving away the words "within the delivery practices of medical providers, as well as the legal frameworks" – to broaden the scope of understanding who addresses health needs, recognising that these needs can be met outside traditional medical care settings. I define healthcare practices as actions that address health needs. This definition encompasses medical services as well as a range of practices that contribute to health and well-being, including caring and empathetic gestures from family and friends who are not healthcare providers.

Furthermore, with the term "asylum system", I refer to both the legal frameworks pertaining to asylum in Austria and the living conditions connected to it. This term encompasses a wide range of elements, including asylum procedures, accommodations for asylum seekers, regulations regarding employment for asylum seekers, and civil society initiatives aimed at assisting refugees.

This broad understanding of the asylum system also pertains to recognised refugees, whose lives often continue to be shaped by their experiences as refugees.

The revised research question redirected the focus towards the processes involved in shaping health needs. Moving away from an essentialised notion of health needs as an inherent feature that refugees bring to Austria, I consider health needs as being co-produced by refugees, their experiences before coming to Austria, and their medical and other experiences within the country.

1.5 Understanding Health as a Personal, Dynamic, and Relational Practice

In this thesis, I adopt a holistic perspective towards health, viewing it as personal, dynamic, and relational. This perspective stands in contrast to biomedical perspectives towards health, where medical practitioners wield authority over health and disease, largely disregarding the patient's biography and social context (Jewson, 2009). One of the most notable critiques of this biomedical approach came from Michel Foucault's (1994 [1963]) book *The birth of the clinic*, in which he examined the transformation of medical discourses and practices in the late 18th century. In the era of Enlightenment, scientific interpretations replaced religious and mystical understandings of health and disease. Foucault introduced the notion of the "medical gaze" to denote how medical professionals focused solely on the patient's body, disregarding their personal history, identity, and social position. He interpreted this shift was an epistemological rupture, altering the perception of disease and knowledge from speculation to "truth".

Foucault's work rejected the notion of objective truth in medicine, showing that conceptions of health and disease are contingent on the prevailing system of knowledge influenced by political contexts. According to Foucault and succeeding scholars, medical institutions mirror and shape broader social norms. For example, clinical practices in the United States of America (US) during the 1950s contributed to the emergence of the sex/gender binary (Eder, 2022). Modern biomedicine continuously creates contingent truths, as seen in developments such as genome editing (Rabinow & Rose, 2006), genetic counselling (Svendsen, 2006), and personalised medicine (Prainsack, 2017), which promise objective knowledge but remain elusive.

To better understand the factors omitted in this narrow biomedical perspective, it is useful to distinguish between "disease", "illness", and "sickness" (Schramme, 2012). Disease reflects the characteristics of biological organisms, often measured through clinical tests. It is typically defined as a deviation from the norm within the broader population. Illness designates a mode

of being and experiencing; it represents the personal and subjective experience of being unwell. Illness also includes the co-construction by medical professionals and the patient, considering the influence of persons close to the patient and cultural aspects (Kalitzkus & Matthiessen, 2009). Sickness refers to the social role of the sick person within their community (Schramme, 2012). While disease refers to an objective perspective, illness and sickness facilitate the introduction of more personal and relational perspectives, respectively (Lenk, 2011). Health can be perceived differently from each perspective, illustrating that one may be considered healthy from one angle but not from another. For instance, a person may have a disease due to a genetic mutation but not feel ill because they lack symptoms.

Furthermore, when researching refugee health, it is essential to consider the native languages of refugees and the non-Western cultural context shaping their health knowledge. Schiocchet (2019) showed that Arabic-speaking refugees in Austria often described their health in culturally specific terms, emphasising well-being and social belonging:

> [I]n the context of the displacement of Arab-speaking refugees to Austria … social belonging tends to be greatly perceived and expressed as an issue of wellbeing, defining individual and social health and individual and collective capacity to engage productively with society. (p. 233)

Schiocchet (2019) also found that Arabic-speaking interlocutors often described a state of "fatigue" and feelings of disenfranchisement. He interpreted several expressions as framing states of depression that do not map onto depression in Western biomedical terms. In addition, he showed that refugees' narratives

> entail different overcoming strategies rather than identifying these as symptoms of illness and turn to medicalization. While a few of my interlocutors expressed having psychological distress or crisis (*azma nafsya*) or depression (*ka`aba*), many others expressed (*ghurba*), which in this context, among other things, means feeling disfranchised, having their selves tired (*nafsy ta'abana*) or being psychologically tired (*nafsya ta'abana*), and being without capacity/power (and in this case, motivation) (*qudra*; *qwa*) to act upon their lives and upon the world. (Schiocchet, 2019, p. 260)

This thesis adopts a broad definition of health, allowing refugee participants to define healthcare and their health needs. This aligns with Whitbeck's (1981) view of health as the psychosocial ability to (re)act appropriately with regard to one's own goals, considering bodily, psychological, and social aspects. My doctoral work understands health as a dynamic practice influenced by larger life circumstances and social determinants. Thus, it is in accordance with scholarship on how capabilities and factors based on the larger life situation shape health (Cheng et al., 2018;

Venkatapuram, 2013) and scholarship on how health is dependent on social determinants, such as income and the housing situation (Marmot, 2005).

1.6 The Austrian Context

This thesis unfolds in the context of policy responses to an increase in asylum applications around 2015 and the Austrian healthcare system; the following sections introduce these briefly (for a detailed description, see Chapter 3). Subsequently, I discuss how the logics of exclusionary asylum policies and inclusive health policies contradict each other.

1.6.1 Asylum Policies

Narrowly defined, asylum policies primarily focus on assessing the legitimacy of residency for persons who have applied for asylum, thereby mostly adopting a restrictive approach in Austria: The Asylum Act of 1991 marked the beginning of a trend in which policymakers across the political spectrum consistently tightened asylum laws (Gruber, 2017; Merhaut & Stern, 2018; Welz, 2022; see Chapter 3). In more broader terms, and in correspondence with the interpretive policy analysis (Bevir & Waring, 2018; Fischer et al., 2015; Münch, 2016; Yanow, 1996, 2007; see earlier section in this chapter) approach taken in my doctoral work, my definition of asylum policies also includes their wider meaning and context. To understand Austria's asylum context, acknowledging the pivotal impact of the "refugee policy crisis" (Rosenberger & Müller, 2020) is crucial. This crisis signifies the policy responses to the significant surge in asylum applications that occurred nearly a decade ago.[8] In 2015, Austria, with a population of 8.5 million, received 88,340 asylum applications, primarily from Syrians, Iraqis, and Afghans. At that time, Austria was one of the European countries with the highest number of asylum applications per capita. The refugee policy crisis encompassed a series of challenges faced by state institutions in terms of providing accommodation and social services, as well as disputes over responsibilities. These challenges developed in the context of a shift to the political right. This shift was characterised by the electoral successes of the right-wing populist Freedom Party of Austria (FPÖ), which won 18% of

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[8] Rosenberger and Müller (2020) proposed using the term "refugee policy crisis" when describing post-2015 developments in Austrian asylum and reception policies. This term was inspired by a newspaper article written by the human rights lawyer Manfred Nowak. It reconceptualises the issue by discouraging the perception of refugees as the cause of the crisis, a notion that had been implied by politicians, media, and academic publications that used the term "refugee crisis".

the votes for the National Council in 2008, 21% in 2013, and 26% in 2017. Public debates during this period often depicted refugees as potential threats to financial stability and social cohesion, relying on stereotypical portrayals of refugees as a "dehumanised mass" (Greussing & Boomgaarden, 2017).

Anti-asylum rhetoric was not confined to the FPÖ; it was also employed by politicians from the liberal-conservative and Christian-democratic Austrian People's Party (ÖVP) and the Social Democratic Party of Austria (SPÖ), engendering corresponding policy shifts (Merhaut & Stern, 2018; Rheindorf & Wodak, 2018; Scheibelhofer, 2017) and a growing normalisation of right-wing populist discourse in the latter half of the 2010s (Liebhart, 2020; Wodak, 2018). In 2017, the Austrian government changed from a coalition between the SPÖ and the ÖVP to a coalition between the ÖVP and the FPÖ, further solidifying the country's restrictive approach towards refugees.

Moreover, religion played a significant role in the refugee policy crisis. The majority of refugees who arrived in Austria in 2015 identified as Muslim, even though many of them did not consider themselves particularly religious (Buber-Ennser et al., 2018). Against the backdrop of right-wing political discourses that portrayed Muslims as a threat to Austrian culture and security (Sauer, 2022), religion became "a marker for self and otherness. A Christian 'self' … [was] distinguished from a Muslim 'other'" (Mattes, 2021, p. 225). This dynamic was part of a longer history in Austria, where restrictions on Muslims had been implemented for several decades, ultimately culminating in the introduction of the Islam Act (*Islamgesetz*) in 2015 (Dautović & Hafez, 2019; Liebhart, 2020; Mattes, 2021; Sezgin, 2019).

The stigmatisation of being Muslim, along with calls for a Christian identity, has occurred within the context of broader societal trends marked by secularisation and an increasing Muslim population. The religious composition in Austria has undergone significant changes over the last few decades. In 1961, 89% of the population identified as Roman Catholic; however, by 2021, this figure had dropped to 55%, with Christians in total constituting 68% of the population. In the same period, the percentage of Muslims exhibited substantial growth, particularly in recent decades. It increased from 0.3% in 1971 to 1.0% in 1981, 2.0% in 1991, and 4.2% in 2001, reaching 8.4% in 2021. This trend is even more pronounced in Vienna. In 2021, every third person in the capital reported having no religious affiliation (34%), followed by Catholics (32%) and Muslims (15%) (Statistik Austria, 2022).

1.6.2 Health Policies

In contrast to legal, practical, and discursive exclusions for refugees, the Austrian public healthcare system is generally characterised by an inclusive approach that also extends to documented migrants. It stands out for delivering high-quality care within a generally equitable system that provides good access to healthcare for 99.9% of the population (Bachner et al., 2018).[9] The healthcare system's financing exhibits a fragmented funding structure, relying on a combination of general tax revenues and mandatory social health insurance (SHI) contributions (Bachner et al., 2018; LSE Consulting, 2017). This system operates on the premise of redistributing financial burdens, with higher contributions from high-income groups compensating for lower contributions from other groups. Guided by the principle of solidarity, this approach ensures that all beneficiaries, regardless of their prior contributions, have equal access to the same range of services (Habimana et al., 2019; Leichsenring et al., 2011). However, the Austrian healthcare system faces significant challenges due to fragmented responsibilities among the federal government, the *Länder*[10], and the SHI funds, as well as privatisation trends and demographic shifts. These challenges have prompted health policy reforms (Bachner et al., 2018; Hable & Wesenauer, 2019; Österle & Heitzmann, 2016).

Austria performs relatively well in addressing the health needs of non-citizens. According to the Migrant Integration Policy Index (Solano & Huddleston, 2020), Austria ranks sixth among 56 countries in terms of healthcare provisions for immigrants. Refugees have access to the same facilities and services as all other beneficiaries of the public healthcare system; these facilities and services include public hospitals, general practitioners, and specialist practices under SHI contracts as well as psychological care. Since the introduction of the Basic Care Act (*Grundversorgungsgesetz*) in 2005, asylum seekers have been entitled to services offered within the healthcare system, with only a few exceptions (such as co-payments for specific dental procedures). The federal government covers their SHI contributions, and they are exempted from deductibles associated with medications and other co-payments "from day one", as the Ministry of Interior confirmed to me in a written statement:

> Regarding the medical care of aliens in need of assistance and protection in basic care, it can be generally stated that they are covered by health insurance from day one, which means that for

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[9] Alternative calculations suggest slightly lower coverage rates (Czypionka et al., 2018; Fuchs, 2019; see Chapter 3).

[10] Austria has a federal system consisting of nine provinces known as *Länder*.

> the time they are in federal as well as provincial basic care, they are entitled to medical services to the same extent as Austrian citizens, according to Art. 6 para. 1 no. 5 of the agreement on basic care (*Grundversorgungsvereinbarung* [GVV]) pursuant to Art. 15a B-VG (GVV). In addition, the said target group is exempt from prescription charges, and the costs of any additional medical services are covered, provided they are medically indicated or after a case-by-case assessment (Art. 6 para. 1 no. 6 GVV). (written statement by the Ministry of Interior from August 2020; my own translation from German)

Once a person is recognised as a refugee, they are granted the same rights and treatment as Austrian citizens under social and healthcare laws. Recognised refugees who are employed contribute to SHI funds through their employers. For those who are unemployed, healthcare insurance contributions are jointly covered by the federal government and the *Länder* within the general needs-based minimum benefit system (Bachner et al., 2018; Knapp, 2019; see Chapter 3). However, empirical research showed that barriers to accessing healthcare services, such as a lack of adequate information and interpreter services (Kohlenberger et al., 2019; see Chapter 2), persisted for refugees who had come to Austria around 2015.

1.6.3 Exclusionary Asylum Policies and Inclusive Health Policies

Soon after embarking on this research project, I began to consider asylum and health policies in Austria in terms of conflicting exclusionary and inclusive logics. In an earlier section in this chapter, I discussed how Austria has already since the beginning of the 1990ies implemented restrictive asylum laws. Following the shift to the right in Austrian discourse and politics after 2015 (for details, see earlier sections in this chapter and Chapter 3), this restrictive approach became even more pronounced. Moreover, in Austria, asylum seekers are subject to intense scrutiny in the process of establishing the validity of their claims regarding the need for protection. This scrutiny extends to physical examinations, such as X-ray procedures for age determination (Dursun & Sauer, 2021) and evaluations by medical specialists who confirm cases of torture and conduct psychological assessments (Ammer et al., 2013; Knapp, 2019; Uranüs, 2018). In conjunction with “softer factors” such as increasing anti-Muslim racism and a xenophobic discourse that portrayed refugees who had arrived around 2015 as threats to Austrian society (for example, Greussing & Boomgaarden, 2017; Scheibelhofer, 2017; for details see earlier sections in this chapter and Chapter 3), I consider Austrian asylum policies as exclusionary.

In contrast, the fundamental logic of the Austrian healthcare system is inclusive. It follows the tradition of the welfare state and is firmly rooted in the principle of solidarity. In essence, healthcare policies aim to promote the overall well-being of everyone living in Austria. This inclusivity extends to all insured persons, including asylum seekers and recognised refugees. They have the right to access comprehensive healthcare services within the country, with these entitlements applying to asylum seekers "to the same extent as Austrian citizens", as articulated by the Ministry of Interior in the written statement quoted earlier in this chapter. The notion of refugees being regarded as equal to Austrian citizens in terms of healthcare "from day one" significantly influenced my thinking on refugee health. Based on my empirical findings, this thesis argues that this equality in healthcare access, along with the practices resulting from it, ultimately contributes to the inclusion of refugees in Austrian society.

The stark contrast between inclusive health policies and exclusionary asylum policies raises the question of what the right to healthcare, enshrined in legal regulations and upheld across a broad political spectrum, means for refugees in practice. This question lies at the core of my research. My doctoral work can be situated in a broader body of research that has linked social policies with migration governance. Studies discussed how welfare services can function as disciplinary mechanisms of control for migrants (Geiger & Pécoud, 2013; Karlsen, 2021) and other marginalised groups, such as the unemployed (Dubois, 2009). This "migration control-social policy nexus" (Ataç & Rosenberger, 2018) shows how social policy is inextricably linked to the goal of migration control. For example, a comparison of policy rationales underlying welfare restrictions for migrants in Germany, France, and the UK found that these restrictions were significantly shaped by immigration considerations. Across the different countries, linkages between welfare and immigration policies "were largely interior-ministry driven efforts to control 'unwanted,' spontaneous forms of immigration, or to communicate symbolically about immigration with a domestic political audience." (Slaven et al., 2020, p. 3)

This thesis' focus on healthcare for documented refugees in Austria follows a different logic. In contrast to a logic that is primarily driven by immigration concerns and results in social service restrictions, I aim to illustrate how healthcare plays a role in fostering societal inclusion for refugees. Thus far, this aspect of healthcare has received limited attention, and to the best of my knowledge, this thesis is the first comprehensive study of this topic in the Austrian context.

By exploring how healthcare can be a driver of inclusion against the backdrop of exclusionary asylum policies, this thesis builds upon scholarly work spanning various disciplines, including political science, anthropology, sociology, and history. It aligns with research that has addressed

how medical care, or its denial, holds meaning beyond meeting medical needs. It holds personal, social, and political meaning: Health policies and healthcare have been shown to perpetuate the exclusion of immigrants, categorising them as "others" who import disease and forming the basis of discourses that depict refugees as "undeserving" (see Chapter 2). By focusing on healthcare's meaning with regard to inclusion, I am entering into a dialogue with scholarship that relates healthcare to solidarity (Gould, 2018; Prainsack & Buyx, 2017; Chapter 7), belonging (Mattes & Lang, 2021; Raffaetà, 2019; Chapter 8), and citizenship (Pols, 2016; Probst, 2022; Chapter 9). Consequently, this thesis regards healthcare practices as a tool for inclusion and raises key concerns that intersect with empirical approaches to biopolitical theory (Aradau & Tazzioli, 2020; Fassin, 2018).

1.7 The Absence of Refugees in Health Policies

When I embarked on this research project, I anticipated that refugee health would be a topic of political concern in Austria, engendering the creation of laws and political discussions. To my surprise, despite refugees being a frequent topic in exclusionary discourses, they were largely absent in health policymaking. The following example from my fieldwork vividly underscores the complex ambivalence of refugee health. As part of my efforts to recruit healthcare professionals for interviews, I reached out to a general practitioner. He declined involvement in my study, explaining that asylum seekers and refugees "receive care as everyone else does". However, he added that a large non-governmental organisation (NGO) would provide care if they encountered difficulties in accessing healthcare.

My unsuccessful attempt to recruit the just mentioned general practitioner for an interview highlights a reluctance to engage in discussions about refugee health. The same general practitioner briefly mentioned the existence of comprehensive legal entitlements, despite being well aware of the practical challenges refugees may encounter when seeking medical services. The following sections further discuss the institutional and discursive absence of refugees in health policymaking. First, beyond the Austrian context, I show that migration and health policies tend to be unintegrated across countries. Second, none of the Austrian political parties addresses refugee health. Third, none of the Austrian healthcare institutions take responsibility for refugees.

1.7.1 General Disconnect between Migration and Health Policies

In recent years, in the prestigious medical journal *The Lancet*, researchers raised concerns regarding the disconnect between migration and health policies. They warned that this disjunction may result in severe health issues, particularly for vulnerable and marginalised migrant populations, such as refugees. For example, in a commentary, Bozorgmehr and Jahn (2019) criticised the detrimental health impacts associated with restrictive migration policies. They spotted a tension between often exclusionary migration policies and generally inclusive health policies, which can have a negative impact on migrants' health.

> Migration policies and health often collide. Migration policies are rooted in concepts of state sovereignty and determine who can stay in a country and who must go, who can access services and who is excluded. In contrast, health policies are governed by the international human right to health, which must be respected on a nondiscriminatory, inclusive basis. (Bozorgmehr & Jahn, 2019, p. e386)

Moreover, researchers advocated for the integration of health considerations into migration policymaking. The UCL-Lancet Commission on Migration and Health urged national governments to pay greater attention to the health of refugees in their migration policies (Abubakar et al., 2018). Another commentary published in *The Lancet* found that "[m]igration and health as a field of public health is still in its infancy" (Wickramage & Annunziata, 2018, p. 2529). Taking a closer look at the policies of United Nations countries, Wickramage and Annunziata (2018) argued that migration governance predominantly falls under the purview of ministries of the interior, immigration ministries, and foreign policy ministries. Migrant health responsibilities are typically not assigned to ministries of health. Cases involving contagious diseases are an exception; in these, refugees and other migrants risk stigmatisation as security threats and are perceived as dangerous "others" who may import diseases (Fang et al., 2015; Grove & Zwi, 2006; Kamenshchikova et al., 2018; Kehr, 2016; Olsen et al., 2016; von Unger et al., 2019; see Chapter 2).

1.7.2 Refugees not Considered in Austrian Health Policymaking across the Political Spectrum

My research on refugee health in Austria corroborates the analyses presented in *The Lancet* discussed above, as exemplified by the quotation from my interview with the health spokesperson of the Austrian Green Party:

> [The topic of refugee health] is just simple, to be honest, this whole story is always like a hot potato, yes? No one wants to deal with it (*Keiner will's angreifen*), it's unpleasant for everyone, it costs money. It's perhaps even completely wrongly located, because the Ministry of Interior is almost certainly responsible for it, yes? (interview, Green Party politician)

In the quotation, the Green Party member of parliament shared insights from his role as a member of the Parliamentary Commission for Health. At the national level, representatives from all parliamentary parties convene in this commission on a monthly basis to deliberate on legislative proposals concerning health, encompassing a broad variety of topics, such as psychotherapy, pharmacies, prevention, and genetic technology. In this commission, refugee health received minimal attention in the years following 2015; I further verified this with others in attendance. Despite the highly politicised discourse surrounding refugees during this period, this crucial political platform for shaping health policies did not address their health concerns. Furthermore, at the *Länder* level of Vienna, refugees remained a non-topic in health policymaking, as another health spokesperson recalled with regard to the second half of the 2010s:

> [Refugee health] was a bit more of a topic. But not to the extent that I would say it had a special priority, even though we had a very specific case with the 2015 refugee wave. But I don't remember that this was a special topic. At that time, it was more a political discussion between the different groups, as you can imagine, and it was less about the issue of health. (interview, NEOS [*Das Neue Österreich und Liberales Forum* (The New Austria and Liberal Forum)] politician)

The lack of attention paid to the issue of refugee health was a shared characteristic among political parties across the spectrum, each holding different reasons for their opposing stances. At the more refugee-friendly end, the Green Party's health spokesperson chose not to make refugee health a political focus due to concerns within the party about potential healthcare restrictions for refugees if this topic became a part of the FPÖ's political agenda. This decision was made despite the Green Party's awareness of certain barriers to access faced by refugees and their wish to improve refugees' situation.

On the other end of the spectrum, the FPÖ's stance on refugee health was that everyone legally residing in Austria, including asylum seekers and recognised refugees, should have access to adequate healthcare. The party's health spokesperson for the federal level of Vienna told me:

> For me there's health, but that applies to everyone. For everyone who is here. Whether they are men or women, what colour his skin is, what religion he belongs to and so on, doesn't matter to me when it comes to the topic of health. .... Those who are here should all receive the best possible care .... Anything else would be perverse. (interview, FPÖ politician)

The FPÖ's pronounced support for healthcare contrasts with the party's calls for stricter immigration regulation and exclusionary positions in other policy areas. Ennser-Jedenastik's (2020) analysis of FPÖ's bills, press releases, and other relevant documents from the 2017–2019 ÖVP–FPÖ coalition government shows that the party's social policies can be characterised as welfare chauvinist (providing generous welfare benefits for native citizens while reducing social benefits for non-natives; see Chapter 2). This stance contrasts with the FPÖ's healthcare policies, in which welfare played a minor, if any, role (Ennser-Jedenastik, 2020).

Notably, there were attempts to establish a segregated health insurance scheme with parallel services (or at least accounting) for non-European Union (EU) citizens (Ennser-Jedenastik, 2020); however, these proposals never progressed beyond preliminary ideas and were discussed non-publicly within the Parliamentary Commission for Health without any practical political effects (interview, Green Party politician). Moreover, the introduction of photos on the electronic health insurance card discursively excluded refugees and immigrants, operating under a welfare chauvinistic banner (Falkenbach & Heiss, 2021). In 2018, the minister of health (FPÖ) sought to justify this measure on discriminatory grounds, alleging insurance fraud by Muslim migrants (see Chapter 3).

1.7.3 No Responsibility for Refugees in Austrian Healthcare-Related Institutions

Relevant healthcare-related institutions did not view themselves as responsible for refugees, which was reflected in the challenges I faced in finding interview participants for my study.[11] At the federal level, the Ministry of Health directed me to other institutions, clarifying that they did not have a dedicated department handling refugee needs. At the *Länder* level, the City Councillor for Social Affairs, Health, and Sport declined to participate in an interview and referred me to the operational level, specifically to the Vienna Social Fund (*Fond Soziales Wien*). The Vienna Social Fund is a privately organised fund of the City of Vienna that serves charitable purposes. One of its key responsibilities is organising and implementing basic care for asylum seekers and recognised refugees for up to four months after a positive asylum decision. At the level of the SHI funds, the third pillar of the Austrian healthcare system, my attempts were similarly unsuccessful.

[11] In early 2020, I began recruiting professionals from healthcare-related institutions. While these institutions can be expected to have limited time resources, especially during the initial months of the Covid-19 pandemic, interview refusals were not primarily attributed to this. Instead, the main reason cited for interview refusals was a lack of responsibility for refugees.

In July 2020, I spoke with an employee from the regional SHI fund in Vienna, the *Wiener Gebietskrankenkasse* (WGKK), with which most refugees in Vienna were insured during my fieldwork. While she was involved in a project related to the health of migrants and offered assistance, she did not consider the SHI as an appropriate interviewee for my study. Instead, she referred me to a few NGOs that she believed were more knowledgeable about refugee health. Moreover, Municipal Department 15 of the City of Vienna, which is responsible for mandatory tuberculosis examinations for asylum seekers in large accommodations, was not available for an interview. The official body that handles patient complaints or issues with the healthcare system, the Viennese Patient Ombudspersons' Office (*Wiener Pflege-, Patientinnen- und Patientenanwaltschaft*), was similarly unavailable. They explained that they very rarely received any complaints or requests from refugees.[12]

During my research, I became aware of a noteworthy but short-lived institutional effort within health policymaking aimed at addressing refugees as a vulnerable group. In 2016, the Ministry of Health commissioned the Austrian Public Health Institute (*Gesundheit Österreich GmbH* [GÖG]), a publicly funded research institute, to establish a national coordination platform for the psychosocial support of refugees and helpers (*Koordinationsplattform zur psychosozialen Unterstützung für Geflüchtete und Helfende*) (Ministry of Social Affairs, Health, Care and Consumer Protection, 2020). I had the opportunity to interview one of the members involved in setting up and coordinating this platform. He explained that a primary objective had been to facilitate dialogue between policymakers, from the federal and *Länder* levels, and stakeholders from the realms of research and NGOs. However, as a result of the 2017 election and the subsequent change in government to a coalition between the conservative ÖVP and the right-wing populist FPÖ, the initially ambitious project of a political advisory platform underwent substantial downsizing and transformed into an expert networking group.

> So the platform has de facto disbanded itself. .… After the election, even before, it was somehow clear how the coalitions would somehow look. The *Länder* no longer came to the meetings. .... Well, to be honest, the downsizing was possibly also a bit of an anticipatory obedience from all those involved, because we were relatively certain at the time that this, so to speak project will

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[12] The City of Vienna publishes annual reports on the activities of the Viennese Patient Ombudspersons' Office. In accordance with the information from the persons I was in contact with, the most recent 114-page report did not make any mention of refugees, nor did it reference migrants in a broader sense. With regard to vulnerable groups, the report focused on the elderly and dementia patients (Viennese Patient Ombudspersons' Office, 2020).

> no longer get an order from the Ministry of Health. (interview, member of the coordination platform at GÖG)

Those actively involved in the platform, largely comprising pro-immigrant experts and NGOs, feared that the incipient government might dismantle the platform. According to the interviewee, this deliberate reduction in the platform's scope and the depoliticising of the platform's activities represented a form of "anticipatory obedience".

1.8 Overview Chapters

In this chapter, I introduced the conflicting dynamics between an inclusive healthcare system and an exclusionary asylum system in Austria. The following three chapters serve as a foundation for presenting the empirical insights in this thesis. First, a literature review discusses the challenges of delivering healthcare to refugees and introduces various concepts, which have addressed refugee health as embedded in destination countries' socio-political contexts. These concepts include "un/deservingness", "othering", "belonging", "biopolitics", and "solidarity" (Chapter 2). The subsequent chapters provide an in-depth exploration of the Austrian healthcare system and the asylum system (Chapter 3) and explain my doctoral work's methodology (Chapter 4).

The empirical findings of this thesis (Chapters 5–9) are divided into two parts. The first part focuses on aspects of refugees' lives in Austria that shape and meet their health needs outside of institutionalised healthcare structures. Chapter 5 discusses how the lived reality of refugees in Austria often has detrimental effects on their health. I demonstrate how the exclusionary logic of the asylum system continues to impact refugees even after they receive a positive asylum decision. Chapter 6 highlights the self-care practices that refugees employ outside of institutionalised care to stabilise their health and well-being.

The second part of the empirical findings focuses on refugees' experiences within the healthcare system. Health policies in Austria – examined through the multiple perspectives of legal texts, patient experiences, institutional provisions, and provider practices – take on additional meanings in the context of refugees. Beyond the provision of medical care, they form a counterpart to the exclusion prevailing in other parts of refugees' lived reality. The Austrian healthcare system serves as a driver of societal inclusion for refugees and contests the exclusion faced by refugees in other aspects of their lives in Austria. This inclusive function of the healthcare system is discussed in terms of practices of lived solidarity by care providers (Chapter 7), the development of a personal sense of belonging through navigating the healthcare system (Chapter 8), and the healthcare system's role in shaping citizen–state relationships (Chapter 9).

This thesis' last two chapters synthesise my doctoral work. The discussion chapter (Chapter 10) relates the empirical findings to the broader literature on the social determinants of health and post-migration stressors as well as the literature on the embeddedness of refugee health in destination countries' socio-political contexts. I focus on my doctoral work's contribution to the concepts of solidarity, belonging, and citizenship in the context of healthcare systems and to empirically nuanced approaches to biopolitics that have evolved in migration studies and medical anthropology (for example, Aradau & Tazzioli, 2020; Fassin, 2018). Focusing on the coexistence of exclusion in everyday experiences and inclusion facilitated by institutionalised healthcare, which Chapters 5–9 unfold, Chapter 10 discusses how healthcare practices enact, negotiate, shape, and reconfigure refugees' positions in society. Additionally, Chapter 10 addresses policy implications of my findings and reflects on the strengths and limitations of this thesis' methodology. The final chapter (Chapter 11) concludes with a summary and lessons learned for future health policymaking, emphasising healthcare systems' potential in driving inclusion for marginalised groups.

Chapter 2: Literature Review

2.1 Introduction

This chapter provides an overview of social science research concerning refugee health, with a specific focus on European high-income destination countries. I summarise findings relevant to my research context of refugees who filed an asylum claim in Austria around 2015. The discussion omits research on refugee health in other Western countries, notably the US, Canada, and Australia, as well as countries of the Global South, which are characterised by distinct contexts, healthcare systems, and refugee compositions. Moreover, I do not consider research on minors, a group whose health vulnerabilities have been acknowledged across multiple destination countries and to whom special regulations apply (Bamford et al., 2021; Fazel et al., 2012; for the Austrian context, see Glawischnig, 2018; Grois & Rath-Wacenovsky, 2018; Huemer et al., 2011; Kerbl et al., 2018). Furthermore, I only marginally address the repercussions of the Covid-19 pandemic on refugee health.[13]

The first part of this chapter outlines the challenges in providing healthcare for refugees, focusing on how healthcare systems in destination countries address refugees' health needs. It discusses legal access to healthcare services and the practical barriers to and facilitators of receiving adequate medical care. The second part extends the focus beyond the medical aspects of healthcare service provision and utilisation. Research has addressed health policies as embedded within larger socio-political contexts of destination countries. Specifically, I discuss how health policies can act as vehicles for inclusion and exclusion, the biopolitical perspectives regarding this topic, and the role of solidarity.

[13] Since the outbreak of the pandemic, research across a broad range of contexts suggested serious negative impacts on refugee health. For example, in Greece, overcrowded and unhygienic conditions in reception centres resulted in increased health problems (Vozikis et al., 2021). The risk of contracting a COVID-19 infection was 2.5 to 3 times higher among reception centre residents than among the rest of the population (Kondilis et al., 2021). Similarly, a review of global policies found difficult conditions in detention centres and camps, inadequate health information, barriers to accessing mental health services and the absence of refugee inclusion in policy decisions (Lupieri, 2021). A report summarised health challenges for migrants and refugees during the beginning of the pandemic in Austria (Kohlenberger et al., 2021b).

2.2 Challenges in Delivering Healthcare to Refugees

The refugee policy crisis in Europe, which followed the rapid increase in asylum applications in 2015, led to increased scientific interest in this topic within the region and beyond (Kocot & Szetela, 2020). Extensive research has examined the health needs of refugees alongside those of other migrants and ethnic minorities, partly due to shared challenges (Keidar et al., 2019). Research on refugee health employs diverse methods and methodologies across various disciplines. In addition to the medical sciences, social science research – encompassing psychology, political science, anthropology, sociology, and economics – has studied this subject. In general, research indicates that refugees face elevated health risks compared to the native population. The risk factors are related to dangerous experiences in their home countries, the strenuous migration process, and stress factors within the host country, such as limited career opportunities and restricted healthcare access (Bischoff et al., 2011; Hassan et al., 2016; Newbold & McKeary, 2018; Pérez-Molina et al., 2016).

Recent reviews provide insights into the state of research on refugee health in European host countries. A review spanning 2015-2019 concluded that knowledge in areas such as reproductive health, non-communicable diseases, nutrition, and economic assessment remains limited. The countries with the most publications on refugee health in Europe are Germany (290 publications), Sweden (113), Turkey (111), the United Kingdom of Great Britain and Northern Ireland (UK) (106), and Italy (78). Austria ranks 14th with only 18 publications (Ibragimova & Žužak, 2020). In a narrative scoping literature review covering the healthcare access and utilisation of migrants and refugees in EU countries (77 papers, published between 2011 and 2017), persistent disparities were found between these groups and the native population (Lebano et al., 2020). These disparities were most pronounced in mental and dental health (for details on oral health problems among refugees in Europe, see the review by Zinah & Al-Ibrahim, 2021). The barriers included limited legal access, language and communication challenges, and instances of discrimination. Furthermore, the review highlighted the underutilisation of primary healthcare services and excessive reliance on emergency services as significant challenges (Lebano et al., 2020).

In the following sections, first, I discuss the barriers to and facilitators of healthcare access for refugees. Second, I detail how mental health and post-migratory stress are particularly challenging aspects. The first part of this chapter concludes with an overview of empirical findings in the Austrian context.

2.2.1 Barriers and Facilitators for Receiving Medical Care

Research has identified practical difficulties refugees encounter in accessing healthcare services in European destination countries: For example, an interview-based study involving healthcare professionals and officials from six European countries, including Austria, highlighted discrepancies between policies and the actual provision of healthcare to asylum seekers and refugees with infectious diseases (Bozorgmehr & Jahn, 2019). A scoping review by Nowak et al. (2022) presented a thorough narrative summary of findings on the healthcare experiences of asylum seekers and refugees in high-income European countries (comprising 44 studies in English and German, published between 1992 and 2021, with 28 studies published after 2015), offering a comprehensive overview of the encountered barriers and facilitators. The most commonly cited barriers to accessing healthcare were language difficulties (mentioned in 19 studies), insufficient knowledge of healthcare access procedures (14 studies), administrative barriers (10 studies), and financial obstacles such as co-payments (seven studies). Moreover, qualitative research has shown that it is crucial to consider the broader context of discrimination and racialisation when addressing refugees' healthcare needs. Qualitative studies have also emphasised how refugees' health is adversely affected by various aspects of their living conditions in host countries. Specifically, an uncertain legal status, hostile living conditions, and the lack of a social network contribute to health challenges (Nowak et al., 2022).

A systematic review of barriers and facilitators related to refugee healthcare found that studies often differentiate between the individual patient level, the institutional level (including the role of health personnel and healthcare facilities), and the systemic level (including legal policies, remuneration schemes, and provisions in the health system) (Jallow et al., 2021). At the individual patient level, studies have identified barriers concerning language, communication, cultural beliefs, existing health problems, financial constraints, logistical and transport difficulties, vulnerability, and a lack of knowledge about the healthcare system in the host country (Filler et al., 2020; Hawkins et al., 2021; Jallow et al., 2021).[14] At the institutional level, the focus is on obstacles within healthcare facilities. These barriers comprise insufficient cultural sensitivity among healthcare personnel, inadequate interpretation services, incomplete knowledge among

[14] The scoping review conducted by Filler et al. (2020) examined studies on patient-centred care for immigrants and refugees. I included the results of this review because they identified common barriers and facilitators that were applicable to both groups. The review analysed 16 studies that were published between 2010 and 2019. The majority of these studies used qualitative research designs and were conducted in Western host countries, including five European countries.

healthcare staff about refugees' legal entitlements (Jallow et al., 2021), and communication problems between healthcare facilities (Hawkins et al., 2021). Furthermore, barriers at the level of clinics include patients feeling judged, delayed diagnoses, a lack of training in cultural competence, longer consultation times for refugees, and increased difficulty in establishing a patient–doctor relationship (Filler et al., 2020). Barriers at the systemic level encompass legal barriers, insurance complications, coordination and communication deficiencies, and issues related to racism and stigma (Jallow et al., 2021). Moreover, refugee patients indicated difficulties with paperwork and navigating the system to be problems, while health workers highlighted a lack of language services, problems with interpreters (inaccuracy and time), ethical problems with family interpreters, inadequate remuneration for the increased time required for immigrant and refugee patients, a lack of community services, and the inflexibility of the Western model of healthcare as barriers (Filler et al., 2020).

In terms of facilitators, Filler et al.'s (2020) review found the impact at the patient level to be negligible. The manner of healthcare delivery was deemed more significant. For example, establishing a doctor-patient relationship by offering a warm welcome, dedicating time to informal conversations, and maintaining an overall friendly attitude were considered advantageous for delivering quality care to refugees. Other factors facilitating care included clear communication, access to language services, the promotion of diversity, orientation about health services, the use of multidisciplinary approaches, and the continuity of care (Filler et al., 2020). Furthermore, a systematic review of public health interventions addressing healthcare barriers for refugees (covering studies published between 2010 and 2019, primarily in North American countries) highlighted facilitating factors such as peer support from people with a shared language and cultural background, health education, a comprehensive perspective on accessibility that encompasses waiting times and accessible locations, and a multidisciplinary approach both within and outside the clinic that also involves interpreters and social workers (Jallow et al., 2021).

In addition to these aspects addressing the health system's practices and structures, the integration of community facilities was also highlighted as a facilitator (Filler et al., 2020). Another scoping review on refugee women's health also emphasised the role of the community level (Hawkins et al., 2021). This review synthesised findings from 63 articles and publications (published between 2009 and 2019, mainly focusing on Western host countries). It highlighted the favourable outcomes of healthcare providers collaborating with community leaders, which

enhanced health education, facilitated dialogue, and promoted social support within the community (Hawkins et al., 2021).

2.2.2 Mental Health and Post-Migratory Stress

Research in the EU context indicates a higher likelihood of mental health problems among refugees compared to the native population (Lebano et al., 2020; Pfortmueller et al., 2016). However, notable disparities exist based on refugees' nationality, destination country, and variations in study designs (Bogic et al., 2015; World Health Organization, 2018). Mental health presents a particularly challenging area for refugees in terms of access. The reasons include perfunctory examinations in reception centres (*Erstaufnahmestellen*), insufficient cultural awareness, misdiagnosis of psychosomatic problems, and stigmatisation (Pollard & Howard, 2021; Zenner et al., 2021). There is a growing scholarly focus on post-migratory stress factors. Below, I focus on how refugees' socio-economic situations and experiences in destination countries adversely impact their mental health and overall well-being.

The period of seeking asylum is marked by a particularly high occurrence of post-migratory stress (Juárez et al., 2019). Review studies on the impact of post-migration stressors on asylum seekers indicate that a long duration of the asylum procedure, detention, and uncertainty regarding visa status increase the likelihood of mental health problems (Gleeson et al., 2020; Li et al., 2016). Qualitative studies on post-migration stress determined its negative effects on asylum seekers' ability to be healthy. These effects encompass legal uncertainty, worries about the asylum decision, a lack of work permits, housing conditions within asylum accommodations, unstructured days (Schein et al., 2019, in the Norwegian context), a lack of privacy, overcrowded facilities, and unhygienic conditions (Whitehouse et al., 2021, regarding reception centres in Belgium). The experience of receiving a negative asylum decision is particularly associated with a heightened incidence of mental health issues (Schoretsanitis et al., 2018).

Furthermore, housing has a crucial impact on refugees' mental health, with particularly adverse effects in camp environments (Ziersch & Due, 2018). Specific setups within asylum accommodations can either facilitate or impede healthcare access. The presence of helpful on-site nursing staff was identified as facilitators (Nowak et al., 2022), while other arrangements in asylum accommodations can present obstacles: For instance, in Switzerland, the requirement for asylum seekers to articulate their health concerns to accommodation managers before obtaining healthcare was identified as a hindrance that complicates access (Melamed et al., 2019).

Even after obtaining legal refugee status, post-migration stressors persist and affect well-being detrimentally (James et al., 2019). Restrictive policies, such as exclusionary criteria for receiving benefits and documentation requirements, present considerable health risks (Juárez et al., 2019). In Germany, Kikhia et al. (2021) conducted qualitative interviews with Syrian refugee mothers. As recognised refugees, they lived in private accommodations and were entitled to full benefits from the public health system. The women explained how persisting stress within Germany had adverse effects on their health. They associated their experiences of stress with challenges in navigating German bureaucracy, the loss of family and other informal support structures, experiences of discrimination (especially targeting those who wore the hijab), and the complexities of balancing old and new responsibilities, such as family care and learning the German language. Women from the upper middle class and those with academic degrees expressed concerns about their social status and career prospects. Moreover, certain stressors, such as family separation and poor social integration, adversely affected mental health regardless of legal status (Gleeson et al., 2020). There is a continuity of increased health risks, extending from the asylum process to living as recognised refugees in a destination country, as illustrated by Isaacs et al.'s (2022) interview study on forced migrants in Scotland. It identified persistent experiences of discrimination and isolation as well as continuous difficulties in finding paid work.

2.2.3 Studies on Refugee Health in Austria

Thus far, in Austria, a limited number of studies focused on the health of refugees. To gain a more comprehensive understanding, I also included studies on migrant health this review. Based on an overview of the literature concerning migrants and health in Austria, I conclude that persons with a migration background tend to rate their health condition worse compared to the native population. They are less inclined to adopt preventive health measures or visit general practitioners and specialised doctors. Instead, they tend to overuse hospital services (Anzenberger et al., 2015). Furthermore, migrant status, regardless of other social factors, has a negative impact on health status in Austria. This impact is particularly pronounced for people with Turkish and ex-Yugoslavian backgrounds but is less significant for other groups, such as citizens of EU member states (Sardadvar, 2015).

Regarding the health status of refugees who arrived in Austria around 2015, a relatively low risk of contracting infectious diseases was found, with the infections primarily originating from the host population (El-Khatib et al., 2019). The migrants assessed their own health as poorer compared to the general population, with the discrepancy being more pronounced among

women (Kohlenberger et al., 2019). Moreover, variations in health status among the refugee groups were identified. In particular, Afghans were more likely than Syrians to rate their health as poor. Additionally, Afghans exhibited a heightened risk of depression (14%), surpassing both Syrians (6%) and Iraqis (8%). This difference was largely attributed to the prolonged asylum procedures and the extensive history of conflict in Afghanistan (Hofmarcher & Singhuber, 2021).

Regarding refugee health in Austria, social science research has mainly focused on barriers to healthcare; I discuss this in detail in the following sections. In particular, studies indicate persisting problems in the area of mental healthcare.

2.2.3.1 Health Status and Healthcare Access

In Austria, both asylum seekers and recognised refugees are entitled to healthcare in the public healthcare system, receiving care in the same facilities and with the same services as all other beneficiaries (see Chapter 3 for an overview of the legal framework in Austria). Nevertheless, asylum seekers may encounter problems regarding legal access. They may find themselves excluded from the public healthcare system, and it was found that they occasionally face delays when attempting to register with the SHI system: Fuchs et al. (2017) showed that the percentage of people without insurance in Austria rose to 5% in 2016 from the 2% in the preceding three years. This increase can be attributed to delays in registering asylum seekers (Fuchs et al., 2017). Furthermore, in situations involving unauthorised changes of residence or instances of violent behaviour, asylum seekers face the loss of their fundamental benefits, including health insurance (Fuchs et al., 2017; Knapp, 2019).

A survey study involving a sample of 515 asylum seekers who arrived in Austria during late 2015 and early 2016 compared their responses with the outcomes of a representative survey on the physical and mental health of the Austrian population (Kohlenberger et al., 2019). Female asylum seekers exhibited a tendency to seek specialist and psychological care more frequently than their male counterparts. Overall, asylum seekers showed a twofold higher rate of hospital visits as day patients compared to Austrians (Kohlenberger et al., 2019). Schober and Zocher (2022), analysing administrative data from on of the Austrian *Länder*, Upper Austria, found that public health expenditures were notably higher for refugees compared to the native population. This difference was particularly striking during the first year following their arrival in Austria and diminished once the applicants attained refugee status.

A report analysed primary care provider interviews from early 2016 that focused on refugee care in Austria, identifying the associated challenges (Mayrhuber et al., 2016). Both doctors and refugees face knowledge gaps. Cultural differences pose challenges in non-verbal communication and symptom interpretation. Treating patients with a history of displacement is hindered by inadequate training and language barriers. General practitioners and paediatricians reported a lack of adequate information regarding the initial medical examinations (see Chapter 3) conducted on their patients at reception centres, including information about vaccinations. Furthermore, treatment is complicated by limited knowledge about refugee patients' pre-existing conditions, flight experiences, the healthcare systems of their home countries, and cultural factors such as diet and taboos (Mayrhuber et al., 2016).[15] These findings align with Robertshaw et al.'s (2017) literature review on primary care for asylum seekers and refugees in high-income countries.

Refugees mainly identified a lack of information as well as interpretation services as barriers to accessing healthcare. Co-payments are another issue, particularly in the context of dental care (causing the frequency of their dental consultations to be more than twice that of Austrians) and psychotherapy (Kohlenberger et al., 2019, 2021a). As persons receiving unemployment benefits, asylum seekers in Austria are exempted from co-payments (Knapp, 2019; see Chapter 3). In the rare instances when additional costs arise, asylum seekers can cover them by submitting applications to the Ministry of the Interior or the *Länder* departments for basic services. Nevertheless, refugees are often unaware of this possibility or may lack the requisite language skills to utilise it (Glawischnig, 2018).

2.2.3.2 Barriers to Access in the Area of Mental Health

Despite refugees having a statistically higher prevalence of mental health issues, their utilisation of psychotherapeutic services is roughly comparable to that of Austrians (Kohlenberger et al., 2021a). In 2019, persons from Syria, Afghanistan, and Iraq rated their quality of life lower than the Austrian population. They frequently reported sleep problems, negative emotions such as despair and sadness, and a sense of limited support from friends (Hofmarcher & Singhuber, 2021).

[15] As part of a larger EU research project, the results by Mayrhuber et al. (2016) were published along with findings from six other European countries in another article (van Loenen et al., 2018).

A survey of refugees from Syria, Iraq, and Afghanistan showed that a relatively high number of respondents (26%) suffered from severe mental health problems (Leitner et al., 2019).

The gaps in the healthcare provision for the 2015 refugee cohort in Austria were particularly pronounced in the realm of mental health (Danzinger et al., 2018). The challenges primarily stemmed from the inadequate identification of mental health issues and prolonged waiting times for SHI-covered psychotherapy sessions with interpreters. Adult refugees faced waiting periods ranging from six to 12 months (Kohlenberger et al., 2019). Moreover, Syrian, Iraqi, and Afghan refugees stated that discriminatory experiences and concerns about family members in their home countries adversely impacted their ability to be healthy. Conversely, mental distress was likely to be lower when refugees were proficient in the German language, engaged in paid or voluntary work, had supportive relationships, and enjoyed satisfactory housing conditions (Leitner et al., 2019). In 2016, Austrian primary care providers confirmed these gaps, stating that diagnosing mental health problems was difficult because of language barriers and a lack of knowledge about how medical staff could support access to mental healthcare (Mayrhuber et al., 2016).

The obstacles refugees face in accessing mental healthcare reflect broader issues within the Austrian healthcare system (see Chapter 3), including limited capacity, extended waiting times for SHI-accredited psychotherapy, and high co-payments for elective doctors. These issues are especially challenging for refugees, owing to the higher prevalence of acute mental health problems among them and their limited financial resources. Additionally, the stigma associated with mental health problems in their home countries often prevents refugees from acknowledging their own mental health needs, further exacerbating the lack of adequate care in this area. Typically, NGOs play a limited role in providing medical services to refugees in Austria (for a general discussion of the role of NGOs in refugee assistance in Austria, see Jong & Ataç, 2017). Yet, they take on a more active role in mental healthcare, particularly due to the system's general shortcomings, notably the widespread out-of-pocket expenses stemming from limited SHI coverage in this sector (see Chapter 3). For example, the NGO Hemayat specialises in providing psychotherapy to survivors of war and torture in their native languages. Another example is AFYA (meaning health and well-being in Arabic and Swahili), a Vienna-based NGO that offers trauma education support to migrant children in public schools and adults.

Thus far, political efforts to bridge the mental health gap have yielded limited success. For asylum seekers who experienced torture and trauma, a single NGO in each province provides psychotherapy funded by the Austrian Integration Fund (*Österreichischer Integrationsfond*), the

Ministry of the Interior, and the SHI funds. However, in most cases, waiting times exceed six months, and the available capacities fall short of the demand (Knapp, 2019). Furthermore, in 2016, the Ministry of Health commissioned the GÖG to establish a national coordination platform for the psychosocial support of refugees and helpers (Ministry of Social Affairs, Health, Care and Consumer Protection, 2020). In 2017, this platform was included in the target-based health governance system as one of 47 measures focused on overall mental health.[16] Other measures specifically targeting refugees included a survey on their health needs and improving access to psychosocial services for migrants in general (Ministry of Labour, Social Affairs, Health, and Consumer Protection, 2019).

2.3 Embedding Refugee Health in Destination Countries' Socio-Political Contexts

Studies have shown how refugee health is intertwined with and embedded in specific social and political dynamics. The existing scholarship has contextualised health policies within the broader framework of power structures. First, I discuss the role of health policies in the exclusion of refugees. I introduce the concepts of "un/deservingness" (social benefits reserved for immigrants who are considered deserving, such as sick people or minors), "welfare chauvinism" (social policies that favour the native population), "othering" (the process of distinguishing between a normalised "us" and an "othered them"), and "belonging". Second, I discuss how biopolitical analyses can enrich our understanding of refugee health. Third, I provide an overview of discussions on solidarity in the context of refugee health.

2.3.1 Social and Health Policies as Vehicles for Inclusion and Exclusion

In this section, I introduce four concepts that have been used to understand the link between health policies and the inclusion and exclusion of refugees: "un/deservingness", "welfare chauvinism", "othering", and "belonging".

[16] Note that none of the ten national health targets specifically addressed migrants or refugees (Ministry of Health and Women, 2017).

2.3.1.1 Un/Deservingness and Welfare Chauvinism

Deservingness concerns the perceived worthiness of persons or groups to receive specific rights, resources, or social benefits. Unlike claims grounded in rights that presume equality under the law, such as legal entitlements to healthcare, deservingness claims are expressed in a moral language that depends on situational and contextual factors (Willen, 2012). The concept of deservingness, alongside its counterpart undeservingness, raises complex questions surrounding fairness, equity, and justice in the allocation of resources and opportunities, particularly in healthcare:

> Debates about health-related deservingness involve divergent and often competing moral stances about whose health—whose bodies, lives, and life chances—matters. The focus of such debates can range from questions of individual access to a particular form of clinical treatment … to questions of system-wide access for entire populations. (Willen & Cook, 2016, pp. 95–96)

Healthcare is an intriguing arena for thinking about un/deservingness. Public opinion research suggests that individuals afflicted with disease, as opposed to, for instance, the unemployed, are more likely to be perceived as deserving across various social groups (Jensen & Petersen, 2017). However, disparities in perceived deservingness persist between native populations and immigrants, as was for example shown by a study on disability benefit insurance procedures in Switzerland (Thomann & Rapp, 2018).

Refugees encompass a diverse spectrum, where certain refugee groups may be considered deserving while others are not. For example, Sales (2002) described how new asylum policies in the UK contributed to portraying asylum seekers as undeserving, in contrast to recognised refugees considered deserving. These policies, which included introducing a voucher system and dispersing asylum seekers, exacerbated their social isolation. Similarly, media portrayals of refugees in Germany in the years of 2015 and 2016 constructed undeservingness based on various criteria, including voluntariness, economic productivity, host population security concerns, and gender relations (Holmes & Castañeda, 2016; Holzberg et al., 2018).

Health-related deservingness has garnered specific attention concerning undocumented migrants, who, lacking legal entitlements to medical services, often rely on volunteer services, NGOs, and local initiatives (see for example, Marrow, 2012). Huschke (2014), in her ethnographic research on undocumented Latin American migrants in Germany, introduced the concept of "performing deservingness" to elucidate how migrants presented themselves as helpless and in need of support to ensure medical treatment. Moreover, a special issue focusing on deservingness and healthcare for undocumented migrants in *Social Science & Medicine* compiled

articles that situated their findings within larger societal dynamics of inclusion and exclusion, illustrating how "the clinic serves as a window into specific ideologies of inclusion and exclusion that affect 'illegal' migrants in the larger society" (Sargent, 2012, p. 857).

Another relevant concept is welfare chauvinism,[17] initially introduced by Andersen and Bjørklund (1990). It pertains to the political stance that "welfare services should be restricted to our own" (p. 212). Over time, welfare chauvinism has evolved to signify that welfare benefits should be generous but restricted to the native population.[18] This concept was sometimes depicted as the social policy outcome stemming from the portrayal and perception of immigrants as undeserving (Jørgensen & Thomsen, 2016). It is prominent in political science and has frequently been utilised to comprehend the health and social policies advocated by radical right-wing populist parties (see, for example, Careja et al., 2016; Ennser-Jedenastik, 2018; Ketola & Nordensvard, 2018). However, research showed that welfare chauvinist strategies were adopted by other parties as well. For instance, the Social Democratic Party in Denmark followed this approach during the post-2015 refugee policy crisis (Jørgensen & Thomsen, 2016).

A small body of research examined the impact of right-wing populist parties within European governments on health, as indicated by a scoping review (Rinaldi & Bekker, 2020). Across European countries, right-wing populist parties were found to generally overlook health as a political issue[19] (Falkenbach & Greer, 2018). In line with these findings, health policies in Austria were not characterised by welfare chauvinism in Austria in recent decades (Ennser-Jedenastik, 2020; Falkenbach & Heiss, 2021; for a detailed discussion of FPÖ's stance on refugee health, see Chapter 1). In the next section, I introduce "othering" as another concept, which helps to

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[17] I would like to thank Michelle Falkenbach for conceptual discussions on welfare chauvinism in the context of right-wing populist parties' health policies.

[18] Note that various terms have been introduced to enhance welfare chauvinism's nuance. A Google Scholar search on January 12, 2021, returned nearly 4,500 results for "welfare chauvinism", as well as fewer results for similar concepts: 831 for "welfare nationalism" – a concept that focuses on cultural factors and national histories (Keskinen, 2016); 14 for "welfare exclusionism" – a concept that advocates scaling back welfare benefits based on attributes such as ethnicity and contribution amounts (Keskinen, 2016); 24 for "liberal chauvinism" – a concept "that combines exclusion of outsiders from benefits with cuts to benefits for the insiders" (Falkenbach & Greer, 2018, p. 16); and 398 for "welfare populism".

[19] This changed substantially with the Covid-19 pandemic, during which right-wing populist parties across Europe and other continents – including the FPÖ, which has not been a part of the Austrian government since 2019 – were strongly criticising governmental measures to contain the virus.

understand how healthcare serves as a vehicle to exclude refugees. Following that, I discuss "belonging", a concept that aptly explains inclusive dynamics.

2.3.1.2 Othering

The origins of the conceptual notion of "othering" can be traced to Beauvoir's (2011 [1949]) seminal book *The second sex*. It has since been expanded by a considerable number of scholars, especially in postcolonial studies (for an overview, see Johnson et al., 2004).

> "Othering" defines and secures one's own identity by distancing and stigmatising an(other). Its purpose is to reinforce notions of our own "normality", and to set up the difference of others as a point of deviance. The person or group being "othered" experiences this as a process of marginalisation, disempowerment and social exclusion. This effectively creates a separation between "us" and "them". (Grove & Zwi, 2006, p. 1933)

Othering is commonly understood as the construction of a particular group as not belonging to a particular society. Alongside the demarcation between a normalised "us" and an "othered them", the essence of othering lies in its implicit nature, which often makes it difficult to name and empirically study othering processes.

> Othering is not an explicit process; rather, it is implicitly embedded in social beliefs and discourses surrounding ''the refugee". Because the Othering of refugees is implicit, it is effectively invisible and largely goes uncontested. (Olsen et al., 2016, p. 60)

In the context of refugee health, scholars have shown how experiences of othering in destination countries detrimentally affect refugees' well-being. In an influential paper titled *Our health and theirs: Forced migration, othering, and public health*, Grove and Zwi (2006) synthesised findings from empirical studies, primarily in the English-speaking Global North, and illustrated how instances of othering in destination countries, such as the marginalisation of refugees in political and media discourses, have a negative impact on refugees' health. Similarly, everyday encounters with discrimination and racism were shown to have adverse health consequences (Bourabain & Verhaeghe, 2021; Harnois, 2021; Hou et al., 2020).

Another dimension of othering within the context of forced migration and health involves how an increasingly securitised logic in public health interventions (re)constructs refugees as others. In this context, othering is not primarily understood as a health risk; rather, it highlights how healthcare practices can contribute to the exclusion of marginalised groups. For example, the obligatory requirement for asylum seekers to undergo lung X-rays to prevent tuberculosis, as well

as its medical function of providing preventive care, can mark refugees as “a threat of disease” (Grove & Zwi, 2006) to the host country. Within the logic of securitisation, refugees are thus constructed as a potential hazard requiring control and as carriers of disease with the potential to strain the host country’s health system (Fang et al., 2015; Grove & Zwi, 2006; Kamenshchikova et al., 2018; Kehr, 2016; Olsen et al., 2016).

There exists a long history of depicting immigrants as a potential medical threat to the host population, a narrative propagated by diverse institutions, actors, and ideological positions. For instance, during the emergence of the public health movement in the early 19th century, US newspapers disseminated images depicting medical examinations of newly arrived immigrants (Lupton, 1995, pp. 35–39). Such constructions of immigrants as contagious health threats have persisted up to the present time. Recent research, for example, showed how antimicrobial screening measures in the Netherlands contributed to the “stigmatization of refugees as dangerous ‘others’” (Kamenshchikova et al., 2018, p. 43), how communication regarding tuberculosis in Germany and the UK constructed immigrants as “carriers of disease” (von Unger et al., 2019), and how forced migrants in Canada were increasingly regarded as health risks rather than people in need of medical care, as evident from limitations placed on refugee healthcare (Olsen et al., 2016).

> As far as policy is concerned, the health status of refugee claimants is only important if it affects the health or safety of others; the health and wellbeing of refugees is not considered valuable in and of itself. (Olsen et al., 2016, p. 60)

This quotation highlights that, in Canada, the focus was not on refugee health as an independent policy objective but on its instrumental role in maintaining the well-being of the host population.[20]

[20] Amidst the Covid-19 pandemic, public health measures were interpreted as (re)constructing refugees as others. Examples in Austria include the mandatory isolation of non-infected asylum seekers in reception centres and asylum accommodations as well as delays in providing pandemic-related information to refugees in languages other than German. An analysis of Germany’s Covid-19 responses suggests that medically unjustified mass quarantines for asylum seekers can be perceived as a continuation of othering, which has historically shaped asylum regulations (Tallarek et al., 2020).

2.3.1.3 Belonging

Belonging is another concept that has been used to describe how health policies engender inclusion and exclusion in welfare state societies. In the fields of political science and anthropology, this concept was developed in the 1990s as an alternative to more static notions such as identity, citizenship, and migrant assimilation. The aim was to "move away from essentializing notions towards a more constructivist and processual view that attends to individual perspectives and pathways" (Thelen & Coe, 2019, p. 282). This approach explicitly distinguishes itself from the aforementioned concepts of welfare chauvinism and un/deservingness. For example, Carmel and Sojka (2020) introduced "rationales of belonging" to better capture the intricacies of governing immigrant rights in the EU. They took historical developments and cultural factors into account, emphasising the dynamic reshaping of the criteria for belonging and exclusion over time and in various contexts.

Yuval-Davis' (2006) seminal work on belonging that makes a distinction between "belonging" and the "politics of belonging" is worth highlighting in this context:

> Belonging is about emotional attachment, about feeling "at home" and […] about feeling "safe". […] The politics of belonging comprises specific political projects aimed at constructing belonging in particular ways to particular collectivities that are, at the same time, themselves being constructed by these projects in very particular ways. An analytical differentiation between belonging and the politics of belonging is, therefore, crucial for any critical political discourse on nationalism, racism or other contemporary politics of belonging. (p. 197)

The politics of belonging primarily pertains to the broader social aspects that determine who is considered part of a community or society from a somewhat abstract macro perspective. Similar to the discussed approaches of un/deservingness and welfare chauvinism, this approach analyses how social and health policies, such as legal texts, parliamentary discussions, party politics, and the rationales of policymakers, influence and redefine who belongs and who does not.

In the context of healthcare, research has also shown how healthcare workers enact the politics of belonging in medical settings. Drawing upon ethnographic research conducted in Canadian healthcare institutions, Kirkham (2003) explored the politics of belonging from the perspective of nurses. She showed how "certain people, both patients and health care providers, were constructed as belonging in the social fabric, whereas some were left on the margins, constructed as Other" (Kirkham, 2003, p. 763). Another example is Cassidy's (2019) study on healthcare access control for migrants in the UK. She identified the links between everyday experiences in healthcare settings and the increased restrictions in immigration law, notably the 2014 and 2016

Immigration Acts in the UK. These legislative changes extended the scope of "borderwork" beyond traditional immigration authorities to include non-traditional actors such as employers, bank clerks, and healthcare professionals, who were now required to perform document checks. Subsequently, healthcare professionals began refusing treatment to patients who were legally entitled to it, such as asylum seekers. Lacking knowledge about the specific legal changes, they inadvertently perpetuated a restrictive approach. The immigration regime, driven by an economic rationale seeking cost savings for the UK healthcare system, permeated care logics. Cassidy's (2019) study yields valuable insights into the significance of healthcare practices within the context of forced migration and illustrated how "the UK's political project of belonging [is administered] in the NHS (i.e., National Health Service, publicly funded healthcare system in the UK)." (p. 87)

As opposed to the politics of belonging, the concept of belonging emphasises aspects that emerge "from below". Yuval-Davis emphasises belonging as a personal dimension that highlights migrants as active participants in creating belonging. It evolves through migrants' emotional attachment and is manifested at three interconnected levels: emotional attachment with social locations (for example, home country, race, and place of birth), identifications with collectivities (for example, culture and religion), and ethical and political values (for example, valuing human rights and democracy). Furthermore, "belonging is always a dynamic process, not a reified fixity, which is only a naturalized construction of a particular hegemonic form of power relations" (Yuval-Davis, 2006, p. 199). With regard to the aforementioned three levels, social locations are considered relatively fixed and challenging to alter, whereas affiliations with collectivities and especially values are more susceptible to alteration. Belonging is fluid. For instance, a refugee who previously advocated for authoritarian rule in their home country may come to appreciate the democratic system in their host country, thereby fostering a sense of belonging in terms of political values.

Regarding migrant healthcare, research has been increasingly highlighting how migrants establish a sense of belonging through healthcare services in their host country. These studies, primarily in medical anthropology, have addressed the personal dimension of belonging by foregrounding migrants' perspectives and lived experiences. An ethnographic study on Eastern European sex workers in Germany, for instance, traced how national belonging is enacted through the public healthcare system. It found that "obtaining health insurance acquired new meanings as an expression of belonging and successful integration" (Probst, 2022, p. 2). The recent special issue "Embodied Belonging: In/exclusion, Health Care, and Well-Being in a World in Motion" (Mattes

& Lang, 2021) in *Culture, Medicine, and Psychiatry* concentrated on the perspectives of migrants and other marginalised groups, including undocumented migrants in Norway (Bendixsen, 2020) and migrants seeking mental healthcare at an NGO in the UK (Brenman, 2021). This research addressed the role of healthcare practices in constituting belonging and showed how belonging is embodied through the emotions and affection evoked by medical care and institutions. This means to

> also attend to the productivity and agency involved in marginalized people's and medical professionals' strategies, activities, and investments in creating and sustaining spaces of inclusion, participation, mutual recognition, and ultimately care and well-being. (Mattes & Lang, 2021, p. 4)

In this special issue, von Poser and Willamowski (2020) analysed the experiences of Vietnamese migrants in Germany who were receiving treatment at an outpatient psychotherapeutic clinic. Their study showed that engaging in therapeutic outings to public places alleviated the participants' feelings of isolation and exclusion. These shared and embodied experiences fostered a sense of belonging within what the researchers described as an "ephemeral community of care" among the participants (von Poser & Willamowski, 2020).

In a recent survey conducted among elderly migrants who had moved to urban China for family reunification, healthcare practices and institutions emerged as significant contributors to their sense of belonging in their new environment. Those with chronic conditions, such as hypertension and diabetes, experienced a stronger sense of belonging when residing in areas with a higher concentration of doctors and hospitals. Furthermore, healthcare infrastructure played a role in increasing the sense of belonging, even for persons without chronic health issues. For example, the provision of social security cards and health education contributed to an increased sense of belonging for those with and those without chronic conditions (Chu et al., 2022).[21] Furthermore, Raffaetà (2019) interviewed immigrants in Italy who were seeking healthcare in their home countries Morocco and Ecuador. She showed how

[21] Studies have also explored the impact of a sense of belonging on health. For example, a survey conducted in Canada found that persons who indicated a stronger sense of belonging to their "local community" tended to have better physical and mental health (Shields, 2008). For an overview of various perspectives on this connection, see Gireesan (2022).

> [m]edical situations are not only about the relationships between therapeutic professionals and patients, but also about the interface between a person and the state, the private and public spheres, involving both therapeutic regimes and the politics of entitlements. (p. 72)

Migrants in Italy reported dissatisfaction with the medical care they received in the country. However, when these same persons travelled back to their home countries for healthcare services, they expressed contentment and even pride in the care they received there. Raffaetà (2019) interpreted these transnational healthcare practices to symbolise a sense of not belonging in Italy and of belonging in their respective home countries.

2.3.2 Biopolitical Perspectives

Foucault coined the term "biopolitics" to describe novel forms of governance that emerged after the late 19th century, which focused on managing the human body and promoting the well-being of the population. Biopolitics has since been adopted by scholars from various fields, including medical anthropology, political science, political sociology, and history, to examine how people are governed through their bodies in different historical periods and contexts.

In the following sections, I outline the fundamental aspects of Foucauldian biopolitics and elucidate key concepts such as power, regulation, subjectification, and normalisation. Moreover, I discuss two perspectives that yielded valuable insights into refugee health. First, scholars highlighted the exclusionary aspect of biopolitics, exploring its implications for those who lack formal citizenship. I focus on Mbembe's (2003, 2019) concept of "necropolitics", which has been employed in recent empirical studies on forced migration. Second, biopolitics faced criticism for making generalised and often abstract claims. Medical anthropology (Fassin, 2018) and recent research on migration (Aradau & Tazzioli, 2020; Minca et al., 2021; Wiertz, 2021) have endeavoured to reconcile the abstract dichotomies between biopolitics' inclusive and exclusionary sides through empirical research.

2.3.2.1 Biopolitics

During his lectures at the Collège de France, titled *Society must be defended* (Foucault, 2003 [1975–1976]) and *Security, territory, population* (Foucault, 2009 [1977–1978]), Foucault introduced the concept of biopolitics. This term was coined to describe a particular mode of governance that emerged in the late 18th and early 19th centuries. It pertains to the regulatory mechanisms employed by the state to counter "illness", which began to be perceived

> as phenomena affecting a population. Death was no longer something that suddenly swooped down on life – as in an epidemic. Death was now something permanent, something that slips into life, perpetually gnaws at it, diminishes it and weakens it. (Foucault, 2003 [1976], p. 244)

During the 19th century, factors such as population growth and industrialisation exposed people to unhealthy living conditions and hazardous working environments. Foucault showed how newly developed power mechanisms aimed to mitigate these health risks.

In this context, a novel form of power – "biopower"[22] – assumed a central role. Consequently, power was no longer solely associated with domination, as commonly observed in political institutions such as monarchies and parliaments. Instead, power became dispersed across a wide array of institutions and actors as well as intimately linked with the concept of "truth". This truth referred to the prevailing scientific and social understanding of the world, namely what qualified as knowledge. Biopower is the complex interplay of legal texts, public discourse, educational literature, institutions such as schools and hospitals, and other similar factors. It is not external to people but operates through them, shaped by their actions and self-understanding. In this process, people embody specific forms of subjectification, willingly adhering to certain norms and rules without the explicit need for external domination. With biopower, states "regulate" populations at a collective level and institutions "discipline" individual bodies (Lemke, 2011). Rabinow and Rose (2006) described these three dimensions of biopower – knowledge, regulation, and subjectification – as follows:

> a form of truth discourse about living beings and an array of authorities considered competent to speak that truth; strategies for intervention upon collective existence in the name of life and health; and modes of subjectification, in which individuals can be brought to work on themselves, under certain forms of authority, in relation to truth discourses, by means of practices of the self, in the name of individual or collective life or health. (pp. 203–204)

An illustrative example of how biopower operates can be seen in the implementation of public health measures across various institutions and practices. The emergence of statistics as a novel form of knowledge played a pivotal role in this context. It enabled the quantification of populations and the classification of persons according to a "normal" standard. Biopolitical

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[22] Foucault did not make a clear distinction between "biopolitics" and "biopower". In response, Rabinow and Rose (2006) suggested using the term "biopolitics" to specifically describe certain aspects of biopower: "We can use the term 'biopolitics' to embrace all the specific strategies and contestations over problematizations of collective human vitality, morbidity and mortality; over the forms of knowledge, regimes of authority and practices of intervention that are desirable, legitimate and efficacious" (p. 197).

normalisation positions persons, often via their bodies, in relation to a desirable "good" average, serving as the foundation for the governance of populations through various techniques. These techniques encompass the dissemination of images depicting "healthy" bodies and "sick" bodies, educational guidelines, and the establishment of medical institutions.

For instance, the emergence of photography facilitated the portrayal of what constituted a normal body shape and what deviated from the norm. This new technology, along with other tools such as population censuses and regular medical check-ups, contributed to the realisation of biopolitical rationality. Another example is the distribution of educational materials, such as advisory books on childcare hygiene provided to mothers. These materials became significant safeguards for population health. These technologies shaped persons in specific ways, ultimately influencing the composition and form of a population (Lupton, 1995). At the core of biopower lies the process of "normalisation":

> By the process of normalization, attempts are made to construct a privileged type of subject through the web of expert judgements surrounding the body. This expertise is employed in the measuring of populations, documenting and establishing trends against which to compare individuals and to make decrees on their relative 'normality' in comparison to others. (Lupton, 1995, p. 10)

Biopolitical normalisation invariably entails the construction of categories for persons who deviate from the norm. For instance, this involves defining bodies as outside the norm using metrics such as the body mass index (Evans & Colls, 2009) or the construction of "disabled bodies" through statistical methods such as the bell curve (Davis, 2018). In her research on German reparation policies for victims of the Nazi regime, Braun (2021) referred to the devaluation of individuals who fall outside these constructed norms as the "dark side" of biopolitics:

> [S]trategies of managing, improving, and optimizing human life are never only supportive. They have a dark side as well. They inevitably involve norms and standards for measuring achievement, criteria for what qualifies as better, desirable, or improved and what does not. Thus, they constitutively imply scales of differential value of humans. (Braun, 2021, p. 17)

2.3.2.2 Necropolitics: Biopolitics' Exclusionist Side

The original Foucauldian concept of biopolitics was closely tied to the establishment of European nation-states and rested on the assumption of a unified citizenry within a specific territory. A strand of scholarly discussion has emerged to explore the implications of biopolitics for those who do not hold formal citizenship. Adopting a post-colonial perspective that transcends national

borders, Mbembe (2003, 2019) introduced the concept of “necropolitics”. While biopolitics aims to maximise the life expectancy of a population, necropolitics directs attention to the consequences of biopolitical regulations for those who are not recognised as part of the population – those who are, in Mbembe’s words, “let die”. In a globalised and post-colonial world, Mbembe argues that a state’s efforts to nurture its own population are paralleled by the acceptance of the death of marginalised groups, of the “others” (see earlier sections in this chapter).

> [Necropolitics] account[s] for the various ways in which, in our contemporary world, weapons are deployed in the interest of maximum destruction of persons and the creation of *death-worlds*, new and unique forms of social existence in which vast populations are subjected to conditions of life conferring upon them the status of *living dead*. (Mbembe, 2003, p. 40)

Necropolitics focuses on the shortcomings of biopolitics, raising questions about the distinction between insiders and outsiders. Biopolitics, through nurturing those considered deserving within a nation state logic, is thereby argued to always produce an excluded “other”. In a later book on the topic, Mbembe argues that the “history of modern democracy is, at bottom, a history with two faces, and even two bodies – the solar body, on the one hand, and the nocturnal body, on the other” (Mbembe, 2019, p. 22). Locating present-day mechanisms of governance primarily in separation, Mbembe coins the term “democracy‘s inversion” (Mbembe, 2019, p. 39) to argue that imaginaries of belonging and equality are overlaid by the practical devaluation of certain lives. He identifies a “world of undesirables” (Mbembe, 2019, p. 38), which includes Muslims, Negroes, terrorists, Jews, and refugees.

Necropolitics has been the subject of various empirical studies in the context of migration, particularly in exceptional and dire situations. Examples include the seemingly accepted drowning of people from African and Middle Eastern countries in the Mediterranean Sea (Montenegro et al., 2017; Presti, 2019), the conditions in hazardous camps such as the one in the French city of Calais (Davies et al., 2017), and the control of pregnant women during migration in a French overseas department (Sahraoui, 2021). This body of work has discussed how violence occurring at national borders and in refugee camps results in refugees being seen as less valuable than European citizens. It highlights the presence of structural power dynamics that govern refugees in an oppressive way. Furthermore, Mayblin’s (2019; Mayblin et al., 2020) work shows that a form of necropolitics also operates within host countries. In her research on the everyday experiences of asylum seekers in the UK, she described how they are subjected to a logic that devalues their lives in everyday situations such as shopping and maintaining hygiene. For example, one Eritrean

man had to borrow money for a four-hour journey to a hospital for a crucial medical procedure due to the impoverished conditions asylum seekers live in (Mayblin et al., 2020).

Introducing Black feminist perspectives to biopolitics, Weheliye (2014) critiqued the absence of racial considerations in biopolitical discourse. Drawing on the concept of "racializing assemblages", he argues how racialisation involves "a conglomerate of sociopolitical relations that [categorise] humanity into full humans, not-quite-humans, and nonhumans" (Weheliye, 2014, p. 3). Furthermore, Weheliye argued that racialisation is at the core of biopolitical governance, perpetuating the devaluation of certain groups' lives. The notion of "racializing assemblages" facilitates an understanding of how these intertwined exclusions across multiple dimensions need to be viewed within a logic of perpetuated devaluation. Weheliye (2014)

> construe[s] race, racialization, and racial identities as ongoing sets of political relations that require, through constant perpetuation via institutions, discourses, practices, desires, infrastructures, languages, technologies, sciences, economies, dreams, and cultural artifacts, the barring of nonwhite subjects from the category of the human. (p. 3)

Weheliye's (2014) understanding of racism covers not only race as a naturalised marker for making a distinction between people with, far-reaching consequences, but also class, gender, religion, and other similar aspects. According to his conceptualisation, racism is the biopolitics of such distinctions. These are valuable insights for better understanding the multiple forms of exclusion that refugees have faced in Austria.[23]

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[23] In his book *Habeas viscus: racializing assemblages, biopolitics, and black feminist theories of the human*, Weheliye (2014) presents a critical perspective on necropolitics and other biopolitical theories. He argues that these theories fall short in providing an alternative framework for comprehending human relationships that transcends oppressive terms: "Although my argument resides in the same conceptual borough as Agamben's bare life, Foucault's biopolitics, Patterson's social death, and, to a certain extent, Mbembe's necropolitics, it differs significantly from them, because, as I show later, these concepts, seen individually and taken as a group, neglect and/or actively dispute the existence of alternative modes of life alongside the violence, subjection, exploitation, and racialization that define the modern human." (Weheliye, 2014, pp. 1–2) Weheliye's (2014) critique of biopolitics primarily builds upon Foucault's original concept and Agamben's (1998 [1995]) "tanathopolitics". Tanathopolitics discusses the consequences faced by those deprived of citizenship during the Nazi regime. Weheliye finds that these concepts tend to make sweeping generalisations and inadequately address the pivotal role of race in their analyses.

2.3.2.3 Re-Thinking Biopolitics Empirically: Beyond Grand Theories

Another line of criticism emphasises that biopolitics' universal claims overlook specific contexts and encourages empirical research situated in specific historical moments and places (Rabinow & Rose, 2006). The overarching theories of biopolitics, including necropolitics, are criticised for oversimplifying the often complex and multiple positions – beyond the binary logics of death/subjection/domination and life/resistance/agency – along which people navigate their lives.

In the field of migration studies, recent contributions indicate a need to examine the diverse ways in which biopolitics can manifest in the everyday lives of refugees (Aradau & Tazzioli, 2020; Minca et al., 2021; Wiertz, 2021). For example, claiming that

> key themes of biopolitical theory, such as sovereignty, life, difference, and population, appear problematic from the viewpoint of researchers interested in migrants' experiences, the dynamics of particular settings, and possibilities for resistance and change. (Wiertz, 2021, p. 1376)

This focus on migrants' experiences highlights the heterogeneity of biopolitical technologies. It shows that inclusion, exclusion, and other forms of biopower often occur concurrently. Aradau and Tazzioli (2020) illustrated this complexity with examples from the Calais refugee camp and the implementation of electronic cash assistance for refugees in Greece, introducing the concept of "biopolitics multiple". They

> proposed understanding the pluralisation, dispersal and proliferation of biopolitical technologies of migration control as "biopolitics multiple". Through this coinage, … [they drew] attention to biopolitical technologies that are characterised by heterogeneity, but also that at the same time 'hold together' through a sort of inclusive disjunction: in fact, migrants' lives and mobilities are contained and obstructed precisely through such heterogeneity that often translates into a substantial opacity and disorientation for migrants and even NGOs. (p. 219)

Biopolitics multiple draws attention to how being governed by multiple rationales creates disorientation and confusion for refugees and their care providers. The absence of consistency leads to ambiguity and uncertainty, which are difficult to navigate in practice.

Moreover, critical scholarship within the field of medical anthropology has added nuance to biopolitical theories while moving away from binary distinctions between death/subjection/domination and life/resistance/agency. This approach has particularly thrived in the French scholarship on this topic since the 2000s, with numerous empirical studies examining the healthcare as embedded in a specific country's socio-political context, often in the context of migration (Kehr, 2015).

A particularly influential figure in this regard is the anthropologist Didier Fassin. Drawing from his ethnographic fieldwork on migration and health in South Africa and France over the past few decades, he challenged the predominant emphasis on populations in several biopolitical theories. His proposition was “to reinterpret forms of life, to turn from the ethical life to ethics of life, and to replace biopolitics with politics of life” (Fassin, 2018, p. 18). He examined how biological life has come to dominate other aspects of life and argued for an “ethics of life” that acknowledges other aspects, such as biographical life that highlights how personal experiences shape lives, conveyed in personal narratives. The “politics of life” directs attention to concrete forms of life that allow the examination and addressing of inequalities between individuals and groups of people:[24]

> The moment one adopts this perspective – asking not how technologies govern populations but what politics does to human lives – the question of inequality becomes essential, since not all lives are treated equally and since these differences in treatment convey differences in the value they are granted. (Fassin, 2018, p. 85)

Fassin’s work has inspired numerous empirical studies; for example, one study attempted to understand the health issues arising from living in the Calais refugee camp (Dhesi et al., 2018). Based on Fassin’s interpretation of Foucauldian biopolitics, Tomkow (2020) introduced the concept biocredibility, which foregrounds asylum seekers’ need to place their experiences of health and illness within a coherent and “credible” narrative. Tomkow explained how forced migrants in the UK embedded their narratives of disease within socio-political conditions, drawing attention to how the restrictive UK asylum system shapes refugees’ understanding of their own health.

Finally, medical anthropology has highlighted how refugees’ bodies and health have increasingly become intertwined with political rights and worthiness (Fassin & D’Halluin, 2005). This includes a focus on how asylum decisions have increasingly hinged on biological evidence, such as indicators of disease and signs of torture (Ticktin, 2011) and DNA analysis (Heinemann & Lemke, 2014). Those who are vulnerable and suffering from illness are allowed to stay, while the others are not (Fassin, 2001; Ticktin, 2011). In a similar vein, the concept of “biological citizenship”

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[24] “The politics of life” also allowed Fassin (2007) to criticise necropolitics for making simplistic binary distinctions: “While it may be fallacious to reduce the war makers to a consistently barbaric ‘necropolitics’ and humanitarians to a purely altruistic ‘biopolitics’, it is much more interesting to compare them in terms of the politics of life they effectively engender” (p. 511).

understands health as a driver of citizenship and underscores how exposure to physical harm and disease can serve as a basis for claiming rights against the state (Rose & Novas, 2005). Originally introduced by Petryna (2004) to refer to the changing relationship between citizens and the state after the Chernobyl disaster, this concept has since been used to describe various relations between social rights and the state, as illustrated in the case of refugees with the human immunodeficiency virus in Turkey (Bänziger & Çetin, 2021).

2.3.3 Solidarity and Refugee Health[25]

The concept of solidarity has been a prominent theme in discussions about refugee health, including a broad range of practices such as the solidarity within national healthcare systems and the support offered by civil society organisations and volunteers. To disentangle the various meanings of solidarity in this context, I draw from Scholz's (2008) useful categorisation of solidarity into three types: "political solidarity", which signifies "a moral relation that marks a social movement wherein individuals have committed to positive duties in response to a perceived injustice" (Scholz, 2008, p. 6); "civic solidarity", which describes institutionalised obligations to citizens, such as healthcare and welfare services; and "social solidarity" within a community.[26]

In the following sections, I discuss the relationship between healthcare systems based on civic solidarity and refugees. Public debates have increasingly framed migration as a challenge to these forms of civic solidarity, engendering controversies related to refugees' entitlement to healthcare and other social services. Second, I address forms of political solidarity, specifically solidaristic practices aimed at integrating refugees and addressing health and social inequities.

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[25] This part incorporates sections from a previously published article in *Bioethics* in which I analysed empirical data from my doctoral work as a contribution to solidarity theory (Spahl, 2023).

[26] Tava (2021) specified the difference between Scholz's forms of solidarity: "Political solidarity is also characterised by the presence of explicit moral obligations. However, these obligations are not meant to maintain social cohesiveness (like in social solidarity) or to guarantee social security (like in civic solidarity), but to ignite social change. When people form what Scholz calls political solidarity, they do so in response to conditions of injustice and oppression that they cannot tolerate and decide to amend." (p. 213)

2.3.3.1 Solidaristic Healthcare Systems

Healthcare systems in Western European welfare states and elsewhere have solidarity as a key principle, institutionalising reciprocal support at the national level (Hofmann & Spieker, 2022; Prainsack & Buyx, 2015; Ter Meulen et al., 2011).[27] For example, the Austrian healthcare system

> is financed by a combination of income-dependent social insurance contributions, taxpayers' money and private direct and indirect co-payments. This solidarity-based financing ensures fair access to health services – regardless of age, gender or origin. (Ministry of Labour, Social Affairs, Health, and Consumer Protection, 2019)

All beneficiaries have equal access to the same services, including people who have not previously contributed. This includes persons such as recognised refugees who do not have employment and are exempt from co-payments such as prescription fees for medication (see Chapter 3). However, across welfare states, this solidaristic principle shows signs of erosion (Ter Meulen, 2016). In addition to the trends of privatisation and demographic change, the diversification resulting from migration may pose considerable challenges to nationally organised institutions built on the principle of solidarity, such as the healthcare system (Banting & Kymlicka, 2017; Lahusen & Grasso, 2018).

Empirical research has shown that the meaning of solidarity in healthcare systems is not consistent across different countries; furthermore, it varies over time. While support for healthcare-related solidarity is generally high among European citizens, Hrast et al. (2018) found that this support is based on different interpretations of solidarity. For instance, in the UK, solidarity is closely tied to an exclusionary attitude towards outsiders, whereas in Germany, it

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[27] While Europe has a more established tradition of solidarity in healthcare compared to many other regions, such as the US (Prainsack & Buyx, 2015), recent developments in the US strengthened the solidarity principle. The Affordable Care Act (also known as "Obamacare"), enacted in 2010, sought to enhance the affordability of health insurance for a broader population, including via the expansion of the Medicaid programme. Some analysts interpreted this change in law as strengthening the principle of solidarity within the American healthcare system. However, since the law's implementation, factors such as federalism, fiscal pluralism, privatisation, and an emphasis on individualism have posed practical challenges to the actual implementation of solidarity (Fuse Brown et al., 2020). These challenges were evident in the attempts by the Trump administration to repeal the Affordable Care Act (West-Oram, 2018b). Furthermore, initiatives in precision medicine that invoke the principle of solidarity, as proposed by policymakers, encountered structural obstacles within the US healthcare system (Van Hoyweghen & Aarden, 2022). Furthermore, the principle of solidarity in healthcare in the US encounters practical difficulties, such as economically disadvantaged people having little trust in the government and in healthcare professionals (Vargas, 2016).

strongly relies on joint contributions to the healthcare system. A survey conducted in Denmark examined "solidarity actions in support of marginalized groups" (Trenz & Grasso, 2018, p. 20) and identified a recent shift in the traditionally inclusive welfare state towards a more liberal orientation. Given the diversified population, the results suggested that the survey respondents associated solidarity more with deservingness than with universalism, which had been the case in the past. Furthermore, a study encompassing Germany, Israel, and the Netherlands emphasised how the changing meaning of solidarity in healthcare systems has evolved, underscoring that "solidarity has traditionally been a flexible concept, varying considerably across countries and across historical periods in the types of content it covers and for whom" (Saltman, 2015, p. 6). Changes in the scope and funding of healthcare services frequently mirrored the shifting nature of solidarity in healthcare systems. Financial crises and budgetary constraints pose a risk of excluding vulnerable and marginalised groups (Saltman, 2015).

Moreover, scholars argued that addressing the health needs of immigrants should be in the interest of destination countries for reasons such as epidemiology-related considerations (West-Oram, 2018) and health being a global public good (Illingworth & Parmet, 2015). However, such moral and pragmatic arguments about entitlement fail to address empirical problems: In Europe and other regions, refugees generally have access to healthcare services. The main issue does not concern entitlement but how the right to healthcare is put into practice.

2.3.3.2 Solidaristic Practices against Inequities

In the context of the exceptionally high number of asylum seekers arriving in Europe in 2015, the concept of solidarity gained prominence among migration scholars. In line with what Scholz (2008) referred to as "political solidarity", they drew attention to individual and collective struggles with a shared political goal: the inclusion of vulnerable groups, such as refugees (Agustín & Jørgensen, 2019). Several special issues in *Citizenship Studies* (Ataç et al., 2016; Schwiertz & Schwenken, 2020) and *Social Inclusion* (Vandevoordt & Verschraegen, 2019) focused on solidarity as a political struggle for refugee inclusion. In migration scholarship, the concept of solidarity ultimately encompasses "a redefinition of citizenship on a broader scale" (Schwiertz & Schwenken, 2020, p. 406). These discussions typically focus on non-state actors, including civil society support for refugees (Fleischmann, 2020), neighbourhood projects supporting refugees (Kubaczek & Mokre, 2021), and civil society protests against deportations (Kirchhoff, 2020). For example, Heimann et al. (2019), drawing from policy documents and qualitative interviews with EU policymaking experts and city networks, illustrated how eroding solidarity within European

welfare state institutions can be countered by transmunicipal solidarity. Notably, Gould (2018) voiced criticism against the healthcare and solidarity literature, pointing out its insufficient consideration of these political aspects. She highlighted a lack of attention towards addressing structural injustices and advocated for a normative understanding of solidarity that aims to fight structural injustice. In alignment with this political interpretation of solidarity, welfare state institutions, such as healthcare systems, are not considered truly solidaristic because they do not aim to foster inclusion (Agustín & Jørgensen, 2019).[28]

Furthermore, scholarship has highlighted the negative and exclusionary aspects that solidarity can take on. Research on right-wing populism introduced the term "exclusionary solidarity" to emphasise how right-wing populist social policies are designed to exclude immigrants and refugees from accessing services (Flecker et al., 2018; Lefkofridi & Michel, 2014).[29] An excellent example of how nationally organised solidarity-based healthcare systems can be exclusionary is the case of undocumented refugees. They are not entitled to benefits and must rely on other forms of support.

Moving beyond a binary view of solidarity as either inclusive or exclusionary, empirical research conducted in German-speaking countries on the 2015 refugee cohort demonstrated that solidaristic practices can acquire an ambiguous meaning. For example, Kirchhoff (2020) researched solidarity actions against asylum seekers' deportation in Germany during 2014 and 2015, introducing the concept of "differential solidarity". This concept highlights that the deportation protests not only constituted acts of solidarity with refugees but also reinforced notions of neediness. At the systemic level, these protests were not necessarily fighting for an inclusive system.

Similarly, Fleischmann (2020) employed the concept of "contested solidarity" to explain how support for refugees simultaneously fought for inclusion and contributed to the existing order of

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[28] In my previous publication, I argued that "inclusionary practices also take place within 'civic solidarity' structures such as the healthcare system. I showed that it is through the healthcare system as 'moral infrastructure of the welfare state' (Hinrichs, 1995) that political forms of solidarity emerge: Being a beneficiary of the healthcare system accessing services as a patient for refugees also means inclusion." (Spahl, 2023, p. 9).

[29] In the book *Erfolg des Rechtspopulismus durch Exkludierende Solidarität? Das Beispiel Österreich* (my own translation from German: "Success of right-wing populism through exclusionary solidarity? The example of Austria"), Flecker et al. (2018) use the term "exkludierende Solidarität", which can be translated to "exclusionary solidarity". Lefkofridi and Michel (2014) draw upon the term "exclusive solidarity" in their analysis of radical right parties and European welfare states.

oppression. Based on interviews with NGO workers, engaged citizens, and asylum seekers, as well as observations made in Germany between 2014 and 2016, she showed

> how the contested solidarities of the migration summer constantly *oscillated* between political possibilities to bring about alternative ways of living-together in an age of intensified migration, the fulfilment of personal needs [of the supporters] and a complicity in the governance of migration. (Fleischmann, 2020, p. 16)

Ambiguities in the expression of solidarity were also found in the Austrian context, as shown by Haselbacher (2019). In her research on asylum accommodations in rural areas during 2015 and 2016, she illustrated how solidarity claims made by refugee support initiatives were "interwoven with exclusionary narratives on integration, deservingness and performance" (Haselbacher, 2019, p. 81).

Against the backdrop of the growing prevalence of exclusionary forms of solidarity, scholars have endeavoured to reinstate more inclusive conceptions of solidarity. For example, Prainsack and Buyx (2017) stated "that solidaristic practices that are likely to increase the well-being of all members of society are worthy of support" (p. 71). In an effort to present an alternative to exclusionary nationalism, a recent special issue in *Citizenship Studies* concentrated on real-life instances of inclusive solidarity existing beyond the scope of state institutions. The editors stated that civil society

> initiatives have challenged and bypassed structures of exclusive solidarity and have enacted forms of more inclusive solidarity … demonstrate practices, enable relations, and build institutions of solidarity that can potentially contribute to social cohesion and a redefinition of citizenship on a broader scale. (Schwiertz & Schwenken, 2020, p. 406)[30]

2.4 Conclusion

This chapter discussed the diverse perspectives of social science scholarship regarding refugee health. The first part, addressing challenges in healthcare for refugees, primarily focused on the

[30] Other scholars refused to consider exclusionary forms of solidarity as solidaristic. Scholz (2008), for example, used the term "parasitic solidarity" to refer to seemingly solidaristic practices that do not qualify as solidaristic in her understanding: "Parasitical solidarity draws on some of the elements of a form of solidarity but rarely has the strong positive duties that constitute social, political, or civic solidarity. Parasitical solidarity is a rhetorical tool rather than a moral relation. By identifying and delineating the other forms of solidarity, we stand a better chance of rescuing this important moral and political concept from slipping into cant." (p. 5)

factors facilitating or hindering access to care. The discussed studies largely adopted a positivistic approach, interpreting health narrowly in a medical sense focused on disease. This approach rarely considers personal experiences of illness and provides limited information on the social and political role that healthcare holds (Schramme, 2012; see Chapter 1). Some studies discussed the significance of considering post-migration stressors and living conditions in destination countries when addressing refugee health. The second part emphasised the embeddedness of health policies within larger socio-political contexts. It drew attention to non-medical dimensions of refugee health, providing an overview of the concepts of "un/deservingness", "welfare chauvinism", "othering", and "belonging", as well as biopolitical approaches and the scholarship on solidarity, addressing important personal, social, and political dimensions of refugee health. This body of research highlights the role of healthcare, or its absence, in the inclusion and exclusion of refugees in destination countries.

Chapter 3: The Austrian Context

3.1 Introduction

This chapter sets the stage for understanding the experiences of refugees and the perspectives of care providers such as social workers and doctors, which are described in this thesis' findings (Chapters 5–9). It covers relevant legal frameworks and regulations for refugee health in Austria, as well as the societal context and political landscape. First, this chapter provides an overview of the healthcare system. Second, I offer insights into the asylum system. Third, their intersections are discussed, such as the healthcare entitlements available to refugees. Finally, I address specifics about Vienna, Austria's capital and largest of the nine *Länder*, where I conducted the empirical research for my doctoral work.

3.2 The Healthcare System

The Austrian healthcare system is characterised by the provision of high-quality care in a generally equitable system that ensures good accessibility. Nearly all, 99.9%, of the population is covered by a publicly funded mandatory SHI scheme (Bachner et al., 2018; Hofmarcher, 2013). In 2018, a mere 0.1% of the population reported an unmet need for medical examinations, placing Austria among the EU countries with the highest rates of meeting health needs (Eurostat, 2019). The system's strengths lie in accessibility, fairness, resilience, and high patient satisfaction. It is organised according to the solidarity principle: higher contributions from high-income groups compensate for lower contributions from others such as the elderly and the unemployed (Habimana et al., 2019; LSE Consulting, 2017). This solidarity-based structure has deep roots in Austria and has been supported by all parliamentary parties of the political spectrum (Leichsenring et al., 2011). Austria has a high rate of hospital beds and ranks second in doctors per capita in both the EU (see Figure 1) and the Organisation for Economic Co-operation and Development (OECD) (2017). Overall, it is a relatively wealthy country with a comparatively high gross domestic product (GDP) per capita of €36,972 (well surpassing the EU average of €29,801)[31], along with low rates of relative poverty (13.3%), and unemployment (5.4%) (see Figure 2).

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[31] Numbers from 2020, calculated with purchasing power parity that equalises different currencies' purchasing power (OECD/EOHS, 2021).

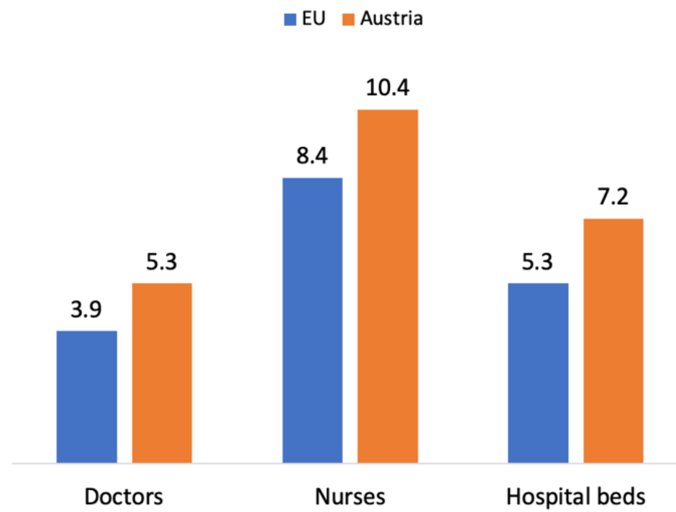

Figure 1. High capacity in the Austrian healthcare system in EU comparison (data for 2019)

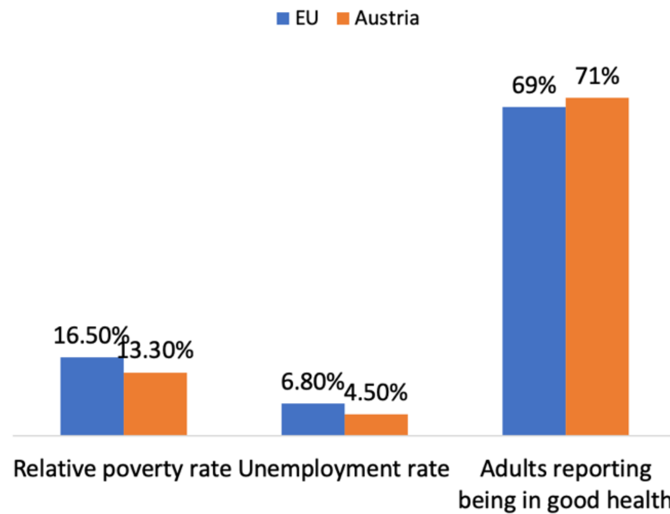

Figure 2. Austria as a relatively prosperous country with high self-reported health in EU comparison (data for 2019)

The Austrian healthcare system faces several challenges. Comparatively high rates of smoking and alcohol consumption were identified as major health threats (Ahammer et al., 2021; OECD/European Observatory on Health Systems and Policies [EOHS], 2021). Anticipated demographic shifts are expected to impact both the provision of adequate patient care and the near-term availability of health professionals. An aging population, with 14.9% aged over 65 in 1990 and 17.8% in 2012, coupled with a relatively low birth rate, contributes to the escalating

welfare expenditures in Austria (Österle & Heitzmann, 2016). The system faces an impending issue as a considerable cohort of general practitioners approaches retirement age in the coming years, compounded by the fact that the proportion of general practitioners in the medical workforce stood at 14% in 2019, significantly below the EU average of 21% (OECD/EOHS, 2021).

Moreover, the healthcare system is characterised by a highly fragmented and complex mix of competencies, and is considered to be comparably expensive (Österle & Heitzmann, 2016). In 2016, healthcare expenditure in Austria amounted to €37.876 billion, marking an almost three percent increase over the past three decades. This expenditure constitutes a significant portion of the GDP, standing at 10.4%, notably higher than the EU average of 9.9% (OECD 2017; OECD/EOHS, 2021). Except for preventive measures, Austria's healthcare spending per capita is higher than the EU average, particularly in terms of inpatient care in hospitals (see Figure 3).

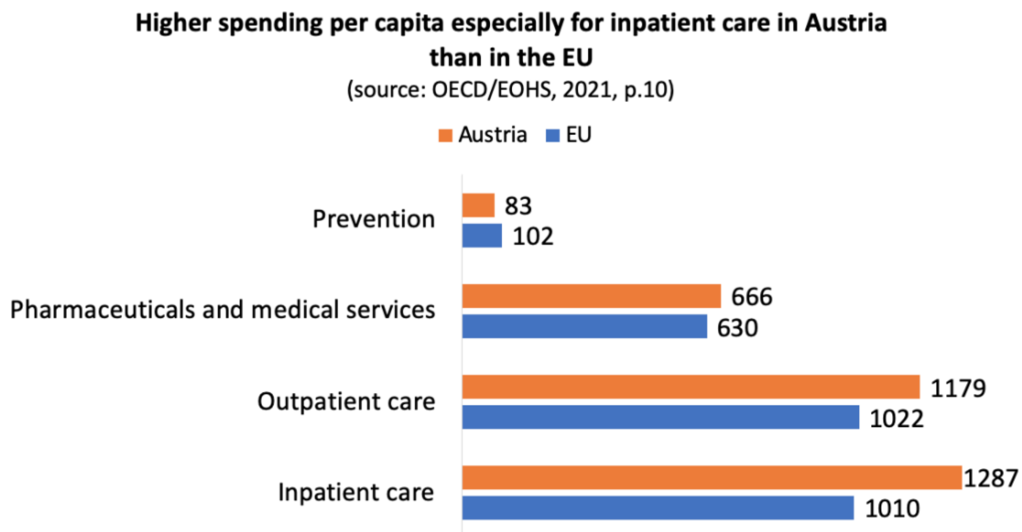

Figure 3. Comparatively high healthcare spending per capita (numbers in euros for 2019)

Efforts to curtail expenses in the financially demanding healthcare sector were amplified by the economic and fiscal crisis of 2008, which resulted in a substantial 13.8% increase in public debt as a percentage of GDP between 2007 and 2012. This increment, however, remained below the 26.3% average difference observed across the EU (Österle & Heitzmann, 2016).

Although the Austrian SHI is typically described to provide coverage for 99.9% of the population (Bachner et al., 2018), alternative calculations and data sources suggest lower coverage rates. According to Czypionka et al. (2018), about 2% of the population lacks insurance, while Fuchs et al. (2017) reported that 0.5% of the population is uninsured. Notably, certain groups face a higher risk of being uninsured, including undocumented persons, homeless persons, unemployed

persons without unemployment insurance, those who lost their insurance due to divorce or bereavement, and persons recently released from prison.[32]

Despite the healthcare system's underlying solidaristic basis, socio-economic factors increasingly influence health status in Austria. Since 2005, there has been a rise in income-related inequality in health status (Hofmarcher & Quentin, 2013). In 2019, only 62% of adults in the lowest income quintile reported good health, compared to 83% in the highest quintile (OECD/EOHS, 2021). Austria displays a notable education gap in life expectancy, where persons with higher education tend to live longer (see Figure 4). In addition, there has been a consistent increase in co-payments over recent decades, which are additional expenses beyond what the SHI covers, such as costs for psychotherapy (fully covered by SHI in select cases), physiotherapy, massages, and traditional Chinese medicine mixtures. Lower-income households experienced a more significant rise in the share of co-payments within their overall health expenditure compared to higher-income households (Czypionka et al., 2018).[33] Waiting times significantly differ for patients with additional voluntary health insurance in comparison to those without it (Bachner et al., 2018) (see Figure 5).

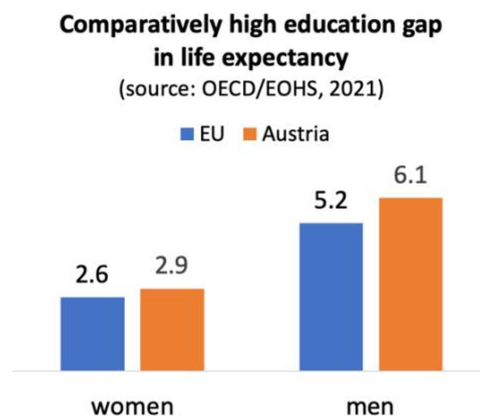

Figure 4. High education gap in life expectancy (numbers in years for 2016 for the age of 30)

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[32] The situation of undocumented migrants is different. They are only entitled to emergency care. For their health situation in Austria see: Fuchs et al., 2017; Muckenhuber et al., 2011; Seidler et al., 2019; Stiller & Humer, 2020.

[33] In nominal terms, the share of out-of-pocket payments increased from €411 in 2004/2005 to €532 in 2009/2010 and €615 in 2014/2015. The data indicated excludes out-of-pocket payments that households subsequently get reimbursed from their SHI or voluntary insurance schemes (relatively common with, for example, psychotherapy, physiotherapy and specific dental services such as oral hygiene). The share was constantly higher for households with higher incomes (Czypionka et al., 2018).

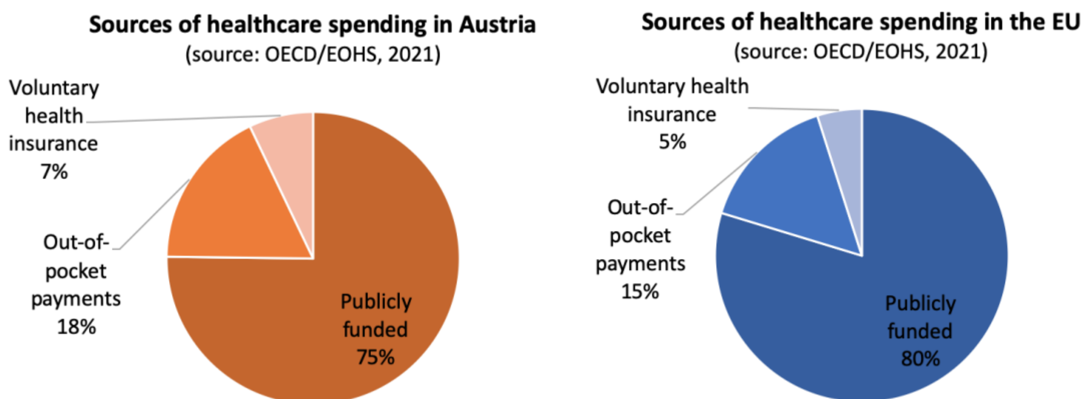

Figure 5. Sources of healthcare spending (data for 2019)

3.2.1 Historical Development

The Austrian welfare system, with insurance against accidents at work and illness, was established in the 1880s. Rooted in that era's compulsory insurance and self-administered SHI funds, the system maintains a close tie with the employment relationship, a defining characteristic that endures today. Conceived as a conservative welfare state, Austria's social policy heavily leans on the family as an institution. This reliance is evident in practices like co-insuring spouses without paid work (Österle & Heitzmann, 2016). While embracing this Bismarckian tradition, its prominence is more conspicuous in areas beyond healthcare, specifically in long-term and social care structures (Österle, 2013; Trukeschitz et al., 2013, 2022; Winkelmann et al., 2015).

Gottweiss and Braumandl (2006) delineated three distinct phases in the Austrian healthcare system since the Second World War. Initially, the system focused on reconstruction until 1955. The establishment of the Main Association of Austrian Social Security Institutions (*Hauptverband der österreichischen Sozialversicherungsträger*) via the Social Insurance Transition Act (*Sozialversicherungs-Überleitungsgesetz*) of 1947 unified pension, accident, and health insurances under a single umbrella organisation, a structure that endures today (Bachner et al., 2018). Second, from 1955 to 1978, the healthcare system can be described as effective and based on solidarity following the introduction of the General Law on Social Security (*Allgemeines Sozialversicherungsgesetz*). Preventive measures including vaccinations and the inception of mother-child pass examinations in 1974 were important developments.

Third, around 1978, economic considerations began to replace the previous solidarity principle. Escalating costs resulting from factors such as increased life expectancy, societal shifts towards

individualisation, and heightened medicalisation of health problems led to financial strain. Initiatives promoting personal responsibility for health emerged to alleviate the healthcare system. The 1978 reform significantly emphasised an economic rationale by introducing performance-based hospital funding (*Leistungsorientierte Krankenanstaltenfinanzierung*) and managed care elements such as deductibles and co-payments for patients (Gottweiss & Braumandl, 2006). From the mid-1990s onward, there was a heightened focus on cost containment and financing in the Austrian healthcare system, especially in the aftermath of the 2008 fiscal crisis (Österle & Heitzmann, 2016).

3.2.2 Shared Competencies in the Public Healthcare System

The Austrian healthcare system is characterised by a complex mix of competencies between the federal level, the nine *Länder*, and SHI funds. According to the Federal Constitutional Law (*Bundesverfassungsgesetz*; § 10 (12)), the federal level, particularly the competent Ministry of Health, holds legislative authority in the health sector.[34] Additionally, the constitution (§ 15a) establishes a separation between the hospital sector managed by the *Länder* and the outpatient sector overseen by the federal level (Bachner et al., 2018; Gottweiss & Braumandl, 2006). In the ambulatory sector, the self-governing SHI funds serve as relatively independent regulatory and executive bodies. Insured persons are allocated to one of 18 funds based on their employment, with contributions deducted from their salaries (varying percentages based on income groups) (LSE Consulting, 2017).[35]

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[34] In Austria, ministries are frequently re-organised by new governments. For example, starting January 2020, the policy field health has been situated within the Ministry of Social Affairs, Health, Care, and Consumer Protection. Prior to that, since 2018, it was situated within the Ministry of Labour, Social Affairs, Health, and Consumer Protection. The ministry responsible for health oversees the SHI funds and is advised by various institutions, including the Supreme Health Board comprising medical science experts, the GÖG and the Austrian Agency for Health and Food Safety (*Österreichische Agentur für Gesundheit und Ernährungssicherheit GmbH*) (Bachner et al., 2018).

[35] Before a recent reform, Austria's 18 SHI funds comprised nine regional funds for employees across the nine *Länder*, four funds catering to specific occupational groups (farmers, railway workers and miners, self-employed, and civil servants) and five funds for employees of five larger companies. The majority of the population was covered by the regional health insurance funds, generating 75% of the total SHI funds' revenues in Austria in 2016 (Bachner et al., 2018). The 2017–2019 coalition government between the ÖVP and the FPÖ initiated a restructuring of SHI funds aimed at cost-saving and enhancing efficiency. By 2020, the SHI funds were merged into a single nationwide fund, the *Österreichische Gesundheitskasse* (ÖGK). This reform also altered the corporatist structure of the SHI funds, historically closely associated with the SPÖ.

Patients contribute to the financing of the public healthcare system through taxes to the federal government and mandatory payments to SHI funds. These contributions are automatically deducted from salaries for employees and directly paid by the self-employed. In 2016, patient contributions accounted for 81.8% of the nearly €18 billion total revenues of SHI funds (Bachner et al., 2018). At the federal level, the Federal Health Agency (*Bundesgesundheitsagentur*) pools tax revenues from value-added tax, tobacco tax, income tax, and a lump sum from SHI funds for various healthcare expenditures. These expenses cover healthcare planning, the electronic health record (*Elektronische Gesundheitsakte* [ELGA]), and health prevention programmes (Bachner et al., 2018). The primary sources funding healthcare expenditures in Austria are SHI funds (45%) and direct government expenditure (30%) (OECD/EOHS, 2021).

Two healthcare reforms in 2013 and 2017 aimed to address coordination difficulties between the federal government, the *Länder*, and the SHI funds, as well as the separation of competences between the ambulatory and hospital sectors as outlined in the constitution. These reforms had some success in addressing these issues but fell short of achieving significant breakthroughs (Hable & Wesenauer, 2019). The 2013 reform established decentralised governance mechanisms in the form of networked governance and a target control system. It also introduced cooperation and coordination mechanisms via "a system of healthcare objectives, monitoring, reporting and sanctioning" (Österle & Heitzmann, 2016, p. 25). For example, the 2017–2020 target agreement aimed at building a stronger connection to the ten Austrian Health Targets, covering areas from strengthening health competencies to promoting social coherence (Ministry of Health and Women, 2017). In the 2017 reform, sovereign rights were transferred from the federal and *Länder* governments to a limited liability company, the *Gesundheits-Planungs-GmbH*, with the aim to enforce the implementation of health targets and structural changes more effectively (Hable & Wesenauer, 2019; Hofmarcher & Quentin, 2013; LSE Consulting, 2017).

In combination with the public financing of for-profit hospitals introduced during the previous ÖVP–FPÖ government in 2002, critics were anticipating a potential erosion of the principle of equity in the Austrian healthcare system (Hofmarcher-Holzhacker, 2019).

3.2.3 Care Structure

3.2.3.1 Ambulatory Care

The ambulatory healthcare sector in Austria encompasses various medical services, including private practices, outpatient departments, transportation, psychotherapy, physiotherapy, medication, speech therapy, hearing devices, and orthopaedic shoemakers. Primary care is organised through general practitioners who operate private practices with support from medical assistants. These practitioners not only offer medical services but also serve as gatekeepers coordinating specialised care (Rosenbrock & Gerlinger, 2009). However, this second role is not particularly well developed in Austria. Patients have the freedom to consult secondary care specialists, such as dermatologists and gynaecologists, without a referral, contributing to the relatively underdeveloped role of general practitioners. In fact, the percentage of general practitioners among all doctors in Austria is lower (54%) compared to the OECD average of 63% (OECD, 2017).[36]

Primary and secondary care operate under distinct financing models. SHI-accredited physicians (*Kassenärzt:innen*), have contracts with health insurance funds that determine flat-rate remuneration and service fees. Medical services provided by them are fully covered for SHI-insured individuals. The distribution of these physicians is regulated jointly by the SHI funds and the Medical Chamber. On the other hand, elective physicians (*Wahlärzt:innen*) and private doctors set their own fees, which patients pay out-of-pocket, and have the freedom to choose their practice location (Sanwald & Theurl, 2015). Elective physicians receive partial reimbursement from health insurance funds (usually less than 50%, varying based on the fund's remuneration model), whereas patients bear the full cost of treatment for private doctors. Regarding patient care, consultation times with SHI-accredited physicians are notably shorter because the SHI fund's remuneration schemes limit the time they can spend with patients. Additionally, patients experience longer wait times for appointments and in waiting rooms at SHI-accredited physicians' practices when compared to elective physicians and private doctors.

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[36] Already since the late 1970s, reforms in Austria have aimed to give general practitioners a more active role in coordinating care (Gottweiss & Braumandl, 2006). The 2013 health reform marked a shift toward prioritising primary health care over advanced medical approaches that were previously emphasised (Sprenger, 2015). As a result of the 2017 Primary Care Act (*Primärversorgungsgesetz*), primary care centres incorporating various medical professionals, including general practitioners, nurses, and psychologists, have been established throughout Austria (Pot, forthcoming).

3.2.3.2 Hospital Care

The underdeveloped role of primary care doctors in gatekeeping, combined with coordination difficulties between outpatient and inpatient services, has led to an oversized hospital sector with significant expenses. Spending on inpatient care constitutes a high portion, reaching 34% (higher only in Greece and Poland, with an OECD average of 28%). This translates into Austria having 7.6 hospital beds per 1,000 people, exceeding the OECD average of 4.7. Notably, Austria recorded the highest hospital discharge rate among all OECD nations in 2015 (OECD, 2017). Even though the hospital sector falls under the jurisdiction of the *Länder*, the main funding contributors are the SHI funds (Hable & Wesenauer, 2019) (see Figure 6).

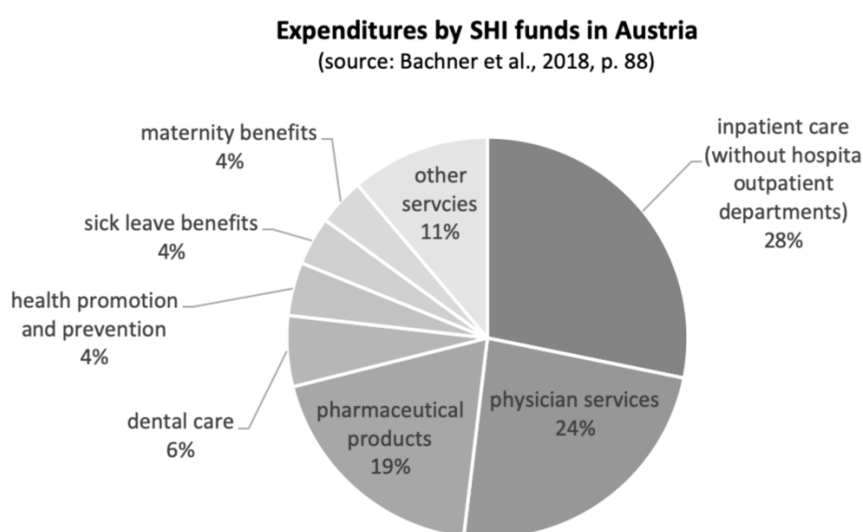

Figure 6. Expenditures by SHI funds (data for 2016)

3.2.3.3 Services Not Covered by Public Health Insurance

Health expenses beyond the public budget primarily stem from out-of-pocket payments and spending covered by private insurance companies, occasionally supplemented by non-profit organisations and businesses. In Austria, private insurance contracts are often in the form of supplementary coverage alongside membership in one of the SHI funds (Sanwald & Theurl, 2015). Overall, private household and insurance spending increased from €5.9 billion in 2004 to €8.9 billion in 2016 (Statistik Austria, 2020c). Although these expenses are relatively small on an international scale, some scholars categorise them as the secondary tier of the Austrian healthcare system after public health insurance (Sanwald & Theurl, 2015).

Out-of-pocket payments in Austria are mainly required for specialised care, pharmaceuticals, long-term care, mental health services, and dental care. They account for 3% of the average household budget, aligning with the OECD average (OECD, 2017), but stand higher than in other EU countries (with an EU average of 2.3% in 2015). Exemptions from co-payments exist for vulnerable groups such as pensioners and the unemployed, with medication deductibles fully covered (Bachner et al., 2018). However, for low-income households, co-payments for dental treatments and, to a lesser extent, medical products remain financial obstacles (Czypionka et al., 2018). In addition, limitations in the capacity of SHI-accredited physicians may lead to hidden costs for patients. Particularly in mental health care, only a few services are entirely covered by health insurance, prompting many patients to seek elective doctors and pay directly out of pocket (approximately €80 to €120 per session). Upon application, the SHI funds reimburse a fixed amount (initially €21.30, rising to €28 in September 2018).[37]

3.3 The Asylum System

In 2015, Austria experienced one of the highest per capita rates of refugee arrivals in Europe, with 88,340 asylum applications accounting for over one percent of its 8.5 million population. The significant surge in asylum seekers (see Figure 7) sparked a refugee policy crisis (Rosenberger & Müller, 2020). This crisis was marked by political unpreparedness and a reluctance to grant protection to refugees, culminating in a political shift to the right.

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[37] The figures provided pertain to the regional SHI fund in Vienna, WGKK (merged into the nationwide fund ÖGK in 2020; see footnote 35). This fund covers employees, as well as asylum seekers and most recognised refugees. Across different SHI funds, the levels of cost-sharing vary, with some offering more extensive subsidies for psychotherapy services.

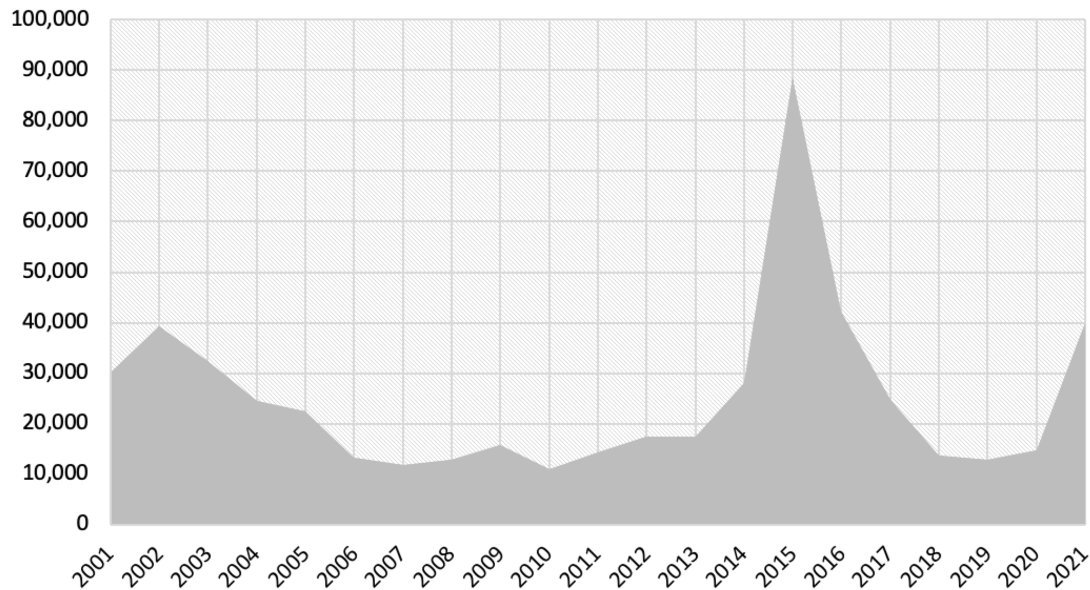

Figure 7. Asylum applications, 2001–2021

This chapter focuses on the admission and asylum procedures of asylum seekers and recognised refugees as defined by the Geneva Convention (according to Asylum Act [*Asylgesetz*] § 3; since 2016, the status can be withdrawn after three years by a court decision; otherwise indefinite). These groups were the primary focus of my empirical research (see Chapter 4). It briefly discusses other legal statuses, such as subsidiary protection (*Subsidiäre Schutzberechtigung*; according to Asylum Act § 8, valid for one year with possible renewal for two years) and a residence permit for humanitarian reasons (*Aufenthaltstitel aus humanitären Gründen*; according to § 8 of the European Convention on Human Rights, valid for one year). In 2018, there were 14,379 positive asylum decisions granting refugee status, 4,099 subsidiary protection entitlements, and 1,848 residence permits for humanitarian reasons (Knapp, 2019).

In the following sections I outline Austria's asylum-related legal procedures, the corresponding rights, and the living conditions during the admission and asylum procedures, as well as after being recognised as a refugee. Following this, I provide context by exploring the historical evolution of asylum regulations and their connection to social and political changes, which contributed to shaping a division between an Austrian "us" and a refugee "them".

3.3.1 Legal Procedures and Social Rights Pertaining to Asylum in Austria

Austria's asylum law is based on the Geneva Convention, which entered into force in 1955. Over time, it has become increasingly complex and restrictive due to multiple reforms since the consolidation of asylum as a policy field with the 1991 Asylum Act. I now detail the rights and living conditions of refugees during various stages: the admission procedure (where eligibility for asylum procedures is assessed), the asylum procedure (when applications are rejected), and when applicants are officially recognised as refugees.

3.3.1.1 Admission Procedures

The federal level is responsible for admission procedures. In most cases, applicants personally submit their international protection application at an Austrian police station (Ministry of Interior, 2020). Exceptions are given for family reunification cases, where eligible family members, such as spouses and minor children of a recognised refugees, stay in their home country until their asylum case is positively decided. Within 48 hours of filing the asylum application, authorities collect fingerprints with an interpreter present and conduct an initial interview (*Erstbefragung*). This interview's record forms the basis for the Federal Office for Immigration and Asylum (*Bundesamt für Fremdenwesen und Asyl* [BFA]) to determine asylum eligibility in Austria or potential deportation to another European country under the Dublin Regulation.

During admission procedures, applicants stay in reception centres managed by the Ministry of the Interior, usually for a few days and occasionally up to several months (Asylkoordination Österreich, 2019; Bundesministerium für Inneres, 2020). The largest reception centre, located in Traiskirchen, a town in Lower Austria, approximately 20 kilometres south of Vienna, experienced overcrowding, hosting over 4,000 individuals at its peak during 2015 and 2016.

During admission procedures, applicants stay in reception centres run by the Ministry of the Interior for a couple of days, usually for a few days and occasionally up to several months (Asylkoordination Österreich, 2019; Ministry of Interior, 2020). The largest reception centre is located in Traiskirchen, a town in Lower Austria, approximately 20 kilometres south of Vienna. During the peak times of 2015 and 2016, the centre, which was already overcrowded by then, accommodated over 4,000 individuals at the same time.

3.3.1.2 Asylum Procedures

Upon admission to the asylum procedure, asylum seekers submit their asylum application to the first-instance decision-making authority, the BFA (Court of Audit Austria, 2019, 2023a). Based on the minutes of the initial interview, the documents submitted, information on the home country and a personal interview, the BFA makes a decision within a specified period of up to six months. In cases of negative decisions, asylum seekers can file an appeal with the Federal Administrative Court (*Bundesverwaltungsgericht*) (Asylkoordination Österreich, 2019; Court of Audit Austria, 2023b; Knapp, 2019; Ministry of Interior, 2020). However, second-instance decisions often face significant delays. Although no official statistics exist on these delays, anecdotal evidence suggests that decisions may take more than five years. This delay is noteworthy, especially considering that there is a relatively high probability of first-instance decisions being overturned. For example, in 2018, 38% of decisions in alien and asylum matters were reversed (Ministry of Constitutional Affairs, Reforms, Deregulation and Justice, 2019).

Negative asylum decisions affect a large number of people and are unevenly distributed unevenly across the applicants' home countries (see Figure 8). From 2015 and 2020, asylum decisions predominantly involved persons from Syria, followed by Afghans and Iraqis. While the vast majority of Syrians received a positive asylum decision within a short time, only between one-third and one-half of the Afghans obtained positive decisions, with slightly higher approval rates for Somalis. The percentage of successful asylum applications from Iraqis was particularly low, mostly below 30%. Moreover, for example, in these years, none of the applicants from Benin received a positive decision (Ministry of Interior, 2022).

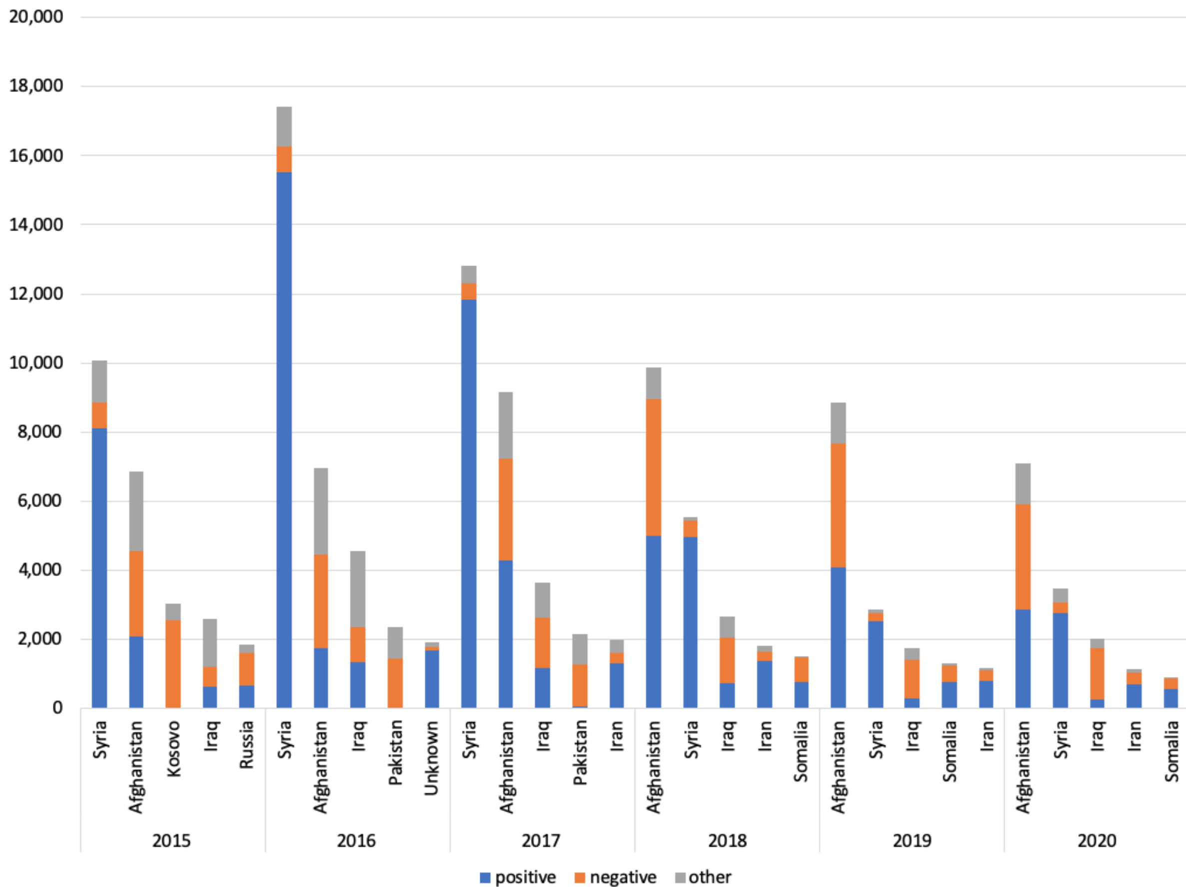

Figure 8. Top five countries of asylum decisions, 2015–2020[38]

The 2014 agreement on basic care regulated the care for asylum, redistributing responsibilities from the federal level to the *Länder*. This shift led to variations among the Länder and ongoing power struggles over competencies (Gruber, 2017). Basic care (*Grundversorgung*) includes housing, clothing, school fees for children, medical care, and a modest allowance (around €40)

[38] Note that the asylum statistics provided by the Ministry of Interior (2022) do not differentiate between first- and second-instance decisions on asylum applications, and there is a lack of systematic data concerning the processing times for second-instance decisions.

(Aigner, 2019; Rosenberger & Müller, 2020).[39] Asylum seekers are excluded from the labour market but may earn limited income in specific low-paid jobs, such as newspaper delivery.[40]

Asylum seekers live either in private accommodations or managed facilities. In rural areas, housing is predominantly organised privately, often in repurposed buildings, such as former hotels. In urban areas, larger facilities run by quasi-autonomous NGOs (quangos) are more prevalent (Haselbacher, 2019; Josipovic & Reeger, 2020). In Vienna, quangos contracted by the Viennese Refugee Aid (*Wiener Flüchtlingshilfe*), a department of the Vienna Social Fund, run asylum accommodations. In 2015, Vienna hosted more than a third of Austria's asylum seekers. In 2016, approximately half of the 21,000 asylum seekers in the city resided in private apartments, while the other half lived in asylum accommodations (Aigner, 2019; Rosenberger & Müller, 2020). These accommodations are scattered across Vienna, often located in larger repurposed buildings, such as former hospitals and offices (Küpeli, 2016). Residents are free to leave and re-enter the building, although gatekeepers oversee entry to prevent unauthorised persons from entering.

3.3.1.3 Rejected Asylum Applications

Persons whose asylum applications were rejected and who exhausted legal remedies are given a 14-day notice to leave Austria, facing potential deportation. However, some may stay legally if deportation is unfeasible due to humanitarian or other reasons. This scenario, labelled the "deportation gap" in research (Ataç et al., 2020; Rosenberger et al., 2018) due to legal uncertainty and limited entitlements, affects non-removed rejected asylum seekers. These persons are barred from integration measures such as language courses. While they retain health insurance,

[39] Basic care is not uniformly regulated across the Austrian Länder (for a detailed comparison between Salzburg, Styria and Vienna, see City of Vienna Court of Audit, 2018; for a detailed description of basic care in Vienna, see Court of Audit Austria, 2013). In 2018, the Vienna Umbrella Association of Social Institutions (*Dachverband Wiener Sozialeinrichtungen*) established guidelines for basic care in the city. These guidelines outlined minimum standards for asylum accommodations and counselling centres (Vienna Umbrella Association of Social Institutions, 2018). Health received relatively little attention in these guidelines; for instance, it was only briefly mentioned as a responsibility for social workers, such as "support for psychosocial and health stabilisation" (Vienna Umbrella Association of Social Institutions, 2018, p. 15).

[40] In 2021, after my doctoral work's fieldwork, the Austrian Constitutional Court lifted the employment ban for asylum seekers. Since then, a general time limit of three months applies, after which asylum seekers can receive a work permit. However, since asylum seekers have little access to integration support such as qualification measures, this option is largely irrelevant in practice (Ebner, 2023).

access to medical services beyond basic care is subject to Austrian authorities' discretion (Rosenberger, 2019; Stiller & Humer, 2020).

An option available for non-removed rejected asylum seekers to stay in Austria is to apply for the status of tolerated stay (*Duldung*). Unlike a residence permit, this status only entails the temporary suspension of deportation due to various reasons, such as humanitarian grounds preventing deportation or situations where a person cannot be deported for practical reasons (for example, lack of cooperation from the country of origin in the deportation process).

Another possibility for non-removed rejected asylum seekers is to seek a residence permit for humanitarian reasons, providing them with at least some degree of legal stability. This permit allows a one-year stay and permits access to the job market after three months. However, in Austria, this status is rarely granted (see Figure 9) (Rosenberger et al., 2018). Furthermore, persons with rejected asylum applications may choose to evade authorities and abscond. Although the number of these persons has decreased in recent years (see Figure 9), the exact count of those remaining in Austria is unknown. As other undocumented migrants, they are only entitled to emergency healthcare (Stiller & Humer, 2020).

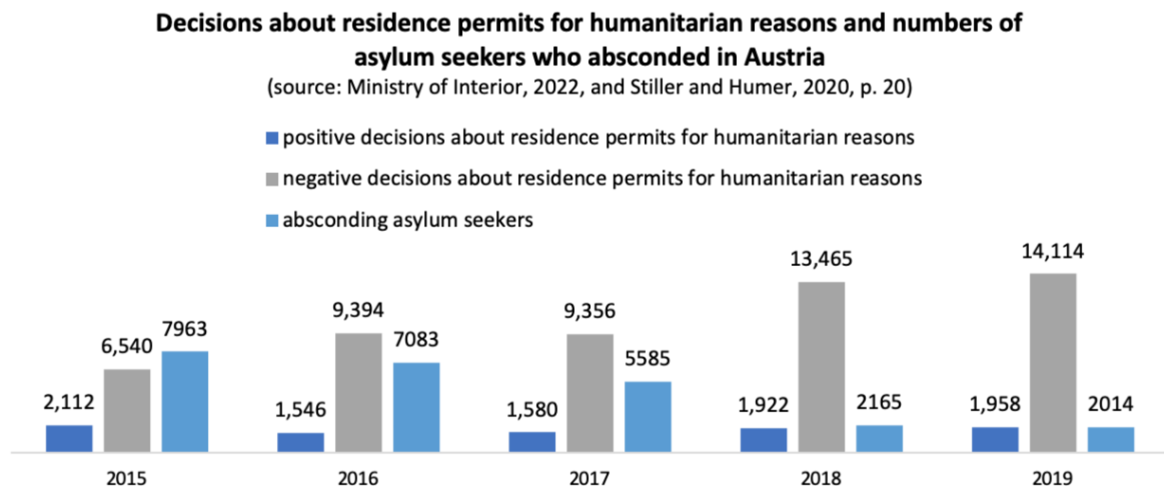

Figure 9. Decisions about residence permits for humanitarian reasons and absconding asylum seekers, 2015–2019

In recent years, there has been growing scholarly attention toward previously understudied aspects of Austrian deportations and non-removed rejected asylum seekers. This heightened interest stems partly from the politicisation of these issues post-2015, marked by increased protests both supporting and opposing deportations (Ataç, 2016; Hadj Abdou & Rosenberger,

2019a, 2019b; Rosenberger, 2018). For example, Küffner's (2022) in-depth ethnographic study showed conflict-ridden practices by different actors in enforcing or preventing the deportation of rejected asylum seekers in Austria. It discussed how bureaucratic processes enforcing the obligation to leave often encounter practical constraints, illustrating agency of refugees and their supporters. Non-removed rejected asylum seekers became a focal point for challenging the Austrian government's restrictive asylum policies (Hadj Abdou & Rosenberger, 2019a; Küffner, 2022).

At the political level, there has been a significant increase in political reactions to asylum seekers who have not been refouled (i.e., forcibly returned to a country where they might be in danger) since 2015. These responses notably contributed to the refugee policy crisis following that year (for details see later section in this chapter on that topic). The policy responses encompassed a mix of substantive measures, such as monetary incentives for "voluntary" return, and symbolic measures, largely unimplemented, such as initiating criminal proceedings for non-refoulement. Nearly all proposed and implemented measures focused on refugee returns, failing to resolve the actual problem of legal insecurity for those remaining in Austria (Ataç et al., 2020).

3.3.1.4 Recognised Refugees

Recognised refugees are on an equal footing with Austrian citizens with regard to social rights. They reside in private housing, have full access to the labour market, and are entitled to minimum social benefits (*Mindestsicherung*) in case of unemployment, akin to Austrian citizens. Recognised refugees have comprehensive access to the public healthcare system. This access is facilitated either through employment or, in cases of unemployment, via the public employment service (*Arbeitsmarktservice*) or minimum social benefits (Knapp, 2019). The 2019 Basic Social Assistance Act (*Sozialhilfe-Grundsatzgesetz*) aimed to reform minimum social benefits, shifting from minimum standards to establishing maximum rates. For recognised refugees, this change means that they might not receive the full amount of minimum social benefits if they fail to attend mandatory courses for orientation and on Austrian values (*Werte- und Orientierungskurse*) organised by the Austrian Integration Fund. In January 2023, implementation laws to the Basic Social Assistance Act were put in place in six of the eight Austrian *Länder*. Vienna and Burgenland have yet to implement the federal act (Ministry of Social Affairs, Health, Care, and Consumer Protection, 2023).

3.3.2 The Socio-Political Context of Asylum

3.3.2.1 Austria's History of Immigration

Austria has a longstanding history of immigration. Between the World Wars, the multi-ethnic Austro-Hungarian Empire dissolved and Austria consolidated as a nation-state in a much smaller territory. In 1938, Austria underwent annexation and became part of Nazi Germany, maintaining this status within the German Reich until 1945. From the 1950s to the 1970s, Austria actively recruited international workers, predominantly from Turkey, many of whom have remained in the country for generations to the present. At the same time, Austria temporarily hosted refugees from neighbouring countries such as Hungary and Poland. During the Cold War, Austria was an important transit country for onward migration to other Western countries. By the early 1990s, amid the Yugoslav wars, Austria transformed into a destination country itself. In the years between 1992 and 1995, Austria granted temporary protected status to over 90,000 Bosnians. While not officially recognised as refugees according to the Geneva Convention, roughly 70,000 of them remained in Austria and were granted long-term residence status by the late 1990s (Jandl & Kraler, 2003). As in many other European countries, asylum applications in Austria increased significantly following the Syrian civil war (2011– present), culminating in 88,340 asylum applications in 2015. In the subsequent years, the numbers decreased until a recent increase, primarily attributed to applicants from Ukraine (see Figure 7 in an earlier section in this chapter) (Ministry of Interior, 2022).[41]

Regarding the political inclusion of immigrants, Austria maintains a relatively strict naturalisation law (Bauböck & Haller, 2021; Stadlmair, 2018). In 2018, almost20% of Austria's 8.8 million residents did not possess formal citizenship (Statistik Austria, 2020a). Austria's ranking is 53rd out of 56 countries regarding migrants' access to citizenship (Solano & Huddleston, 2020). Becoming a citizen in Austria entails meeting specific criteria: maintaining a clean criminal record, demonstrating a B2-level proficiency in German, no reliance on welfare while maintaining sufficient income, passing a citizenship test, committing to Austrian civic values, and renouncing

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[41] In 2001, the European Council introduced the Temporary Protection Directive. As a response to the experience of the influx of refugees in the wake of the Yugoslav wars, the directive provided a legal basis for the non-bureaucratic admission of large numbers of non-EU citizens in need of protection. In March 2022, after the Russian invasion of Ukraine, the European Council adopted this directive for the first time (no adoption for people fleeing Syria and others who arrived in Europe around 2015). There is an ongoing lively social and scholarly debate about temporariness in asylum policies. Critics argue that temporary asylum exacerbates the precariousness of refugees (see, for example, Baban et al., 2017; Buxton, 2020).

any other formal citizenship. Naturalisation is only feasible after ten years of uninterrupted residency in Austria (or six years under specific conditions) (Marik-Lebeck, 2021).

3.3.2.2 Restrictive Asylum Policies and the Refugee Policy Crisis following 2015

Austria is among the European countries that have adopted a restrictive approach to asylum regulations. In the course of the transition from a transit country to a destination country for refugees, the 1991 Asylum Act was introduced. It institutionalised asylum as a policy field in Austrian politics. Since then, subsequent reforms, barring the 1997 Asylum Act, have consistently tightened and complicated asylum laws (Gruber, 2017; Merhaut & Stern, 2018; Welz, 2022). During the 2000s, anti-immigration policies were reinforced under two coalition governments between the liberal-conservative and Christian-democratic ÖVP and the right-wing populist FPÖ (then still a splinter group of the Alliance for the Future of Austria [BZÖ]). These policies manifested in stricter naturalisation laws and intensified integration measures. Simultaneously, right-wing populist ideologies portraying immigrants as burdens on the welfare state and security threats gained prominence in public discourse. Against the background of normalised right-wing populist discourse and politics (Liebhart, 2020; Wodak, 2018), subsequent governments continued this trend in the 2010s, including ÖVP-SPÖ coalition governments, which sustained the restrictive trajectory. Measures introduced during this period included more efficient asylum procedures, stronger action against “irregular” immigration, and a greater emphasis on integration as a mandatory obligation (Rheindorf & Wodak, 2018).

In 2014, a reform depoliticised the decision-making process for asylum. Responsibilities previously held by the Ministry of the Interior were transferred to administrative bodies, specifically the Federal Administrative Court and the newly established BFA, which wielded more authoritative powers than its predecessor, the Federal Asylum Office (*Bundesasylamt*) (Küffner, 2022; Merhaut & Stern, 2018). In 2016, an amendment to the Asylum Act (Section 3(4)) allowed for the re-evaluation and potential withdrawal of recognized refugee status three years after the initial asylum decision.

Since 2013, Austria has experienced interrupted periods of government characterised by corruption scandals, early changes of federal chancellors,[42] and a further shift to the right in

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[42] The coalition government between the conservatives (ÖVP) and the social democrats (SPÖ) was led by two different chancellors between December 2013 and December 2017. In 2016, Chancellor Werner

politics. Campaigns regarding the 2017 parliamentary election in Austria reinforced anti-refugee rhetoric. After a period of SPÖ-led governments, the ÖVP formed a coalition with the FPÖ in 2017. The considerable electoral success of these conservative and right-wing populist parties (ÖVP with 31%, FPÖ with 26%) was partly due to their strongly expressed anti-refugee rhetoric leading up to the elections. The ÖVP–FPÖ government leaned towards welfare chauvinism, evident in reduced social benefits for immigrants (Ennser-Jedenastik, 2020). An example of this approach was a flagship project aimed at reforming social assistance. However, the Basic Social Assistance Act, which came into effect in June 2019, faced a setback when the Austrian Constitutional Court declared it unconstitutional in December 2019. The ruling was due to two measures within the law that linked social policies to the objective of restricting immigration: imposing financial disadvantages on families with multiple children (as statistically migrant families tend to have more children than Austrians), and tying social benefits to language proficiency.

The post-2015 refugee policy crisis marked a decisive moment in Austria's shift to the right. Instead of adopting an inclusive humanitarian approach that fosters belonging, policymakers pursued an exclusionary path. Between late 2015 and the subsequent spring, not only the right-wing populist and national conservative FPÖ, but also the conservative ÖVP and later the social democratic SPÖ, transitioned from an initial welcoming stance towards a humanitarian crisis to protectionist and exclusionary immigration policies (Gruber, 2017; Rathgeb & Wolkenstein, 2022; Rheindorf & Wodak, 2018; Rosenberger & Müller, 2020). During this period, parts of civil society in Austria also turned away from solidarity-based practices towards more exclusionary actions (Simsa et al., 2019).

Despite the legal obligations outlined in the 2015 Federal Constitutional Law on the Accommodation and Allocation of Aliens in Need of Assistance and Protection (*Bundesverfassungsgesetz über die Unterbringung und Aufteilung von hilfs- und schutzbedürftigen Fremden*), most *Länder* and municipalities in Austria did not meet the national quota for the reception of asylum seekers. Additionally, the implementation of EU directives in the field of asylum policy has been slow in Austria. For example, the requirement to grant asylum

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Faymann (SPÖ) resigned and was succeeded by Christian Kern (SPÖ). From December 2017 to May 2019, Sebastian Kurz (ÖVP, 31%) was chancellor of a coalition government with the right-wing populist and national conservative FPÖ (26%). Due to a corruption scandal involving FPÖ Vice Chancellor Heinz-Christian Strache, an interim government independent of the party ruled from June 2019 to January 2020. The following chancellor, again Kurz (ÖVP with 37%), formed a coalition government with the Green Party (14%). Kurz resigned in October 2021 due to another corruption scandal.

seekers access to the labour market within nine months of their application was not fulfilled until 2021. With asylum procedures often extending for several years, applicants were denied access during this extended period (Josipovic & Reeger, 2020).[43]

3.3.2.3 Constructing an Austrian “Us” versus a Refugee “Them”

The post-2015 refugee policy crisis reconstructed and solidified a dichotomy between an Austrian “us” and a refugee “them” along several lines such as neediness, race, values and religion. As described in the previous sections, the 2017 to 2019 ÖVP–FPÖ government pursued a policy direction aimed at reducing social benefits for immigrants (Ennser-Jedenastik, 2020). This approach was accompanied by rhetoric that depicted immigrants, especially refugees, as burdens on the Austrian welfare system. For example, Chancellor Sebastian Kurz (ÖVP), who held office from 2017-2019 and later from 2020-2021, claimed in 2019 that every second recipient of minimum social benefits in Vienna was a foreigner, without addressing relevant context, such as the challenges faced by newly recognised refugees in finding employment.[44] At the same time, the FPÖ, as the coalition partner at the time, fostered a narrative portraying foreigners as “welfare scroungers” (*Sozialschmarotzer*) and publicly accused institutions caring for asylum seekers of profiteering, terming it the “asylum industry” (*Asylindustrie*) (Mittelstaedt, 2019).

Moreover, a change in health policy explicitly portrayed refugees as outsiders. The 2020 reform of the General Law on Social Security (§ 31a (8)) mandated that newly issued or replaced electronic health cards (e-cards) for individuals over 14 must include a photo of the cardholder. Although officially justified as preventing insurance fraud, politicians from the FPÖ framed it as a problem caused by non-natives. Beate Hartinger-Klein, then Health and Social Affairs Minister from the FPÖ, argued that the photo on the e-card prevented “people outside Austria from keeping their health at the expense of our welfare state and our taxes” (Austria Press Agency, 2018). This created a divide between Austrians contributing to the welfare state and non-

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[43] In 2021, the Austrian Constitutional Court removed the employment ban for asylum seekers. Subsequently, asylum seekers are now eligible to obtain a work permit three months after submitting their asylum application (Ebner, 2023).

[44] In 2018 in Vienna, around 30% of those receiving minimum social benefits were recognised refugees, while about 5% were individuals eligible for subsidiary protection, totalling 49,349 people (Municipal Department 40 of the City of Vienna, 2019).

Austrians supposedly exploiting it. Notably, the discussion about costly fraud was unfounded, as subsequent calculations revealed.

Additionally, statements by politicians from the FPÖ, ÖVP, and SPÖ in 2015 and 2016 racialised and sexualised refugees through invoking imageries of "foreign masculinity" that portrayed male refugees as security threats (Scheibelhofer, 2017). This aligned with a broader trend across Europe and beyond, framing migration as a security issue (Jaskulowski, 2019).[45] Criticism also centred on refugees having different values than Austrians. The Integration Act (*Integrationsgesetz*) of 2017 tied social benefit entitlements for newly recognised refugees and those with subsidiary protection to mandatory attendance at German courses and courses for orientation and on Austrian values funded by the Austrian Integration Fund (Taubald, 2018). Myott & Vasileva (2020) argued that the courses on values reconstructed identities of "the Ideal Austrian" versus "the Refugee".

Another constructed division between the Austrian "us" and the refugee "them" was based on religion. The 2015 refugee cohort was portrayed as conflicting with "Christian European values", part of a larger trend of increased restrictions on Muslim communities and anti-Muslim racism in Austria. In contrast to this narrative, only 11% of the refugees who arrived in 2015 and the following year indicated being very religious, with high levels of religious tolerance, while 20% indicated not being religious (Buber-Ennser et al., 2018). This emphasis on Christian values conflicts with the diminishing role of Christianity in Austria, especially in Vienna, where the largest "religious group" comprises people without a religion (34%) (Statistik Austria, 2022).

Austria had a longstanding tradition of religious tolerance, evident in its historical documents, such as the 1867 Constitution of the Austro-Hungarian Empire, which guaranteed respect for all religions, and the legal recognition of Islam as a state religion as early as the 1912 Islam Law. However, the 2015 Islam Act signified a significant departure from this tradition, with Islam being increasingly regarded as a threat and Muslims as "the Other" (Mattes, 2021; Sezgin, 2019). From a legal perspective, the Islam Act was criticised for "massively unequal treatment and thus discrimination against Austrian Muslim people as members of a legally recognized religious society" (Dautović & Hafez, 2019, p. 28). I It was also faulted for tightly regulating Islam separately

[45] The article "East-West inequalities and the ambiguous racialisation of 'Eastern Europeans'" (Lewicki, 2023) discusses how the racialisation experienced by the 2015 refugee cohort persists, albeit in different form, for refugees coming from Ukraine since 2022.

from other religions, thereby exacerbating anti-Muslim racism[46] in Austria (Sezgin, 2019). Moreover, Austria's departure from its long-standing tradition of tolerance also encompassed policies, such as the controversial 2016 ban on face veiling and restrictions on headscarves in 2018, as well as political aspects, including the politicisation of Islam in parliamentary debates and the increased emphasis on "Christian Identity" (Mattes, 2021; Sauer, 2022).

In the 2010s, anti-Muslim racism, previously mainly on the agenda of the right-wing populist FPÖ, was taken up by other parties and thus normalised in Austria. The ÖVP and parts of the SPÖ adopted the FPÖ's anti-Muslim stance and supported the Islam Act of 2015 (Liebhart, 2020). The issue of the Muslim religion also made its way into the discourse of a variety of political parties during parliamentary discussions on immigrant integration. In 2007, the FPÖ had a dominant role in this matter, but by 2015, "Muslim integration" had become an issue equally discussed by the ÖVP and the economic liberal party NEOS, which has been represented in the National Council as a new party since 2013. Notably, Chancellor Kurz (ÖVP) significantly contributed to the politicisation of this topic. Around 2014, by then foreign minister, Kurz led a transformation within his party that also marked immigrant integration as a cultural topic (Mattes, 2021).

Noticeably, distinctions between a Christian "self" and a Muslim "other" (Mattes, 2021) were also perpetuated by those who consider themselves as anti-racist, through appealing to a progressive Europe. Abstracting xenophobia and racism from party politics, Opratko (2019) showed how Austrian journalists who considered themselves as liberal and anti-racist also engaged in forms of anti-Muslim racism:

> In contemporary hegemonic discourse about Islam in Austria, Muslims are interpellated as not only immature, but as in a profound sense non-contemporaneous: As subjects of the "not yet". They are not yet where "we" have arrived, they have not yet gone through "our" struggles, and, most importantly, they have not yet learned the lessons of what are assumed to be the defining historical "markers" that constitute the cornerstones of European civilization and/or Austrian national identity. (p. 171)

Acts of racism are framed as protection from security threats, the need to uphold "democratic" and "Western" values, a safeguard against homophobia and sexism, etc. On a more abstract level,

[46] With using the term anti-Muslim racism, I follow Opratko's argument that the more common term Islamophobia wrongly exceptionalises this form of racism (Opratko, 2019, p. 172).

these insights on the Austrian context show how anti-Muslim racism became largely unnoticeable because it is rationalised and given a logical coherence.[47]

3.4 Intersecting Systems: Healthcare for Refugees

Turning to refugees' health needs, the healthcare and asylum systems outlined so far overlap. Asylum seekers and recognised refugees are entitled to the same services as other beneficiaries of the public healthcare system (Knapp, 2019). Furthermore, the Federal Equal Treatment Act (*Bundes-Gleichbehandlungsgesetz*) stipulates that no patient can be discriminated based on ethnicity (Leitner, 2018). I now discuss legal entitlements to healthcare of documented refugees in Austria, covering their access during admission and asylum procedures and after being recognised as refugees. I do not elaborate on the health status of refugees in Austria and barriers to healthcare in practice (for an overview about research on that topic, see Chapter 2). Detailed information on the situation of undocumented or "irregular" refugees, whose circumstances differ significantly from documented refugees, is also be omitted. These persons lack formal entitlements to medical services and can only access free emergency care, having to pay for other health services out of pocket. Moreover, a limited number of hospitals and NGOs offer free medical services to people without insurance (Fuchs et al., 2017; Muckenhuber et al., 2011; Seidler et al., 2019; Stiller & Humer, 2020.).[48] Subsequently, I outline the significance of medical information concerning asylum rights in Austria and highlight particularities in Vienna, the capital and at the same time one of the nine Austrian *Länder*.

3.4.1 Medical Service Provision for Refugees in Austria

3.4.1.1 Initial Medical Examinations in Reception Centres

During admission procedures, medical care takes place in the reception centres. In 2012, the Ministry of the Interior outsourced this care to a private Swiss security company, ORS Service

[47] Thanks to Nisha Zadhy for this thought.

[48] In Vienna, the following organisations are examples for organisations, which offer medical care for persons without insurance: AmberMed (https://www.amber-med.at), neunerhaus (https://www.neunerhaus.at/hilfe/gesundheit/), Louisebus (https://www.caritas-wien.at/hilfe-angebote/obdach-wohnen/mobile-notversorgung/medizinbus-louisebus) and the hospital Barmherzige Brüder (https://www.barmherzige-brueder.at/portal/wien/home).

GmbH, which contracts health professionals. The medical services in reception centres include an initial medical examination within 24 to 72 hours after an asylum application has been submitted and on-site medical care based on personal needs (El-Khatib et al., 2019; Mayrhuber et al., 2016). In 2015, around 53,800 out of nearly 70,000 initial medical examinations in Austria were conducted at the largest reception centre in Traiskirchen. These examinations include the physical examination of vital signs, skin conditions, and injuries, tuberculosis screening via X-ray, and standardised oral questioning about medical history and current medical issues such as chronic diseases, substance addictions, psychological conditions, and medication needs. If necessary, persons are referred to specialists outside the reception centres (Ministry of Interior, 2016). Prior to the initial medical examination, asylum seekers must consent in writing to share their medical data with the authorities.[49] Generally, few information is available on these initial medical examinations. For example, in August 2015, the ORS Service GmbH contracted eleven physicians for the reception centre in Traiskirchen. It was reported that about 4500 residents did not undergo an initial medical examination because of the overcrowded situation by that time. Although voluntary vaccinations are part of these initial medical examinations, they are sometimes not provided in practice. Moreover, general practitioners in the regular healthcare system expressed challenges in receiving medical reports and obtaining information about the content of the examinations and the vaccinations administered (Mayrhuber et al., 2016). Moreover, since the outbreak of the pandemic, Covid-19 were offered.

Regarding care quality, a quantitative study based on data from general practitioners in reception centres suggests that infectious diseases were adequately addressed after the substantial increase in inhabitants in Traiskirchen's reception centre in 2015 (El-Khatib et al., 2019). However, a legal counsellor in Traiskirchen described a lack of systematic recording and treatment of mental health issues, indicating inadequate care in this domain (Kux, 2017). Empirical research on medical services within reception centres is unavailable as access is limited to residents and staff.[50] Initial medical examinations at times deviated from the prescribed protocol; The

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[49] The information on the written consent to medical data sharing was provided by an employee of a large quango in a meeting of an expert group on migration and health in Austria, in which I participated in 2019.

[50] My own empirical research proved limited regarding medical care in reception centres. The responsible Ministry of Interior declined an interview, providing only a brief written statement. Refugee research participants appeared to have trouble recalling details of the initial medical examination due to the overwhelming stress of their arrival or chose not to share, stating that they could not remember. When talking about reception centres, they mostly they addressed their duration of stay, which they described as either lengthy or short (ranging from weeks to just one day). The political representatives interviewed

participants of a meeting of an expert group on migration and health in Austria, in which I participated in 2019, agreed that these examinations often fail to accurately identify health needs – a sentiment consistent with the experiences of social workers interviewed for this study (see Chapter 7).

3.4.1.2 Healthcare Access during Asylum Procedures

In Austria, asylum seekers have access to the same services and facilities as other beneficiaries of the public healthcare system, including public hospitals, SHI-accredited general practitioners, SHI-accredited specialist practices, and psychological care (Knapp, 2019). The 2005 Basic Care Act extended SHI coverage to asylum seekers, persons under subsidiary protection, and persons without a right of residence, who cannot be expelled on legal or factual grounds. The federal government covers their insurance contributions and they are exempted from medication deductibles and other co-payments (Bachner et al., 2018). Asylum seekers are insured with one of the regional SHI funds; in Vienna, with WGKK (in 2020, a reform merged the regional funds into the ÖGK, which by then covered around 84% of the insured population in Austria; see footnote 35) (OECD/EOHS, 2021). They receive the e-card[51].

3.4.1.3 Medical Care for Recognised Refugees

Once refugees are granted asylum, they remain under basic care for a duration of four months (Basic Care Act § 2 (1)). Following this period, they receive the same healthcare entitlements as Austrian citizens under social and healthcare laws. If employed, they pay SHI contributions through their employer and can opt for family members' co-insurance. This means that they have to pay deductibles, such as medication expenses, unless they apply for an exemption due to income falling below the legal threshold. In addition, if a person cannot cover their living

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for this study also had limited information. During one informal conversation, an interviewee expressed a sense that the Ministry of the Interior was not interested in openly communicating the medical protocol of the examinations. In another informal conversation, an employee from the Traiskirchen municipality told me that the Ministry of the Interior declined researchers' requests for observations and interviews at the reception centre. She highlighted the centre's isolation from urban life in Traiskirchen, as it is spatially separated and inaccessible to locals.

[51] In Vienna, asylum seekers directly receive the e-card. In some *Länder* they initially receive a replacement document (Knapp, 2019).

expenses, they can apply for social assistance under the means-tested minimum social benefit system. In such cases, they receive health insurance with WGKK (since 2020, ÖGK; see footnote 35) and are exempt from co-payments such as deductibles (Ministry of Social Affairs, Health, Care and Consumer Protection, 2019). While the federal government covers insurance contributions for asylum seekers in basic care, minimum social benefits are jointly funded by the federal government and the *Länder* (Bachner et al., 2018).

3.4.2 The Relevance of Medical Information to Asylum Rights

Aside from answering to healthcare needs, medical procedures for asylum seekers can significantly impact their claims to social benefits and the granting of asylum. For example, the deportation of rejected asylum seekers may be postponed due to medical conditions. Before deportation, persons must receive clearance from public health officers confirming their fitness to fly. Postponing deportation dates is also justified by the lack of medical treatment options in the home country or necessary medical visits in Austria (Küffner, 2022; Rosenberger et al., 2018).[52]

Furthermore, asylum seekers with increased support needs may receive a place in suitably equipped accommodations. The federal government provides higher supplements to the facility operator for such cases (Glawischnig, 2018). While the special needs of vulnerable asylum seekers are protected under national and international law, claiming these entitlements relies on the accommodation landlord and the person in need or their social carer. Care allowances can be granted to disabled persons (Knapp, 2019).

The European Convention on Human Rights (§ 4) specifies that "[n]o one shall be subjected to torture or to inhuman or degrading treatment or punishment" (European Court of Human Rights, 2021, p. 7). Determining the status of a torture victim requires medical confirmation of related physical and psychological injuries. In Austria, despite the legal requirement (Asylum Act § 30), the medical reports often fail to meet the international standard of the Istanbul Protocol. These reports, usually conducted by court-licensed doctors and psychotherapists lacking specialised training in treating torture victims, lead affected asylum seekers to seek additional reports from other professionals at their own expense. Moreover, the first-instance decision-making

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[52] These cases are not recorded statistically in Austria (in Germany, 141 asylum seekers were not deported for medical reasons in the first half of 2018) (Küffner, 2022).

authorities often do not take psychiatric reports sufficiently into account in practice (Ammer et al., 2013; Knapp, 2019; Uranüs, 2018).[53]

Health facilities occasionally function as instances of control for asylum authorities. Wrist X-rays are employed to determine the age of unaccompanied minors whose documents do not credibly confirm their age (Knapp, 2019). Furthermore, an amendment to the Aliens Police Act (*Fremdenpolizeigesetz*) turned hospitals into control bodies for asylum authorities. Rejected asylum seekers recuperating from medical treatment can legally stay in Austria, delaying their deportation. Since September 2018, the Aliens Police Act (§ 46 (7)) mandates hospitals to report to the BFA the discharge times of aliens facing imminent deportation and update on any changes in discharge schedules (Knapp, 2019; Simoner, 2018).

3.4.3 Particularities of Vienna

Vienna has 1.9 million inhabitants, which accounts for nearly a quarter of Austria's total population.[54] It stands as both the largest city and the most populous of the nine *Länder* in Austria. It has a robust healthcare infrastructure with a remarkably high concentration of doctors, with seven per 1,000 inhabitants (OECD, 2017). Most hospitals and geriatric centres fall under the Vienna Healthcare Group, one of the largest healthcare institutions in Europe. Among these, the Vienna General Hospital (*Wiener Allgemeines Krankenhaus* [AKH]) stands out as the city's largest hospital and one of Europe's largest.

Politically, Vienna has been continuously governed by the social democratic SPÖ since the founding of the Republic of Austria after the First World War, with a notable exception during the Austrofascist regime from 1934 to 1938. From 2010 to 2020, the Viennese government was a coalition between the SPÖ and the Green Party, shifting to a coalition between the SPÖ and the liberal party NEOS since 2020. The capital has a notably high non-Austrian population, with 29.9% of residents (565,000 persons) not holding Austrian citizenship in 2018, compared to 16% for Austria overall (Statistik Austria, 2020a). Notably, 45.3% of Vienna's population either had both

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[53] There is no empirical evidence on the extent to which asylum authorities consider medical reports regarding psychological issues in their decisions. None of the persons interviewed for this study provided specific information on this matter. It should be noted that experiences of physical and psychological violence made on the way to Austria or during the stay in Austria do not impact the courts' decision regarding asylum.

[54] In 2023, Vienna's population exceeded the two million mark again after more than a hundred years.

parents born outside Austria or were themselves born in another country. This is almost twice as high as the national average, totalling 839,800 persons in 2018 (Statistik Austria, 2020b).

In Vienna, measures against social injustices are more institutionally entrenched than in other parts of Austria. Despite the national SPÖ's shift to a more restrictive stance on refugees in 2015, the Viennese government remained committed to human rights principles and avoided populist rhetoric (Rheindorf & Wodak, 2018). Another example of the diverging course between the anti-immigration federal government and the more inclusive Viennese government was the new Basic Social Assistance Act. As described in an earlier section in this chapter, the federal government aimed to introduce language skills as a prerequisite for social benefits and impose financial penalties on families with multiple children. While some *Länder* formulated implementation laws by the end of 2019 as required, the Viennese government rejected these measures (Austrian Broadcasting Corporation, 2019). Austria's federal structure results in varying social benefits for refugees across the *Länder*. Huber and Dellinger (2022) showed that a greater prevalence of integration measures and higher social benefits in Vienna contribute to immigration to the capital: After asylum seekers gain recognition, 44% move to other provinces, with a significant majority relocating to Vienna (88.2%).

3.5 Conclusion

This chapter described the healthcare system and the asylum system in Austria, focusing on healthcare provisions for refugees. Both systems are characterised by fragmentation and a complex governance structure: Austria's federal structures divides legislation and responsibilities between the federal government and the *Länder*. In the field of healthcare, additionally, the self-governing SHI funds play a significant role. The public healthcare system is characterised by high-quality care and equitable access. Financed by higher contributions from the high-income population groups, which compensate for the lower contributions of the poorer population groups, it is often described as based on solidarity. However, concerns arise regarding the growing influence of cost control rationales, potentially eroding this solidarity principle. In the asylum system, the implementation of asylum legislation heavily relies on administrative authorities and quangos responsible for social services such as housing in asylum accommodations. I described how Austria's asylum policy tightened post-2015, accentuating the country's restrictive approach towards refugees amid a strong anti-migration discourse and increased anti-Muslim racism.

It is particularly noteworthy that asylum seekers and recognised refugees receive the same medical services in the same facilities as other beneficiaries of Austrian statutory health insurance, including exemptions from co-payments such as deductibles for medication. Nevertheless, existing research indicates challenges for refugees to access healthcare in practice, citing language barriers and gaps in mental healthcare. This chapter set the stage for a critical discussion of the intersections between generally inclusive health policies and more exclusionary asylum policies in Austria (see also Chapter 1). The chapters on this thesis' findings (Chapters 5–9) discuss what the seemingly incommensurable logics of these two policy fields mean in practice. Before turning to that discussion, the next chapter introduces the methodology underpinning my doctoral work.

Chapter 4: Methodology

4.1 Introduction

This thesis is based on an interpretive approach to studying public policies (Bevir & Waring, 2018; Fischer et al., 2015; Wagenaar, 2011; Yanow, 1996, 2007; see Chapter 1). It examines health policies through the lens of a marginalised group's experiences. Methodologically, I conducted a critical ethnography of policies, centring on refugees' personal experiences and on healthcare practices. This entailed an analysis of how power relations are expressed and challenged through these experiences and practices (Dubois, 2015; Schatz, 2009; Shore & Wright, 2011; see Chapter 1).

The research design sought to achieve coherence among the epistemological assumptions, methodological considerations and methods employed (Carter & Little, 2007). The chosen methods for data collection, including ethnographic fieldwork, qualitative interviews, literature synthesis, and document analysis, were aimed at achieving a comprehensive "thick description" (Geertz, 1973) within an interpretive tradition (Bevir & Waring, 2018; Fischer et al., 2015; Wagenaar, 2011; Yanow, 1996, 2007; see Chapter 1). From the beginning of data collection, data analysis was an integral part of the research process. Analytical tools from grounded theory – constructivist grounded theory (CGT) and in particular, SitA – allowed me to interpret practices within the data (Charmaz, 2006) and to critically examine the interconnectedness of these practices with non-human elements, normative concepts, legal documents, and discourses (Clarke et al., 2018). Approval for my research design was granted by the Ethics Committee of the University of Vienna in July 2018 (reference number 00348). Given the sensitive nature of refugee health, I integrated ethical considerations into every phase of the research process (Spahl & Pot, 2021). These considerations are discussed throughout this chapter.

I want to emphasise that I view refugees as a marginalised group[55] to acknowledge both the shared disadvantages inherent in being a refugee and the personal characteristics that might not

[55] I decided against a number of alternative terms. For example, the term "vulnerable" tends to mark all refugees as vulnerable, instead of perceiving vulnerability context- and person-specific (for a nuanced critique of the conceptualisation of vulnerability in research ethics policies and guidelines, see Racine & Bracken-Roche, 2019). Moreover, I decided against the term "community", used in ethnographic studies that informed my research (Pacheco-Vega & Parizeau, 2018) as this would imply a community of refugees – something that I did not encounter in my fieldwork (see Chapter 6). With my use of the term "group", I

overtly categorise them as vulnerable. By paying attention both to the specific disadvantages that refugees face and to personal characteristics, I nuance generalised understandings of vulnerability. Different refugee participants in my doctoral work were differently vulnerable according to personal characteristics and situational circumstances. For example, I consider Maria – a female recognised refugee from Syria with substantial financial resources, a higher education degree, good conduct of English and a fastly processed asylum application – considerably less vulnerable than Paulin, who, at the time, had been an illiterate asylum seeker living in shared rooms in asylum accommodations for years before his asylum application was rejected.

Throughout fieldwork, I reflected upon on my position as a non-refugee researcher in doing fieldwork with forced migrants (Krause, 2017; Runfors, 2016). I adhered to understandings that foreground multiple positionalities along which trusted relationships emerge and which are constantly renegotiated in the research process (Ryan, 2015; Schiller et al., 2006). For me, dichotomous, one-dimensional understandings of positionality solely based on co-nationality or co-ethnicity have the flaw that they do not grasp other features such as gender, age, and educational status and their consequences on the produced data beyond the refugee status. For example, think about Maria with whom I shared being a young woman and a similar educational background to mine. Such commonalities contributed to reducing interpersonal hierarchies that derived from my position as researcher. Furthermore, the difficulties in the health system are partly the same for refugees and non-refugees. When talking to non-refugee friends and colleagues about the research participants' experiences in the healthcare system, they often expressed having had similar experiences. Similarly, I had already had similar experiences myself in this regard, for example with regard to short consultation times with doctors and relatively long waiting times for appointments.

In the following sections, I first elaborate on this thesis' research design and its empirical methods. The main focus is on my two-year ethnographic fieldwork in Vienna with seven refugee participants. Furthermore, I elucidate my approach to conducting qualitative interviews with care providers, representatives of political parties, and other professionals. Second, this chapter discusses how I employed the analysis methods of CGT (Charmaz, 2006) and SitA (Clarke et al.,

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draw upon scholars who emphasise the constructed, fluid and contingent aspect of groups, while acknowledging that the grouping of persons has real life outcomes for them (Anthias, 2013). In the case of marginalised groups such as refugees, these outcomes may include negative effects on their life chances.

2018) to make sense of the collected data, before concluding with a brief remark on practical and personal challenges that emerged during fieldwork.

4.2 Research Design and Methods

This thesis' research design aimed at generating data on patient experiences, on the perspectives of care providers and of policymakers, and on legal frameworks and guidelines from supranational to city level. This comprehensive approach entailed the combination of: (i) an ethnography of refugees' health experiences; (ii) qualitative interviews with care providers such as doctors and social workers, representatives of political parties, and other professionals; and (iii) a synthesis of literature and document analysis pertaining to legal structures and institutions relevant to refugee health (Figure 10).

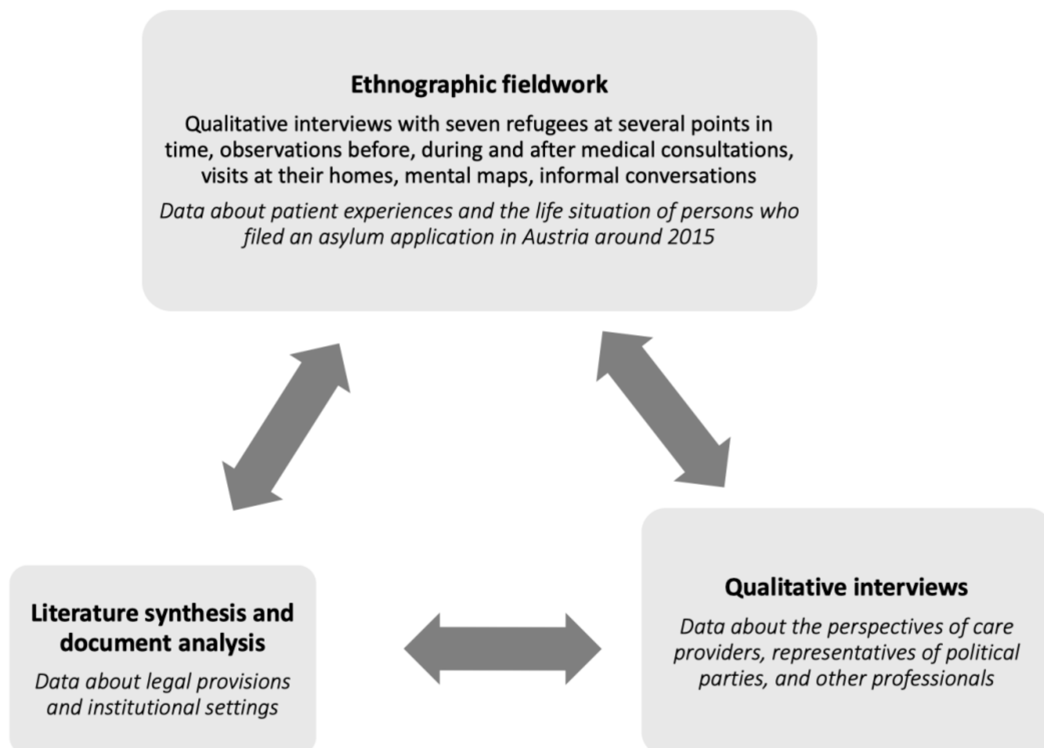

Figure 10. The research design: Combining ethnographic fieldwork, qualitative interviews, and a literature synthesis and document analysis

The research design was informed by seven scoping interviews that I conducted in Vienna between March and May 2018. These interviews included informal dialogues with a refugee, three NGO and social workers, a civil society volunteer, a city level administrator, and a medical

doctor. They were helpful for identifying gatekeepers in asylum accommodation and other places, and they also provided me with an initial understanding of the healthcare institutions that are relevant for refugees in Vienna. Moreover, my active involvement as a volunteer for recently arrived refugees in Austria and Turkey as well as my previous research on refugees' experiences in both countries (Spahl, 2018; Spahl & Österle, 2019; see Chapter 1) prepared me for my doctoral work. Especially, doing fieldwork in Ankara in 2016 provided me with valuable insights into the health needs of refugees originating from Afghanistan, Iraq, and Syria during that period, along with a comprehensive understanding of their living conditions during their transit through Turkey.

When embarking on my doctoral research project in the spring of 2018, I had the aim of creating a comprehensive overview of relevant guidelines, policies, and legal frameworks associated with refugee health. However, the existing literature concerning the intersection of the policy fields health and asylum was limited for Austria. It was difficult to understand the often changing and complex asylum legislation and its intricate links with Austria's fragmented healthcare system, wherein responsibilities are distributed among the SHI funds, the *Länder* and the national level (see Chapter 2). Confronted with these difficulties, I decided to enter the research field empirically. For the time being, I stopped my plan to comprehensively map the legal framework for refugee health and instead, in the autumn of 2018, I began with ethnographic fieldwork focused on the healthcare experiences of refugees. Accompanying them to healthcare appointments familiarised me with medical institutions and care providers whose work I observed during participants' appointments. I only commenced interviews with care providers in the summer of 2019, several months into my fieldwork. In addition to getting to know the perspectives of the care providers, the interviews were helpful in better understanding some data from my fieldwork, the meaning of which had initially not been clear to me. Later, in the summer of 2020, I conducted interviews with representatives of political parties and other professionals.

This sequential approach in collecting data enabled me to ask care providers, representatives of political parties, and other professionals specific questions about ambiguities in the data gleaned from my fieldwork with refugees. This approach also enabled me to delineate pertinent legal frameworks and prevalent discourses through a grounded approach that was rooted in my empirical data. Moreover, approaching the topic through refugees' concrete experiences enabled a closer examination of health-seeking behaviour beyond the boundaries of medical institutions. This perspective allowed to identify missing infrastructures that remained unaddressed by the existing policy measures.

4.2.1 Ethnographic Fieldwork with Seven Refugee Key Research Participants

From November 2018 until August 2020 I engaged in ethnographic fieldwork with seven key research participants (KRPs) in the pursuit of their health needs in Vienna (see Table 1). This included 19 interviews with them at several points in time and 14 observational sessions during health consultations in medical practices and hospitals. Moreover, I gained insights into their health situation through collaboratively mapping health experiences in Vienna, informal conversations, shared experiences such as strolls through the city, and by visiting the KRPs' homes in Vienna.

	Self-chosen pseudonyms	*Gender*	*Approx. age*	*Family Status*	*Health issues*	*Country*	*Interview language*
Asylum seekers	Abdi	Male	20	Single	Troublesome state after rejected asylum application	Somalia	German
	Muhammad	Male	25	Single	Orthopaedic, insomnia, headaches	Afghanistan	German
	Paulin	Male	20	Single	Leg operations after accident, insomnia, headaches	Benin	French
Recognised refugees	Maissa	Female	25	Family	Breastfeeding	Syria	Arabic interpreter
	Maria	Female	35	Single	Anxiety of disease, cosmetic surgery	Syria	German
	Rima	Female	40	Family	Thyroid, cardiac problems	Syria	Arabic interpreter
	Sabah	Female	50	Family	Diabetes, hand operation	Syria	Arabic interpreter

Table 1. Key characteristics of the KRPs, including their self-chosen pseudonyms

The emergence of the COVID-19 crisis in Austria during March 2020 marked the end of the observations during health consultations. The measures implemented to contain the virus prevented any form of accompaniment during medical visits. Whenever the situation permitted, in the summer of 2020 subsequent to the initial lockdown I conducted conclusive interviews with

the KRPs. These conversations centred on their experiences during the health crisis.[56] The longitudinal fieldwork, spanning almost two years, provided me with in-depth knowledge of the KRPs' health situation, including post-treatment, learning processes over time, and the nuanced interplay between their overall life circumstances and their state of health. In the subsequent sections, I discuss my sampling strategy, participant recruitment, and the fieldwork with KRPs, including observations in medical facilities.

4.2.1.1 Sampling

I employed a theoretical sampling approach with the intention of contributing to conceptualisation rather than seeking representativeness. This approach "can be directed to include the broadest range of variation within salient data sources to pursue particular aspects of situatedness, difference(s), and variations" (Clarke et al., 2018, p. 16). When recruiting participants, I aimed at creating at least three embedded cases (Yin, 2003) of three refugees with distinct characteristics, allowing for comparisons of similarities and differences across their various life and health situations. Anticipating potential dropout for various reasons such as psychological distress and deportation, I initially included seven KRPs in the study. Ultimately, only Paulin's participation ended prematurely as he absconded following a negative asylum decision.

The participants had to meet certain inclusion criteria, which included being 18 years old or older, currently residing in Vienna, and having lived in Austria for less than five years. In terms of legal status, they had to possess either refugee status, a pending status application, or a limited right to stay (for example, subsidiary protection). Exclusion criteria included persons who were minors, unable to provide informed consent for various reasons, experiencing acute and severe mental health issues that could impact the validity of their consent, and those whose participation was disapproved by a close family member or someone in the KRP's household. To ensure that the research did not increase participants' psychological stress, I did not recruit KRPs with serious mental health issues, which were defined as those with diagnosed mental diseases or persons

[56] Given the unique circumstances of the pandemic, I chose not to include in this thesis an analysis of the KRPs' experiences during the initial months of COVID-19 measures.

displaying noticeable symptomatic signs of mental health issues, whether diagnosed or undiagnosed.[57]

At the end of 2018, I started with five KRPs, which comprised three single men in the asylum process and two married Syrian women who had received positive asylum decisions. In the spring of 2019, I included Maria in the study to introduce a single woman with higher education as a participant. In the autumn of 2019, the married Syrian woman Sabah was added to the group to collect data from someone over the age of 40.[58]

Due to the inclusion criterion that restricted participants from having lived in Austria for more than five years, all of the KRPs were part of the large cohort of refugees who arrived in Austria around 2015. Their demographic and other relevant attributes largely corresponded to the statistical characteristics of this cohort (see Chapter 2). These KRPs offered a diverse representation across various characteristics, including legal status, gender, age, family situation, housing situation, medical condition, home country, language proficiency, and educational level. While asylum seekers and recognised refugees possess distinct rights within various legal frameworks, I included persons with both legal statuses in my study, as they are generally entitled to the same healthcare services in Austria (see Chapter 2). I also expected that asylum-seeking KRPs might undergo a change in their legal status during the course of the longitudinal research. Furthermore, I was interested in comprehending the shared experiences of seeking asylum and building a life in a host country, common to both asylum seekers and recognised refugees.

When selecting participants, I was attentive to including different forms of vulnerability that were not necessarily linked to illness. I considered these vulnerabilities in terms of intrinsic factors (such as illiteracy and older persons facing heightened health risks) and external factors (such as asylum seekers dealing with uncertain legal status and financial dependence due to restricted work permits) as well as persons with no prior knowledge of the German language. Additionally, I considered relational factors such as reduced autonomy due to dependence on social workers, legal counsellors, and, in the case of family reunification, on the husband. In general, most KRPs

[57] During our third meeting, one of the participants told me that he had been seeing a psychologist for years. The way he talked about this, along with my prior communication with the gatekeeper, led me to conclude that this new information did not warrant his removal from the study. Instead, I interpreted his ongoing psychological consultations as a self-determined practice for managing his mental health, rather than as a sign of acute mental health problems.

[58] While all of the persons I recruited for this study identified either as man or woman, I acknowledge more genders.

experienced multiple vulnerabilities because these factors often intersected, such as when educational level and illiteracy coincided.

4.2.1.2 Participant Recruitment

Recruitment followed a multi-step process, which included gatekeepers reaching out to potential participants, an initial meeting where I met interested persons with a gatekeeper present, and a subsequent period for the KRPs to reflect on their participation. Gatekeepers ensured that KRPs entered the study with a foundation of trust. I recruited each participant through a distinct gatekeeper, with the exception of two KRPs who lived in the same accommodation.[59] The purpose of using different gatekeepers was to assemble a diverse group of participants.

In order to recruit asylum seekers, I sent email requests, containing a clear and concise explanation of my study design, to several asylum accommodations managed by quangos in Vienna. The social workers who responded to my request were generally sceptical and wanted to protect their clients from potentially exploitative research relationships. They explained that refugees in Vienna had been extensively researched following the sharp increase in asylum applications in Austria around 2015 and the subsequent refugee policy crisis. In their experience, the commonly used research methods such as surveys and one-time interviews often did not adequately consider the mental well-being of the participants and sometimes left them with negative feelings revived by the researcher's inquiries. The manager of one accommodation invited me to their weekly staff meeting to present the study to the entire team so they could decide collectively whether to grant me permission to conduct research within the facility. Following some initial scepticism from the social workers present, the long-term research design played a pivotal role in swaying them in favour of supporting my study. They appreciated that this design allowed participants to establish an ongoing relationship with me. This somewhat challenging "audition" within the accommodation prompted self-reflection on my part as a researcher. Additionally, it facilitated my fieldwork within the accommodation since the staff had already become familiar with me. This familiarity made it easier for me to navigate the facility and gain a deeper understanding of the context through informal conversations.

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[59] I doubt that the two asylum seekers who were both contacted by the same gatekeeper were acquainted or had any personal connection. They came from different home countries, had distinct interests, and lived on different floors in a large accommodation. Neither of them asked me about other participants.

I recruited recognised refugees by leveraging my social network in Vienna, which I had cultivated through previous voluntary work and my involvement in a research project on asylum (see Chapter 1). This approach allowed me to sidestep the typical biases encountered when sampling hard-to-reach groups, such as not including persons with limited social connections and no access to support services (Bryant, 2014). For example, Maissa arrived in Austria through family reunification, and at the time of her recruitment she was essentially only acquainted in Vienna with her husband and his friend. I had met the friend during my volunteer work previously and he had introduced us.

The gatekeepers who were willing to connect me with potential participants made a pre-selection based on the inclusion and exclusion criteria I mentioned earlier. I also specifically asked about their assessment of the potential participants' psychological suitability to become KRPs. In most cases, they shared the characteristics of persons they believed were suitable for the study, and upon my expressed interest, they then approached these potential participants to gauge their interest in taking part. To facilitate this process, I provided the gatekeepers with a one-page information sheet for potential participants, presented in easy-to-understand language. These sheets were available in English, German, and Arabic. Notably, non-Arabic-speaking asylum seekers generally already had some knowledge of the German language, as they had been residing in Austria for several years.

In a next step, I introduced myself and the study to potential participants in an initial meeting that was also attended by the respective gatekeeper. For asylum seekers, these meetings occurred in an empty communal area within their accommodation. I met the recognised refugees Rima and Maissa at their respective homes in Viennese apartment buildings, and Sabah at a restaurant of her choosing. During these initial meetings, I introduced myself, explained the project objectives, informed the potential KRPs about the exclusion criteria, addressed any questions they had, and encouraged potential participants to take several days to reflect on their willingness to be part of the study. I also encouraged them to discuss this decision with important people in their lives. Out of eight initial meetings, six persons decided to participate in the study.

There was one exception to this recruitment process. I met Maria when she assisted in interpreting an interview with another KRP, Maissa. She was volunteering as an interpreter in my study. Following the interview with Maissa, Maria and I sat down in a café and it was during that conversation that she expressed her interest in participating in the study as well.

4.2.1.3 Doing Fieldwork with the KRPs

When a participant decided to join the study, I arranged the first interview at the same place where our initial meetings had taken place. This created a pleasant and familiar environment for the participants. These interviews adhered to a loose interview guide featuring various thematic blocks. They were recorded and transcribed verbatim.[60] Consistent with the interpretive epistemology of the project, I employed an "intensive interviewing" approach, which "permits an in-depth exploration of a particular topic with a person who has had the relevant experiences" (Charmaz, 2006, p. 25). Throughout these first and subsequent interviews, I placed emphasis on establishing and maintaining a good relationship between myself and the KRP to ensure that they felt comfortable and to produce meaningful data (Weiss, 1995). My primary focus was on active listening. Whenever possible, I encouraged participants to talk, often using affirming responses like "mm, mm", which fostered the generation of rich data.

> Rich data are detailed, focused, and full. They reveal participants' views, feelings, intentions, and actions as well as the contexts and structures of their lives. (Charmaz, 2006, p. 14)

After the first interview, the fieldwork encompassed a series of follow-up interviews conducted at different points in time. It also involved observations before, during, and after medical consultations, as well as informal encounters, including home visits, walks, and visits to cafés (for an overview of all fieldwork encounters, see Figure 11). The follow-up interviews offered the opportunity to discuss in detail what I had observed during the medical consultations. While I did not rely on interview guides during these interviews, I often prepared specific questions on previous observations and conversations. Throughout the fieldwork, I remained attentive to any signs of psychological distress. Although the option to withdraw from the study was always available, it was not exercised.

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[60] I was lucky to have a budget for transcription expenses but, except for a few cases, I personally transcribed the interviews with the KRPs. This decision was driven not only by privacy concerns but also for practical reasons. Sometimes, the interview locations, such as cafés and outdoor settings, resulted in poor sound quality. Conducting the interviews myself also aided in understanding the recordings because I became familiar with the participants' linguistic styles over time. The flow of conversation in the recordings was frequently interrupted by language challenges, whether in interviews with interpreters or those conducted in German and French (see Table 1 for an overview of the interviews' languages). Furthermore, the interviews often involved non-verbal cues and body language and occasionally intense, emotional moments that were not captured in the audio recordings. Often reminded of these moments when transcribing, I documented this valuable information in my memos.

— Abdi —

1st Interview, 12/2018

2nd Interview, 03/2019

3rd Interview, 10/2019 (incl. mental map)

4th Interview, 08/2020 (Corona)

— Maria —

1st Interview, 03/2019

1st Observation dentist (in Arabic), 03/2019

2nd Interview, 04/2019

3rd Observation dentist (in Arabic), 04/2019

4th Observation general practitioner (in German and Arabic), 09/2019

3rd Interview, 09/2019 (incl. mental map)

4th Interview, 07/2020 (Corona)

— Muhammad —

1st Interview, 12/2018

1st Observation dental centre (in German), 03/2019

2nd Interview, 03/2019

2nd Observation first orthopaedist (in German), 05/2019

3rd Observation second orthopaedist (in German), 05/2019

3rd Interview, 06/2019 (incl. mental map)

4th Observation third orthopaedist at a hospital (in German), 08/2019

5th Observation ophthalmologist (in German) and optician (in Dari), 08/2019

4th Interview, 07/2020 (Corona)

— Maissa —

1st Interview, 11/2018

1st Observation gynaecologist (in German with an Arabic interpreter), 03/2019

2nd Interview, 04/2019

— Paulin —

1st Interview, 01/2019

1st Observation physiotherapy at a hospital (in German), 01/2019

2nd Interview, 04/2019

Absconded after a negative asylum decision before a surgery appointment, 05/2019

— Rima —

1st Interview, 11/2018

1st Observation diabetes check-up at a hospital (in German), 12/2018

2nd Observation diabetes check-up at a hospital (in German), 05/2019

2nd Interview, 09/2019 (incl. mental map)

3rd Interview, 05/2020 (Corona)

— Sabah —

1st Interview, 09/2019

1st Observation ophthalmologist for her daughter (in German and Arabic), 10/2019

2nd Observation general practitioner (in Arabic), 11/2019

Figure 11. Fieldwork data overview, including 20 interviews with KRPs and 14 observations in medical facilities

Obtaining meaningful and rich data for my study and maintaining good relationships with the KRPs over time was a dynamic process. It involved experimenting with different methods and adjusting the research design to align with the needs and expectations of the participants. Originally, my plan was for the KRPs to take the lead in the process after the first interview, contacting me whenever they had relevant health-related matters to discuss or address. As this rarely happened, I regularly reached out to all the participants to inquire about health appointments and arrange meetings. The frequency of our meetings varied, sometimes with several months between them, depending on the KRPs' health concerns and my own availability. It seemed that, for some participants, I served as a reminder to schedule regular medical check-ups.

I had originally intended to conduct interviews with family members and the close social environment of the KRPs, such as roommates and neighbours. However, during the fieldwork, I became hesitant about formally interviewing people close to the KRPs. The participants had shared sensitive personal information with me and I felt it might make them uncomfortable if I also held private discussions with other people they knew. Nonetheless, in the cases of Rima,

Maissa, and Sabah, the perspective of family members in Vienna became a part of my study organically. I had the opportunity to meet them during the fieldwork and they talked to me about their own health problems. For example, Sabah contacted me about an upcoming doctor's appointment, which then turned out to be an eye appointment for her daughter.

Rima's situation was particularly interesting. The first interview with Rima occurred with an interpreter and, at her request, her husband was also present. She consistently spoke of her husband with warmth love throughout the study. When we arrived at their home, besides Rima and her husband, there were two of their children in the living room, who seemed to be happy about the visit and were sent to other rooms by their parents when the interview started. The presence of the interpreter appeared to make the couple somewhat uncomfortable, resulting in a conversation marked by brief responses. Subsequently, during my next meeting with Rima, I accompanied her for a routine diabetes check-up, and I did not bring an interpreter along. Since her arrival in Austria, Rima had been accompanied to medical consultations by her adult daughter, who had come to Austria more than a year before her parents and was already proficient in German by the time I met her. While we were waiting at the hospital, I found Rima more talkative than in the previous encounter with the interpreter, with her daughter serving as an interpreter. In the end, I made the decision to regard Rima as a family unit for analysis, specifically focusing on her role as a mother within the family. Her daughter continued to assist with interpretation in the subsequent interviews.

Originally, I had planned for the KRPs to write down their health needs and their experiences within the healthcare system in health diaries. They were given the option to do this in a language of their choice or to express themselves through drawings or photos within the diary. However, this method turned out to be unsuitable for the context. For example, Muhammad did not want to keep the empty notebook and pens I had brought for this purpose. He explained that handwriting, especially using German letters, was challenging for him, given that he had only learned the language since his arrival in Austria. He did not even want to discuss the possibility of writing the diary in Dari, which could be translated later. Abdi and Rima, on the other hand, accepted the notebook and pens but, like polite host gifts, set them aside and barely listened to the idea of a health diary. During my initial meeting with Paulin, I learned that he was illiterate and had only started to learn to read and write since moving to Europe.

Given these circumstances, I adjusted the mapping techniques to better suit the needs of the participants. While accompanying KRPs to doctor's appointments, I noticed how seeking healthcare served as an active means for them to familiarise themselves with and navigate a new

city. To further explore the role of urban space in the context of my research, I provided KRPs with colourful pens and paper and asked them to draw a map of places that they considered relevant for their health in Vienna. Four KRPs mapped their health experiences. By that time, Paulin had already absconded and I was unable to arrange meetings with Sabah and Maissa before the pandemic led to the conclusion of my fieldwork.

Although the participating KRPs were hesitant to create visual maps, as typically seen in mental maps in geography (Gould & White, 1986), our conversations during the process yielded interesting data. I drew Abdi's map in conversation with him. Muhammed declined to use a pen and was unhappy with me drawing for him, so we exclusively engaged in conversations about the spatial aspects of health relevant to him. Rima (see Figure 13) and Maria (see Figure 13) wrote some words on the paper and explained their meaning, creating a kind of mind-map that conveyed their experiences in a different logic, distinct from the linguistic structure of a typical interview (Wheeldon & Ahlberg, 2019).

Figure 12. Rima's map, the right side translated from Arabic: "– learning the German language, – the future of my children, – we can find work in Vienna, – visit to the doctor, – general health examinations"

Figure 13. Maria's map, translated from German: "– money, studies + work, – health, – a good man, – library + AKH, – friends"

Furthermore, I adjusted my communication to the respective situation and the needs of the KRPs. I spoke German with Maria, Abdi and Muhammad. Maria, as a university graduate from Syria and linguistically proficient, had a strong command of the German language. Abdi and Muhammad had more limited vocabularies and sometimes struggled to articulate complex experiences. The conversations with Paulin, with whom I spoke French, posed similar challenges and I occasionally had difficulty understanding him due to his accent. To address these difficulties when communicating with the three asylum-seeking KRPs, I often repeated what they said in a questioning tone, occasionally using different words. This approach aimed to ensure I had correctly understood what they wanted to express. That seemed to work well because they would correct me when my rephrasing did not align with the intended meaning, sometimes leading to insightful and detailed descriptions. They also often used body language to describe physical impairments, health issues, and other experiences, which I would then verbalise so that the communication was not lost in the later interview transcript. Moreover, through the interviews with the German-speaking participants, I gained valuable insight into the words and phrases they had learned to navigate the Austrian healthcare system.

Interviews with Maria, Rima and Sabah were held with interpreters. Since I had no budget for professional interpreters, I relied on the assistance of volunteer interpreters who generously supported my study. However, working with volunteer interpreters came with several methodological challenges. None of them had formal training as interpreters, resulting in varying quality in their work. Coordinating appointments was also complicated because they had to fit the volunteer work into their schedule. Taking into account these difficulties, I was fortunate that Rima's adult daughter stepped in as an interpreter, as described earlier. Also, I decided not to use an interpreter when accompanying Sabah to her medical appointments as she had a sufficient command of German for us to talk about everyday topics during these situations.

In the chapters on the findings, I made certain language adjustments to the direct quotes from KRPs to enhance readability. I corrected grammatical errors that could hinder comprehension and omitted my follow-up questions from the quotes if they merely received confirmation from the participant without adding new information. In most cases, I rephrased quotes from interpreted interviews into the first-person form to create a smoother reading experience. For example, I converted "she is happy with the health services" to "I am happy with the health services". When relevant, I retained the interpreter's voice in the quotes, for example to emphasise that a participant's statement was provided within the context of a comment made by the interpreter.

This is indicated in the description following each quote. For example, “1st interview, Maissa, interpreted by an interpreter”.

4.2.1.4 Observation in Medical Institutions

Observation before, during, and after the KRPs’ medical consultations was a crucial aspect of my fieldwork. I accompanied them to a total of 14 health appointments at various facilities such as the physiotherapy department of a hospital, an ophthalmologist’s office and a dental centre (see Figure 11). Whenever possible and appropriate during these observations, I took handwritten notes. Furthermore, if time allowed, I would write out the incomplete notes in a Word document immediately after the observation. Observation served as a valuable complement to the interviews. It acquainted me with aspects of KRPs’ health situations that they were either reluctant to discuss or found challenging to express during the interviews, often due to language or emotional constraints. It also provided relevant information about the physical spaces, medical practices, and healthcare staff within the medical institutions.

All KRPs were willing to have me accompany them to their medical appointments. In most cases, we would either meet at their homes or at a convenient public transport stop, and from there we would walk together to the medical facility. The participants were usually familiar with the facility and would guide the way. Even when the KRPs visited a medical facility for the first time, they preferred to find their way independently without asking me for assistance. In a few rare instances, receptionists directed their communication toward me when it came to registering or scheduling follow-up appointments after consultations, instead of addressing the participant directly. I then clarified that my role was solely to accompany the patient and typically stepped aside so they could engage directly with the participant. Although I primarily assumed the role of an observer, I was also actively involved in shaping the situation, understanding my “very presence […] itself (as) a kind of participation” (Aguilera & Amuchástegui, 2014, p. 285).

After completing the registration process, we would proceed to the waiting room, where we spent the majority of our time. The duration of our wait typically ranged from 15 minutes and, in the lengthiest instance, extended to three hours. On a few occasions, such as visits to the ophthalmologist and during a diabetes check-up at the hospital, I also accompanied the participant to several examination rooms, with waiting periods in one or more waiting areas in between. The consultations with the doctors were usually brief, lasting around five minutes, with one lengthier exception of approximately 25 minutes.

During the consultations with doctors, I briefly introduced myself as accompanying the patient as part of a social science study on health needs, without mentioning the word “refugee”. I then provided the doctor with my business card from the University of Vienna, which contained my contact details. Some healthcare professionals inquired with the KRPs whether they agreed to my presence. Contrary to my initial expectations, in most cases, the medical professionals hardly listened to me. Some even interrupted me, suggesting that I simply take a seat in one of the chairs in the treatment room. Throughout my observations, it was common for assistants to open the doors of the treatment rooms and enter without prior notification. On occasions, treatment rooms had no doors to begin with, such as at a dental centre, where they were separated from each other by wider door frames without actual doors. I attribute the general disinterest of both doctors and assistants towards my presence to the fact that they are accustomed to having observers in their working environment. Their training often involves accompanying other doctors and in their everyday work they work closely together with assistants, and relatives as well as other companions are often present. I also had the impression that most healthcare professionals saw their work as “objective” and therefore did not worry about possible criticism of the way they approach, diagnose or treat patients. It seemed to not even occur to them that I would critically analyse their actions.

During the consultations, the doctors rarely seemed to take notice of my presence, with a few exceptions. One doctor turned his gaze toward me and began to discuss Muhammad’s health condition with me. I intervened and explained that I was there solely accompanying him and that he should address the patient directly. A few other doctors smiled at me during the consultations and, in a polite manner, directed their medical explanations to me, much like they would with a family member accompanying a patient. For example, one doctor attempted to uplift Maria, whom he had known since her arrival in Austria, and addressed me as her friend with whom she should enjoy her time to alleviate stress. However, two doctors appeared uncomfortable with the presence of a researcher. A younger doctor, after permitting me to sit in, seemed nervous about my presence. Another older doctor who spoke Arabic openly expressed suspicion about my intentions. It took a few minutes of convincing to assure him that my presence was acceptable to the participant and that I had no intention of portraying him or other foreign-speaking, non-Austrian doctors in a negative light. This doctor was also the only one who made general comments during the consultation about how he treats refugee patients and what the particular challenges are for this group of patients.

When I initially informed KRPs about my study, I told them that I would always leave the room if they wished me to, especially during examinations that required undressing. I also reminded them of this when accompanying them to medical facilities. Throughout the fieldwork, I was only present during relatively non-invasive medical examinations, such as eye and blood tests. There was one exception with Paulin's physiotherapy appointment at the hospital. Upon entering a spacious room with treatment tables, separated by curtains, Paulin's physiotherapist warmly greeted him and directed him to one of the treatment tables. Simultaneously, she indicated a chair for me in the same area. To my surprise, Paulin swiftly removed his shoes, trousers, and shirt, remaining in just his underwear. I felt caught off guard and somewhat uncomfortable in this unexpected situation. But since I did not want to make Paulin feel uncomfortable, I chose to remain seated, observing the surroundings and taking notes in my notebook during the three-quarter hour treatment.

The majority of the medical staff communicated with the KRPs in German. As previously mentioned, Maria had an interpreter accompany her to the gynaecologist. Maissa's dentist spoke to her only in Arabic and did not address me at all. Muhammad's optician switched to Dari upon realising it was a more accessible language for his client. Three Arabic-speaking doctors initially spoke to the KRPs in German, emphasising the importance of learning German. They only switched to Arabic when their patients had difficulty understanding certain information.

Finally, the time following the departure from the medical facility provided valuable insights. The participants and I often found a bench or a café to sit and talk about how they had felt. In some cases, these discussions revealed disparities between the KRPs' behaviour in the health institutions and the emotions they expressed after the appointments. For example, during the first orthopaedic appointment I accompanied Muhammed to, he remained calm and polite. However, after leaving the building, he erupted in frustration. He expressed his exhaustion with the specialist's inability to alleviate his condition and the ineffectiveness of the painkillers he had been repeatedly prescribed.

4.2.1.5 Relationship with the Refugee Participants

I would describe my relationship with the KRPs as a warm and respectful research relationship. During my visits to their homes in Vienna or when we had walks or visited cafés after interviews or medical appointments, we often had casual conversations and laughed together.

The topic of health, particularly when accompanying KRPs to medical examinations, often prompted them to show me their vulnerable sides and share personal experiences with me. In most cases, there was a desire to share experiences, even on everyday topics, primarily related to their lives in Austria. There was one notable exception, Maria, who remained rather reserved in her communication throughout our encounters. Our interpreter, who was also Syrian, suspected that Maria might not have been accustomed to discussing her feelings and experiences openly. Some KRPs also asked about my life, but my responses were usually brief, and we would then go back to our typical conversational mode, with the participants sharing stories about their lives.

I found it surprising that none of the KRPs asked me for help for their healthcare or everyday needs, such as understanding complex official letters. However, I provided help in locating a nutritionist, wrote a confirmation of study participation for an asylum seeker, and offered a debriefing after a medical appointment to reiterate the information conveyed. On one particular occasion, during an interview, Maria mentioned that she had no one to accompany her to the gynaecologist to interpret for her. Consequently, both the interpreter and I accompanied her to a subsequent gynaecological appointment. While the translator went with Maria into the treatment room, I cared for her baby in the waiting room.

To conclude the fieldwork on a positive note and in a respectful manner, I arranged a final meeting with the KRPs, extending my gratitude by inviting them for coffee. During this meeting, I provided each participant with a personal thank-you card, effectively marking the end of their involvement in the study. In these cards, I offered to reach out to me if they ever required legal or medical guidance, which I could help facilitate. This offer was intended to keep the lines of communication open for future needs.

4.2.2 Qualitative Interviews with Care Providers, Representatives of Political Parties, and Other Professionals

Between July 2019 and January 2020, I conducted nine qualitative interviews with care providers, including medical professionals and social workers (interviews 1 to 9, see Table 2).[61] I regard these professionals as street-level bureaucrats (Dubois, 2015; Lipsky, 1980) who are responsible for

[61] The majority of the interviews with care providers, representatives of political parties, and other professionals were transcribed by a commissioned professional who guaranteed me confidentiality.

implementing the formal regulations of the legal framework and guidelines in their day-to-day activities. Most of these interviews took place at the workplaces of the care providers, allowing me to gain valuable insights into the specific care settings, which I documented in my notes.

Care providers		*Contacted via*	*Language of care*
1	Optician	KRP's medical appointment	German, Arabic
2	Orthopaedist	KRP's medical appointment	German
3	Pharmacist	Displayed business card at an Arabic-speaking doctor	German, Arabic
4	General practitioner	Referral from interviewee 4	German, Arabic
5	Social worker large accommodation	Gatekeeper for KRP	German
6	Social worker special needs	Gatekeeper for KRP	German
7	Integration course trainer (including observation in two courses at the Austrian Integration Fund)	Targeted request	German + interpreters
8	NGO psychologist	Targeted request	German + interpreters
9	NGO health trainer	Targeted request	German, Arabic
Representatives of political parties		*Contacted via*	*Level of governance*
10	FPÖ politician (focus: health)	Targeted request	City level in Vienna
11	NEOS advisor in the National Health Commission	Targeted request	National level
12	Green Party politician (focus: health)	Targeted request	National level
13	SPÖ politician (focus: integration)	Targeted request	National level
14	NEOS politician (focus: health)	Referral from interviewee 11	City level in Vienna
Other professionals		*Contacted via*	*Level of governance*
15	Member of the coordination platform at GÖG	Referral from the Ministry of Health	National level
16	Two doctors at the Viennese Medical Chamber	Targeted request	City level in Vienna
17	Director advice centre (publicly financed counselling for newly recognised refugees)	Referral from the Ministry of Health	City level in Vienna
18	Employee at the Vienna Refugee Aid (department of the Vienna Social Fund)	Referral from the office of the City Councillor for Social Affairs, Health, and Sport	City level in Vienna

Table 2. Qualitative interviews with care providers, representatives of political parties, and other professionals with expertise on refugee health in Austria

Recruiting interviewees proved to be challenging, with a low response rate. On the one hand, I recruited interviewees through chance encounters during my ethnographic fieldwork. Two doctors became interviewees after treating some of the KRPs whom I accompanied and subsequently responding to my email inquiries (interviews 1 and 2). I obtained the pharmacist's contact information from a business card displayed at the reception of an Arabic-speaking doctor, who I also accompanied the KRP to. After the interview, the pharmacist provided me with the phone number of an Arabic-speaking general practitioner friend (interviews 3 and 4).

I interviewed two social workers who held positions in separate asylum accommodations managed by different organisations (interviews 5 and 6). These two social workers also served as gatekeepers for three of the KRPs. During the interviews, the social workers did use the KRPs as examples to illustrate pertinent aspects of refugee health and I posed specific questions that had emerged during my fieldwork. However, it was important to them and me to protect the privacy of the KRPs and we were careful not to share sensitive personal information about them.

On the other hand, I employed theoretical sampling (Charmaz, 2006). In the course of my fieldwork, linguistic and cultural aspects proved to be crucial. Throughout my fieldwork, I found that linguistic and cultural considerations played a pivotal role. To identify potential interviewees, I reached out to Arabic and Farsi-speaking doctors whose contact information I obtained from brochures, business cards in medical offices, and online search. Unfortunately, aside from the aforementioned pharmacist and one general practitioner, I received no responses from the doctors I contacted in that way. Finally, three of the interviewees worked for specialised institutions that played a vital role in refugee care (interviews 7 to 9).

Furthermore, between July and October 2020 I conducted interviews with five representatives of political parties (interviews 10 to 14, see Table 2) and four other professionals (interviews 15 to 18, see Table 2) at both the city and national levels. My aim was to interview representatives of all political parties that held seats in the Austrian Parliament at that time. With the exception of the ÖVP[62], the party of the then chancellor, I interviewed representatives from all the other parties in the Austrian Parliament: SPÖ, Green Party, FPÖ, and NEOS. Furthermore, several institutions relevant to the issue of refugee health declined to participate in the study, including the Ministry of Health (for a discussion of the declining institutions see Chapter 1). The Ministry

[62] The ÖVP did not respond to my numerous inquiries and follow-up reminders directed at politicians at the city, *Länder* and federal levels, whose contact details I found on the internet. This also applied to consultative ÖVP staff members whose contact details I acquired during my field research.

of the Interior only agreed to respond to written questions, following an extended email exchange. Their response came in the form of a three-page electronic document from the department responsible for basic care for asylum seekers and for recognised refugees for the initial four months following a positive asylum decision (see Chapter 3). I included this document in my data analysis, alongside other publicly accessible and internal documents and guidelines that were referenced by the interviewees.

All 18 qualitative interviews were conducted in German and the conversations typically ranged from one to two hours in duration. An exception was the interview with the integration course leader (interview 7) who left after just half an hour due to another commitment. They interview style was intensive as described in an earlier section in this chapter. I aimed at collaboratively constructing meaningful and rich data and encouraged interviewees to talk freely (Charmaz, 2006; Weiss, 1995). I actively facilitated the flow of conversation and frequently posed follow-up questions to elicit further details and examples. The interviewees were generally eager to talk, readily sharing their professional experiences and personal perspectives on the topic. Our meetings mostly took place in the interviewees' offices, but also in cafés. Two interviews were conducted online.

I always started the interviews with the care providers by asking about their job title and whether they could guide me through a typical workday. When conducting interviews with the political party representatives and other professionals, I initiated the conversation by inquiring to what extent the health needs of refugees played a role in their daily professional responsibilities. If not already mentioned by the interviewees themselves, the interviews then followed a loosely structured interview guide that encompassed various thematic blocks. These thematic blocks included measures taken by the interviewee's workplace concerning refugees and their particular health needs. As for representatives of political parties and other professional groups, the thematic blocks included the initiatives and overall position of their political party or organisation in relation to the health needs of refugees and a contextualisation of the issue in the broader political landscape in Austria and beyond. Moreover, all interviewees were asked about the general measures in the Austrian healthcare system regarding refugees. In addition, I prepared specific detailed questions tailored to the respective interviewee, such as questions for social workers regarding asylum seeker accommodations.

I obtained informed consent from the care providers, representatives of political parties and other professionals, mostly in written form. In cases where interviews were conducted online during the pandemic, consent was obtained orally. Furthermore, I implemented appropriate

measures to safeguard their privacy. To protect their anonymity, I sometimes changed minor characteristics in writing up my findings. For example, I indicated that care providers were proficient in Arabic without specifying their home country. When describing the healthcare facilities and asylum accommodations where care providers worked, I used fictitious details that blended features from various places to ensure anonymity (see, for example, Fassin, 2014). In the case of political party representatives and other professionals, despite my use of pseudonyms, it is possible that persons familiar with the field may recognise them. They were informed of this possibility.

4.3 The Analysis Process: Combining Situational Analysis and Constructivist Grounded Theory

For analysing my data, I combined SitA (Clarke, 2003; Clarke et al., 2015, 2018) with CGT (Charmaz, 2006). This approach aligned with my interpretive epistemological perspective (Bevir & Waring, 2018; Fischer et al., 2015; Wagenaar, 2011; Yanow, 1996, 2007; see Chapter 1) and enabled me to analyse diverse types of data, integrate in-depth empirical research with conceptual work, and to research refugees' health from a critical standpoint.

4.3.1 Theoretical Foundations and Analytical Foci

SitA and CGT are two grounded theory approaches. In 1967, the sociologists Barney Glaser and Anselm Strauss (2017 [1967]) published the influential book *Discovery of grounded theory: Strategies for qualitative research*. They critiqued the dominance of quantitative methods in social science, which often relegated qualitative research to mere description and the deductive application of pre-existing theories. Instead, Glaser and Strauss advocated for the idea that qualitative research could contribute to theory development. Since the publication of their groundbreaking work, various grounded theory approaches have emerged, each differing in terms of their underlying epistemology, the researcher's role, and the specific focus of their analysis.

Kathy Charmaz's version of CGT, developed from the 1990s onward, was particularly influential. It integrated the interpretive turn in grounded theory. Earlier grounded theory approaches focused on understanding how research participants constructed meaning but did not emphasise the active role of researchers in this process. CGT "explicitly assumes that any theoretical rendering offers an interpretive portrayal of the studied world, not an exact picture of it"

(Charmaz, 2006, p. 10). This perspective emphasises that the production of scientific knowledge is also an act of interpreting reality.

SitA., a grounded theory approach developed by Adele Clarke and colleagues over the past two decades, shares significant commonalities with CGT. Both SitA and CGT are interpretivist grounded theory approaches and were previously used in complementary ways (Rieger, 2019). In both approaches, researchers collect and analyse empirical data simultaneously. They employ an abductive approach, where empirical findings and theoretical insights mutually influence each other in an iterative manner. SitA and CGT guide researchers to continually move back and forth between the data and the development of concepts throughout the analysis process to arrive at the "most plausible explanation" (Charmaz, 2006, p. 104) of what the data mean.[63] Moreover, key components of CGT – including memo-writing, theoretical sampling, systematic comparisons, and coding – were integrated into SitA (Clarke et al., 2018; Mathar, 2008).

SitA and CGT partly differ in their basic assumptions and analytical focus. While CGT follows the earlier grounded theory tradition of seeking a concise categorisation for all collected data, SitA aims to explore differences and avoids simplifying complex data into commonalities (Clarke, 2003), owing to its underlying postmodernist and feminist principles (Clarke et al., 2018). Additionally, CGT, influenced by symbolic interactionism, focuses on actions and practices, emphasising "basic social processes" captured through codes (Charmaz, 2006). In contrast, SitA concentrates on situations as the primary unit of analysis. This can encompass a wide range of elements such as humans, non-humans, technologies, discourses, and symbols and their relationships. The approach offers three cartographic tools: situational maps, social worlds/arenas maps, and positional maps. Regarding the diversity of elements encompassed in this thesis, I perceived that the inclusion of a wide range of elements in the SitA maps, coupled with the advocated flat ontology approach, allowed for a creative and comprehensive analysis of these diverse elements in an intuitive manner.

Grounded theory has a rich history of researching health-related topics that dates back to the its "discovery" by Glaser and Strauss (2017 [1967]). Equally, Kathy Charmaz developed her grounded theory approach within the context of the social studies of health and illness. Similarly, SitA has been recognised as well-suited for interpretively researching healthcare (Fulton & Hayes, 2012),

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[63] In their book on abductive analysis, Tavory and Timmermans (2014, pp. 10–17) argue that CGT and SitA, despite incorporating more theoretical assumptions and concepts compared to the early grounded theory methods, still maintain a foundation in the inductive tradition.

enabling the study of complex systems relevant to public health in real-world settings (Martin et al., 2016).

Furthermore, SitA has an explicit emancipatory aim that aligns with the critical approach taken in this study's policy analysis (Fischer et al., 2015; see Chapter 1). SitA aims to provide insights into power dynamics and engage in a critical discussion of the data collected within broader social structures. SitA hopes to overcome inequities with

> methodologies that take individual and collective difference(s) into account in social life in order to generate more just and equitable social policies from education and welfare reform to health coverage, from caregiving to social security in old age or disability. (Clarke et al., 2018, p. 14)

Social studies of health using SitA have placed a strong focus on issues of equity. This includes addressing gender-based violence (Mainey et al., 2022; Reisenhofer & Seibold, 2013), disparities in maternity care (Baron et al., 2016; Tripathi et al., 2019), service provision for people with disabilities (Tekola et al., 2016), care for people with HIV (Ngwenya et al., 2019) and cardiovascular health among people of colour in the US (Shim, 2000).

4.3.2 Analytical Tools

For my data analysis, I adopted a flexible approach by combining various analytical tools from SitA (situational maps and social world/arena maps) and CGT (initial and focused coding). I did not follow a strict step-by-step process. Instead, I employed an abductive approach, allowing the research design and analysis to evolve as the study unfolded. I started the analysis from the very beginning of data collection and continuously adapted my analytical strategy as I collected new data and new insights emerged. In this methodology, I was also inspired by Karen O'Reilly's (2011) iterative-inductive approach to ethnographic research in that data analysis "moves steadily forward yet forward and back at the same time" (p. 27).

As I did not separate the analytical tools I used in terms of time or process during the research, the following sections are presented sequentially for the sake of clarity and explanation. Throughout the analysis process, I regularly engaged in discussions about my analytical ideas with my supervisor and colleagues and at various academic events, including workshops, conferences, and doctoral student courses. To make sense of my data, it was particularly valuable to discuss my situational and social world/arena maps and my coding of selected interview passages in a self-organised analysis group with doctoral student colleagues.

In addition to employing mapping and coding techniques, I used memo-writing as a complementary analytical tool. Memo-writing, originally developed by Kathy Charmaz for CGT and endorsed in the SitA approach, involves creating written text where researchers describe connections between various aspects of their data, document unexpected insights, and formulate conceptual ideas. In this process, the act of writing itself functions as an analytical tool. Memo-writing is an informal and spontaneous practice, undertaken in plain language for personal use right from the outset of data collection. Often, particularly relevant memos are further developed in the context of collecting new data, compared to other parts of the data and related to existing concepts and theories (Charmaz, 2006).

4.3.2.1 Analytical Tool I: Situational Maps

In January 2019, two months after beginning with ethnographic fieldwork, I created the first situational map for this study.

> The analytic focus of a situational map is the situation broadly conceived. The core goal is to descriptively lay out all the human and nonhuman elements in the situation of inquiry. The questions are: Who and what are in this situation? Who and what else may matter in this situation? What other elements may make a difference in this situation? (Clarke et al., 2018, p. 127)

Situational maps are intentionally messy and do not aim to simplify. Instead, they aim to capture the elements relevant to the situation that is researched. I created a total of 18 such maps between January 2019 and June 2020 (for the last version, see Figure 14). For creating the maps, I used PowerPoint software, which allowed me to insert, expand and delete elements as I collected new data and gained new theoretical insights. Each version of the map corresponded to a slide in the software. The basis for my changes on the map were insights gained during the research process and during CGT coding of the collected data (described in detail below). The commenting function within PowerPoint slides was useful for documenting notes about my changes and for writing memos, which helped me record analytical decisions and later reflect on them. To facilitate that process, I colour-coded elements that I addressed in the comments for each version.

Figure 14. Last version of the situational map for my doctoral work (June 2020)

The situational maps encompassed a broad range of elements, including "human, nonhuman, discourses, historical, symbolic, cultural, political, and other elements in the research situation of concern." (Clarke et al., 2018, p. 17). These maps served to synthesise diverse data from the different sites of the study into an overview of my research topic. They were helpful for constructing the "situation" of refugee health in Austria. To illustrate, I added the discursive element "Young men should work" to the map because it was a prominent statement in my data. It had been articulated by some KRPs, interviewed representatives of political parties and was prominent in the media discourse in Austria. Another instance is the physical object "e-card" on the map, the Austrian electronic health insurance card.

Another element on the situational maps was "Wanda Spahl". By positioning researchers an integral part of the studied situation, SitA highlights their role in shaping the research outcomes and promotes self-reflection among researchers. In addition to this, I included relevant concepts like "solidarity" on the map. Throughout the study, I was a member of a research group on solidarity and believed that this concept would have relevance in my research.[64] The process of

[64] From March 2018 until September 2022, I was a member of the Centre for the Study of Contemporary Solidarity, Department of Political Science, University of Vienna, led by my supervisor Barbara Prainsack.

thoughtfully reconfiguring the situational map and drawing relationships among its elements was useful to critically reflect on the suitability of the concept in the context of my research (for my empirical findings on solidarity, see Chapter 7).

In some maps, I narrowed my focus to the situation of specific KRPs or conducted an analysis of particular interviews. To do this, I placed coloured boxes around particular elements on the map, shaded out irrelevant elements in grey and added lines connecting elements that thematically shared a connection based on the data. In SitA, this emphasis on the relationships between elements within the situational maps is referred to as "relational maps" (see Figure 15).

Figure 15. Working with situational maps (complementing, deleting, remodelling, and memo writing)

4.3.2.2 Analytical Tool II: Social World/Arena Maps

As I created the first situational map, I simultaneously started working on social world/arena maps to gain insight into the institutions, organisations, and collective groups that are relevant for refugee health in Austria.

> [S]ocial worlds/arenas maps lay out all of the collective actors and the arena(s) of commitment within which they are engaged in ongoing discourse and negotiations. Such maps explicitly analyze social, organizational, and institutional dimensions of the situation relying on interpretive assumptions: We cannot assume directionalities of influence; boundaries are open and porous; negotiations are fluid; discourses are multiple and potentially contradictory. (Clarke et al., 2018, p. 18)

Over a span of 20 months, from January 2019 to August 2020, I complemented and remodelled the situational world/arena map for this study using PowerPoint. Figure 16 shows the last version of the map. It centres on the differentiation between two intertwined arenas: the "asylum system" and the "healthcare system".

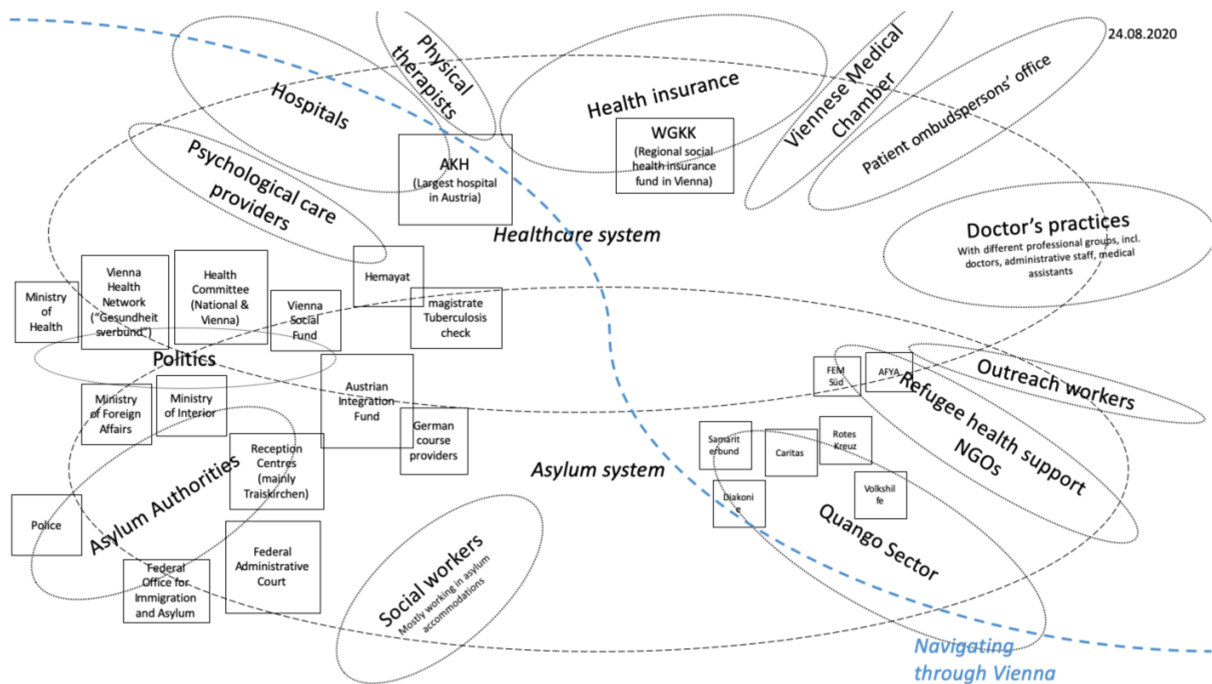

Figure 16. The last version of the social world/arena map for my doctoral work (August 2020)

In the context of SitA, arenas are stable infrastructures that constitute themselves via organisations (depicted as angular shapes, such as "Ministry of Interior") and social worlds (depicted as rounded shapes, such as "psychological care providers"). I linked some of the

organisations to specific social worlds (for example, the outer boundary of the organisation "Ministry of Health" extends into the social world "Politics"). Some elements are positioned at the intersection of multiple worlds or arenas. For example, the organisation "Hemayat", a Viennese association providing psychotherapy in the native language to survivors of war crimes and torture, is located within both the "asylum system" and "healthcare system" arenas.

Notably, refugees themselves are not depicted on the map, as I regard them as "implicated actors" (Clarke et al., 2018). In my ethnographic fieldwork, I rarely encountered self-identification as a refugee, and when I did, it was expressed reluctantly. "Refugees" were rather constructed through other elements, such as political texts and social workers. The blue line labelled "Navigating through Vienna" symbolises how KRPs navigate the social worlds and organisations within both the asylum and healthcare systems, representing both a metaphorical process and actual physical movement throughout the city.

4.3.2.3 Analytical Tool III: Initial Coding

I applied CGT coding to analyse the transcribed interviews with the KRPs, care providers, political party representatives and other professionals, as well as for the observation notes. I systematically incorporated the gathered data into a progressively expanding project repository using ATLAS.ti, a qualitative data analysis software, and concurrently coded my data alongside the ongoing collection of new data.

> Coding means naming segments of data with a label that simultaneously categorizes, summarizes, and accounts for each piece of data. Coding is the first step in moving beyond concrete statements in the data to making analytic interpretations. (Charmaz, 2006, p. 43)

In CGT, the first step of coding is initial coding, which is a spontaneous process aimed at understanding the data's meaning. These initial codes closely reflect the participants' expressions and mostly take the form of gerunds. As Charmaz describes it, the purpose is to "mine early data for analytic ideas to pursue in further data collection and analysis" (Charmaz, 2006, p. 46). In this study, I employed initial coding by going through the data line-by-line and assigning codes (see Figure 17, which includes examples such as the codes "planning the future via health encounters" and "using the e-Card"). While coding, I also captured analytical insights related to specific segments and codes by creating comments and writing memos, using the comment function provided by ATLAS.ti.

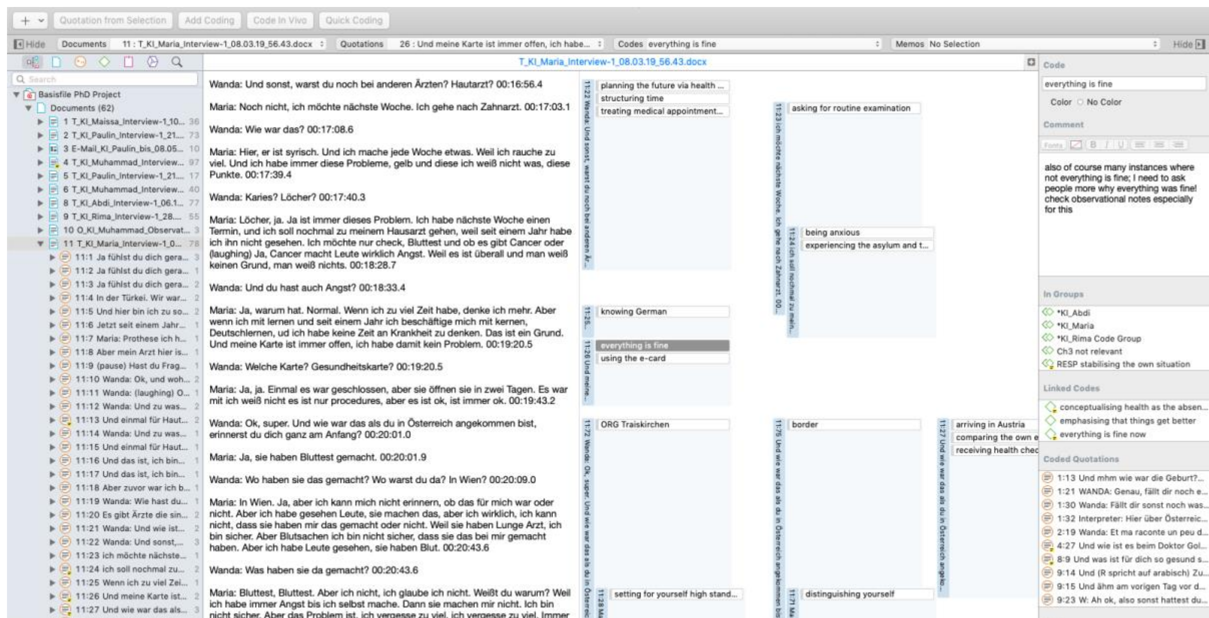

Figure 17. Coding interviews and observational notes with the software ATLAS.ti

After coding a few interviews, I began to consolidate similar codes, merging them into single codes to eliminate redundancy in cases where the wording was only slightly different. Additionally, I started grouping multiple codes into thematic categories to gain a comprehensive overview of the material and identify recurring themes discussed by the participants. For instance, I created a thematic group called "place-making", which encompassed codes like "extending one's space to the city", "navigating Vienna" and "needing time to adapt". These structuring efforts went simultaneous with my ongoing process of initial coding of newly added interviews.

In addition to these procedures aligned with CGT coding, I introduced codes that corresponded with the SitA mapping techniques, diverging from the CGT approach. While CGT primarily focuses on actions and practices, SitA takes into account other elements as well. Consequently, I coded interview segments that I had included in my situational maps and that conveyed relevant discourses. For example, I employed the code "everything is fine". Moreover, I collected information for the creation of social world/arena maps by marking mentions of organisations with the prefix "ORG", for instance, coding passages related to the Traiskirchen reception centre "ORG Traiskirchen".

4.3.3 Developing Theory: Focused Coding and Re-Mapping

In the tradition of grounded theories, I aimed at building theory empirically through qualitative research. As I began to analyse my data, I soon formed conceptual ideas and decided to develop them further. I took promising comments and notes I had written down during the SitA mapping and CGT coding phases and transformed them into more comprehensive text. In parallel, I engaged these evolving ideas in a dialogue with my empirical data. In the words of SitA developer Adele Clarke and colleagues:

> [T]he researcher *tacks back and forth* between the nitty-gritty specificities of *empirical* data and more *abstract conceptual* ways of thinking about them, looping back and forth. Over time, through working with the data and generating conceptual possibilities for handling that data more theoretically, the analyst *conceives, refines, selects, rejects, and ultimately connects robust concepts toward theorizing* a substantive area. (Clarke et al., 2018, p. 28)

Based on the respective conceptual idea, I created text documents in ATLAS.ti. These documents contained segments of codes that were pertinent to the idea, along with the comments I had previously attached to these codes and segments. I proceeded to work through these text documents line by line, aiming to refine the conceptual idea or discard it if the empirical data contradicted it. Additionally, I refined promising conceptual ideas by re-reading interviews and observation data that I had coded before and scrutinising them with the respective conceptual idea in mind. For instance, well after I had completed the fieldwork and authored most of the chapters on the empirical findings in the autumn of 2022, I revisited all the data to further develop the concept of the citizen-state nexus, as addressed in Chapter 9. I selected relevant passages and introduced new codes as needed. These steps involved testing conceptual ideas against the data and largely aligned with the focused coding approach characteristic of CGT.

> Focused coding means using the most significant and/or frequent earlier codes to sift through large amounts of data. One goal is to determine the adequacy of those codes. (Charmaz, 2006, p. 57)[65]

I used SitA mapping techniques to further develop my project and keep track of new findings and analytical decisions about which parts of the data warranted more detailed examination and

[65] I hesitated in applying the second goal of CGT focused coding, which entails creating a comprehensively categorisation the whole data set. Unlike CGT, SitA seeks to highlight differences within the data and recognises them as valuable outcomes of the research. Following this aim, I did not try to fully encapsulate my data within a single, all-encompassing category.

which ideas were worth pursuing in my analysis. The flexibility of adjusting the general situational map by introducing new elements, removing others, and establishing relationships between elements allowed me to dynamically integrate new empirical data and evolving analytical ideas. This process harmonised well with the study's broad and dynamic understanding of health (see Chapter 1) and with my theoretical sampling strategy, which I employed to follow-up on intriguing findings that emerged during the study. Furthermore, I remodelled situational maps in close conjunction with the formation of CGT codes, their organisation into thematic groups and the process of making sense of them. This interplay between mapping and coding helped to refine insights and develop themes that ultimately laid the foundation for the argumentation presented in the chapters on my findings (Chapters 5–9).

4.3.4 Methodological Approach and Data Used in the Five Chapters on my Findings

My empirical insights largely emerged inductively. The first two chapters on the findings, Chapters 5 and 6, focus on the life situation of refugees in Austria. Listening to their health concerns and what they perceive as contributing to their well-being, I began to notice factors and practices that extended beyond institutionalised healthcare. These chapters are based on the interviews with the seven refugees at the centre of my fieldwork as well as my observations within their homes and informal conversations that took place while accompanying them to medical appointments. Moreover, in Chapter 5, which addresses "everyday health risks", insights from qualitative interviews with healthcare practitioners, social workers, and other care providers helped to better understand the refugees' subjective experiences.

The last three chapters on my findings focus on data about experiences and practices within the healthcare system. Chapter 7 deviates from the primarily inductive methodological approach and predominantly utilises a deductive approach. In this chapter, the analysis was guided by a theoretical interest in lived forms of solidarity, employing a coding framework based on a practice-oriented approach to solidarity (Prainsack & Buyx, 2012, 2017). Empirically, this chapter draws from observational notes taken during medical appointments I attended with refugee participants and interviews with care providers. The former offers firsthand accounts of care practices from my perspective, while the latter provides insights into the rich experiences of care providers and sheds light on what motivates their practices.

Chapters 8 and 9, on the other hand, scrutinise inductive insights I obtained from analysing the data concerning experiences and practices within the healthcare system. Chapter 8 can be seen

as an extension of incidental insights I gained from the deductive analysis of solidaristic practices in Chapter 7. In Chapter 7, I showed how health professionals, social workers, civil society actors, and fellow refugees take time and emotional effort to overcome practical barriers to accessing the medical services refugees needed. During the analysis of solidarity within the data, I was confronted with an unexpected divergence in perspectives between care providers and refugees. Care providers predominantly focused on how to aid patients who might otherwise lack access to care. However, for refugees, a different dimension of medical care held greater significance. Their narratives regarding medical care within the healthcare system emphasised aspects of institutionalised healthcare that included them as equals in Austria. In Chapter 8, I further scrutinised the fieldwork data with refugees in relation to this notion of inclusion.

Finally, the starting point of Chapter 9 was inductive findings on how refugees experience and perceive the healthcare system as an instantiation of the "good state", particularly in contrast to their exclusionary experiences in other state institutions such as asylum courts. Intrigued by this notion, I triangulated the data from the refugees' perspective with my interviews conducted with health professionals and representatives of political parties. Bringing together these perspectives, this last chapter of my findings analyses citizen–state relations in the Austrian healthcare system.

4.4 Conclusion

This chapter detailed how I collected and analysed empirical data on refugee health in Austria. I addressed changes and adaptations to my research design as I had originally planned it. On a practical level, it was often necessary to adapt the methods to the needs of the refugee research participants. Their unique circumstances demanded continuous and careful ethical consideration. For example, during participant recruitment, I realised that Paulin had gained literacy skills only after arriving in Austria and that most participants were unfamiliar with the Latin alphabet before leaving their home countries. As a result, my initial plan to work with health diaries proved unsuccessful and employing mapping techniques was only possible to a moderate extent. The combination of theoretical sampling and the analysis methods of CGT and SitA proved ideal for maintaining flexibility, enabling me to pursue intriguing findings and conduct in-depth examinations of the aspects I found difficult to comprehend.

On a personal level, coping with the emotional labour inherent to the research proved challenging. I often accompanied refugee participants to morning doctor's appointments, which usually left me exhausted in the afternoon. Balancing these responsibilities with my other

commitments, such as teaching, was demanding. Moreover, my empirical research was "interwoven with mundane details of [my] 'normal life'" (Cerwonka & Malkki, 2007, p. 7). Researching the health needs of refugees in Vienna transformed my perception of the city irrevocably. Prior to embarking on this doctoral project, the Austrian capital had already been my home for almost ten years. Accompanying and listening to those who shared their stories with me added a new dimension to the city, one that created ruptures and ambivalences with the way I live here and perceive it. For this, I am grateful. Even now, passing by that particular bench in the park, I think of how important this bench was to one young man whom I accompanied there during fieldwork. In the midst of a life filled with uncertainty, he regularly found peace sitting down on that bench. I gained a denser and more layered understanding of the self-perceptions and health and illness experiences of Viennese residents who sought asylum in Austria. This understanding is one I aspire to convey to the reader in the ensuing chapters.

FINDINGS PART 1: MAINTAINING HEALTH OUTSIDE THE HEALTHCARE SYSTEM

Meeting the health needs of refugees involves not only ensuring their legal and practical access to medical services but also creating living conditions that promote health and well-being. Health outcomes are significantly influenced by personal experiences, political factors, and social determinants, including housing, education, and social standing (Marmot, 2005; Venkatapuram, 2013). As a report commissioned by the World Health Organization aptly puts it:

> Member States should ensure that improving the health of migrants and refugees goes beyond providing access to health services. It includes ensuring that the basic needs of migrants and refugees are addressed including adequate nutrition, water, sanitation, hygiene, housing, education and employment. It involves addressing the complex upstream political and socio-economic factors that affect a person's health. (Cheng et al., 2018, p. xi)

The next two chapters discuss how refugees' everyday lives in Austria impact their health. These chapters adopt a personal, dynamic, and relational understanding of health, which differs from biomedical disease-oriented approaches.[66] Instead of defining health purely in biomedical terms as the absence of "disease", the focus is on the personal experience of health, well-being, and illness (for details, see Chapter 1). This experience is decisively shaped by refugees' lived realities in destination countries. Feminist research has emphasised that approaching health and disease solely from a biomedical perspective fails to encompass the adverse health effects of oppression and discrimination:[67]

> While medicine and technical intervention to cure disease is important, it is also fundamental to transform social formations and hierarchies that disempower certain groups on the basis of race, class, sex, sexual orientation, and/or gender so that all humans have access to the means to live healthy lives. (Nelson, 2015, p. 25)

[66] An excellent example of a disease-focused approach with regard to the 2015 refugee cohort in Austria is El-Khatib et al.'s (2019) study about infectious disease syndromes in reception centres.

[67] Health's interconnectedness with social power hierarchies is also recognised in the second principle of the WHO Constitution. This highlights the disparities related to race and other factors that commonly impact refugees in high-income host countries such as Austria: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (World Health Organization, 2014).

In terms of methodology, the following two chapters, Chapters 5 and 6, focus on refugees' narratives of health and illness. I carefully examined how the persons I interviewed experienced and perceived physical pain, mental health, and their overall sense of well-being within the context of their daily lives in Austria. Their narratives of health and illness were often intertwined with institutional and political factors that extended beyond the boundaries of the healthcare system. These factors included awaiting a decision on their asylum application, engaging in paid work, and maintaining connections with family members in their home country.

While Chapter 5 discusses how refugees' particular experiences in the destination country Austria detrimentally impact their health, Chapter 6 centres on the role of self-care practices outside institutionalised care structures in fostering their health and well-being. These chapters collectively underscore the importance of everyday life in the context of refugee health. They show how experiences of exclusion disenfranchise refugees and adversely affect their health, underscoring the importance of mundane self-care practices in maintaining health.

Chapter 5: Everyday Health Risks[68]

5.1 Introduction

This chapter discusses how refugees' living situation in Austria generates new health issues and exacerbates existing ones. The persons who filed an asylum claim around 2015 to whom I talked generally expressed contentment with the medical services offered within the public healthcare system. However, what they described to cause them considerable stress[69] and worries were aspects directly tied to their everyday experiences in Austria. In the following pages, I unfold various forms of "everyday health risks" that emerged from my data. I define everyday health risks as the range of factors, conditions and experiences potentially detrimental for health and well-being that refugees face in their daily lives within a new host country. These risks arise from the complex interplay of institutional, social and political factors, and they negatively impact refugees' health and well-being. They are distinct from immediate health issues resulting from violence, war, and forced displacement. Everyday health risks encompass challenges related to living conditions, socio-political contexts, discrimination and restrictions imposed by asylum policies.

Being a refugee comes with multiple challenges that lead to specific forms of health needs. I argue that refugees' health needs are a consequence of the broader social and political constellations in which they find themselves after entering a destination country. Politically, Austria has adopted increasingly more restrictive asylum policies over the last decades with right-wing populist discourse and politics becoming normalised (Liebhart, 2020). The refugee policy crisis (Rosenberger & Müller, 2020) following the surge of asylum applications in 2015 marked a shift to the political right (Gruber, 2017; Rheindorf & Wodak, 2018; Rosenberger & Müller, 2020; Simsa et al., 2019). The dichotomy between an Austrian "us" and a refugee "them" was constructed and solidified along the lines of race, values and religion: Examples included increasing legal restrictions on Islamic communities (Mattes, 2021; Sezgin, 2019), right-wing discourses against

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[68] I integrated parts of this chapter into a book chapter that will be published in the book *Drawing boundaries and crossing borders: Migration in Theorie und Praxis* (Sievers et al., forthcoming).

[69] Note that the concept of stress is a Western one. For example, Schiocchet (2019) showed how Arabic speaking refugees in Austria seldomly use the word stress for describing health problems, or, if they do so, take it from German or English.

female Muslim body-coverings (Sauer, 2022), islamophobia rooted in racism (Opratko, 2019), courses on Austrian values for newly recognised refugees that re-constructed refugees as the "Other" (Myott & Vasileva, 2020), and the legitimisation of restrictive asylum policies through negative images of foreign masculinities by Austrian politicians (Scheibelhofer, 2017) (for details, see Chapter 3).

Research on refugee health has mainly focused on health problems resulting from the experience of violence, war and flight, often neglecting the impact of living conditions in the concrete contexts of refugees' lived realities in destination countries (Agyemang, 2019, Nowak et al., 2022; see also Chapter 2). Quantitative studies have increasingly focused on everyday life experiences such as discrimination as health determinant for forced migrants (Hou et al., 2020). However, the decontextualised self-assessments used in many of these survey studies to measure, for example, everyday discrimination are limited (Harnois, 2021). Complementarily, recent qualitative research has shown how refugees' health needs unfold in the context of their everyday experiences in host countries (examples include Isaacs et al., 2022, and Mayblin et al., 2020, in the UK; Chase et al. 2017, and Newbold & McKeary, 2018, in Canada; Parkinson & Behrouzan, 2015, in Lebanon). An illustrative example in this regard are Tomkow's (2020) insights on how asylum seekers in the UK closely interwove their narratives on health problems with the socio-political conditions of increasingly hostile and restrictive asylum and immigration policies. Equally, Fang et al. (2015) conducted in-depth interviews with Somali and Iraqi asylum seekers and recognised refugees in the UK about their health. They worked with the notion "normalized absence, pathologized presence" that they defined as "the social exclusion of a particular group or groups based on negative stereotypes and assumptions" (p. 2). Fang et al. (2015) found that refugees' health closely linked to institutional, social, and political factors in the UK:

> Personal accounts explained how immigration systems and structures (such as transient legal statuses) prevented access to vital resources such [as] employment, education, appropriate housing, health care and public funding. Past lives and current social situations, including resettlement, asylum-seeking processes, hostility, racism and social isolation were also predictors of health and well being. (p. 10f)

This strand of research shows how crucial it is to carefully listen to how refugees themselves view their health situation and to adopt a contextual understanding of their specific situation (Agyemang, 2019) for understanding the health needs of refugees in destination countries. Such an approach, which this chapter follows, also takes into account refugees' personal histories and socio-economic situations (Newbold & McKeary, 2018; Parkinson & Behrouzan, 2015). I present

what refugees themselves considered to negatively affect their health and well-being to better understand their health needs.

This chapter shows how refugees' living situations intricately intertwine with their health challenges. Employing an inductive qualitative approach, I do not intend to comprehensively list all health-related issues, but aim to develop a sensitivity towards how the experiences tied to being a refugee can negatively impact health, even within a host country that provides access to high-quality healthcare services, such as Austria. It is important to note that this chapter emphasises distinct aspects that are not equally applicable to all participants, due to the diverse nature of the seven persons at the heart of my doctoral work. For example, life within asylum accommodations was particularly relevant for asylum seekers, and the anticipation of a stable income to support their families predominantly affected men rather than women.

In what follows, I first introduce the health and asylum trajectories of the seven persons I accompanied over a period of two years, utilising overview charts. In doing so, I include relevant past experiences and their future aspirations, which I found to be closely connected with their current life and health situation. Second, this chapter focuses on the situation of asylum seekers, before showing that certain health risks associated with being a refugee also persist among recognised refugees. Fourth, I address the dilemma for healthcare practitioners whose means to treat illness from everyday health risks are limited. Medical professionals are often unable to treat diseases caused by everyday health risks. This chapter's conclusion situates these insights within the socio-political landscape of Austria and contextualises them further by considering the specific temporality of everyday health risks. This temporality highlights the interplay between past adversities experienced in the home country and the ongoing challenges in the host country, which collectively contribute to a persistent detrimental effect on refugees' well-being.

5.2 Health and Asylum Trajectories of the Seven Refugee Participants

My doctoral work adopted a longitudinal research design. By meeting refugee participants several times (between three and nine times, depending on each person, see Figure 11 in Chapter 4), I witnessed shifts in their asylum statuses as well as changes in their health and well-being. However, the dimension of time extended beyond the scope of my fieldwork. The narratives of health and illness that I was told, along with the bodies of the refugees seated next to me, often referred to both past experiences and anticipated futures. These persons carried the weight of past hardships and their bodies showed previously inflicted scars and injuries. At the same time,

an imagined future permeated the conversations and observations, for example in the longing for their own flat after the positive asylum decision, in the desire for security as formal citizens, and the coordination of forthcoming health appointments that held the promise of improved well-being.

Figures 18–24 offer an overview of the migration trajectories of the seven refugee participants (indicated in black) alongside their medical histories (indicated in blue). These visual representations provide insight into the unfolding of both their health and asylum trajectories over time. Common threads ran through the experiences of all refugee participants depicted in Figures 18–24. These included their arrival in Austria around 2015, their endeavours to learn the German language and shared aspirations for the future, such as finding a job and pursuing quality education, not only for themselves but also, for example, in the case of parents, for their children. Within these commonalities, they each recounted significant aspects of their lives that generated substantial stress and concerns, many of which were directly tied to their refugee status.

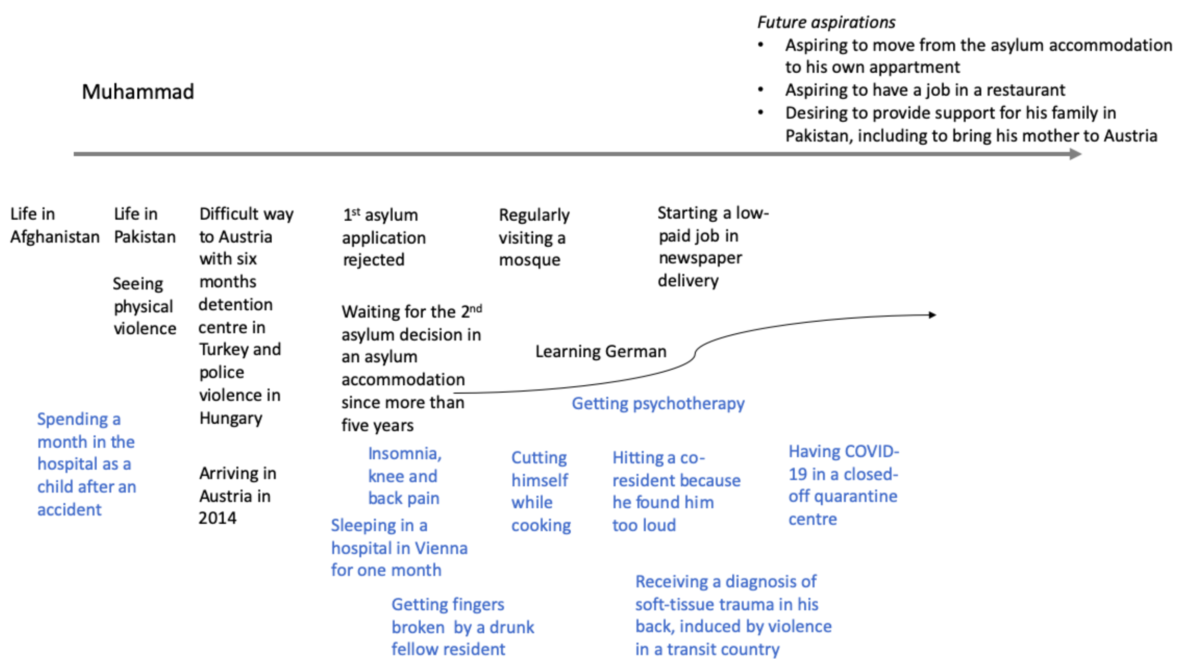

Figure 18. Muhammad (single man at the beginning of his twenties, asylum seeker from Afghanistan)

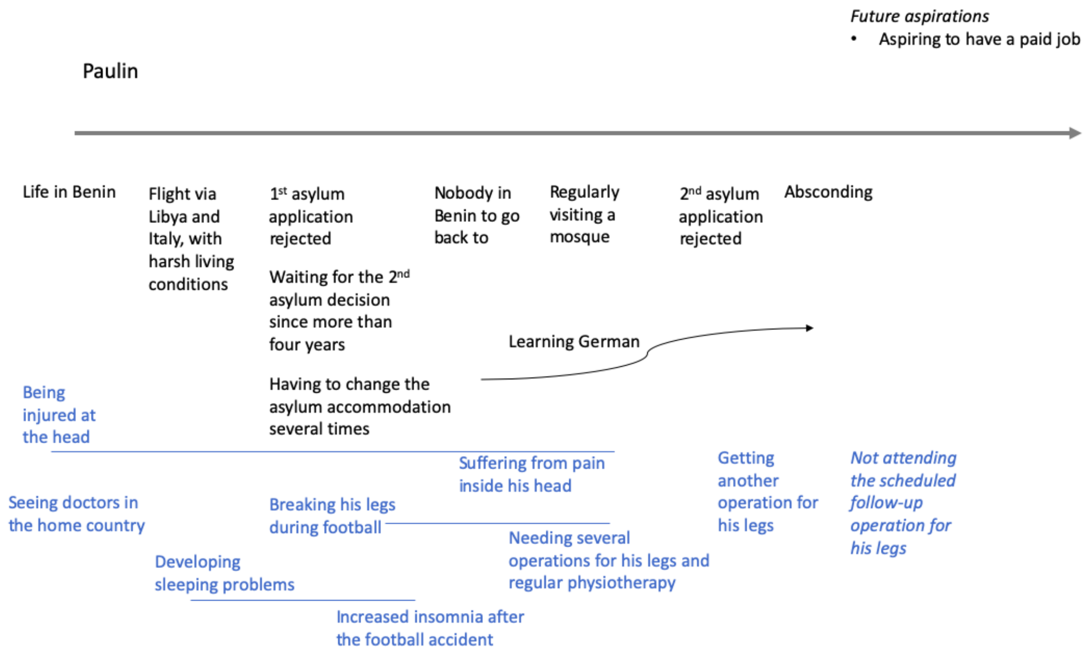

Figure 19. Paulin (single man around 20 years, asylum seeker from Benin)

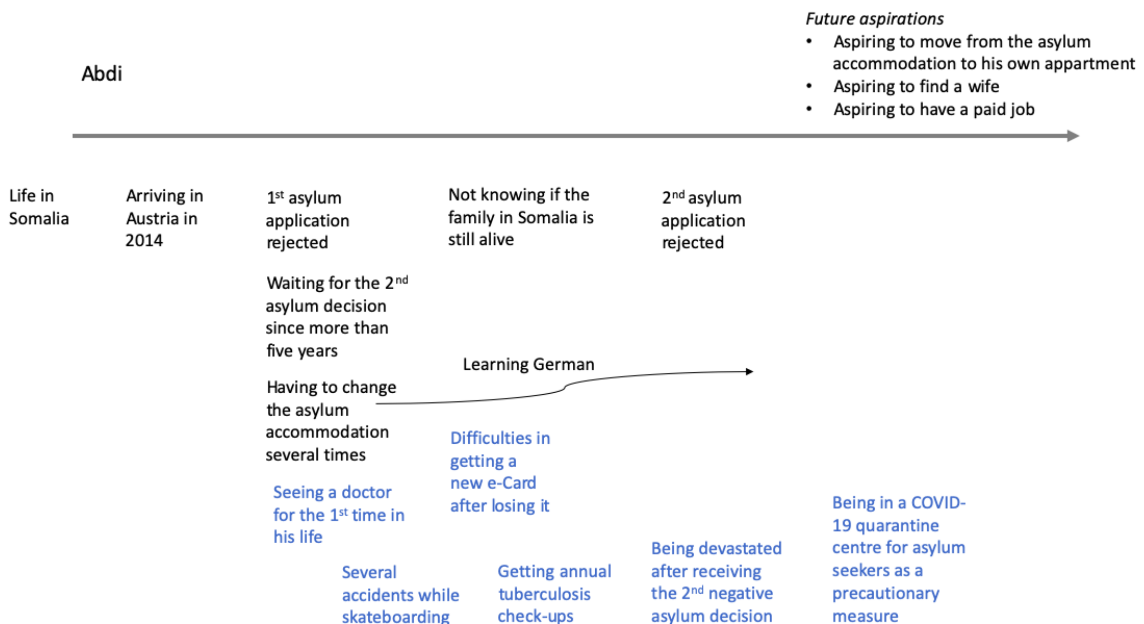

Figure 20. Abdi (single man around 20 years, asylum seeker from Somalia)

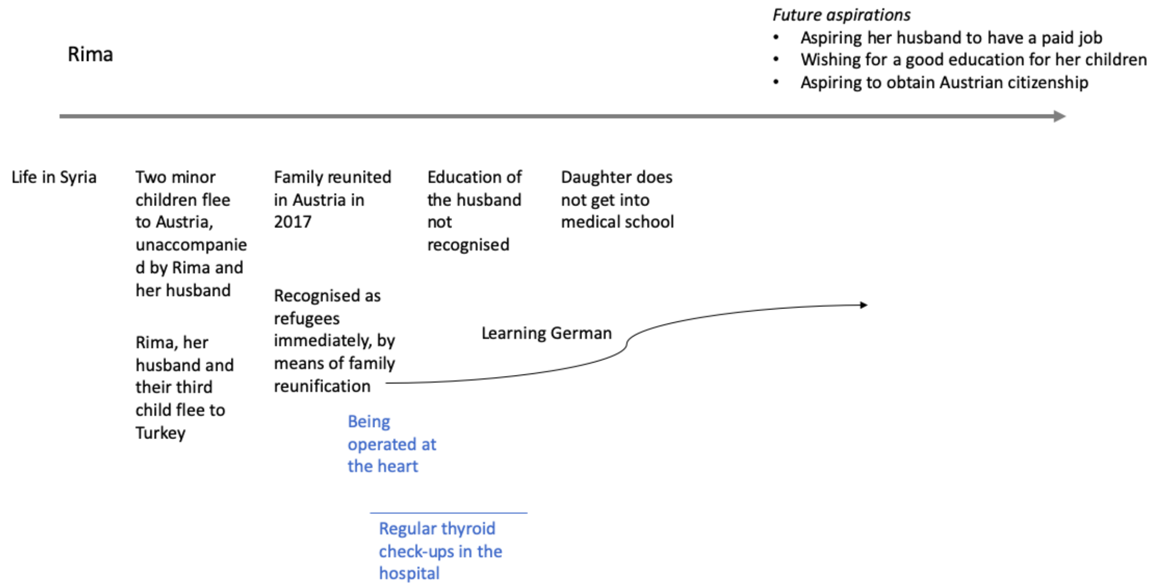

Figure 21. Rima (woman at the beginning of her forties, with family, including a husband and three children over the age of twelve, recognised refugee from Syria)

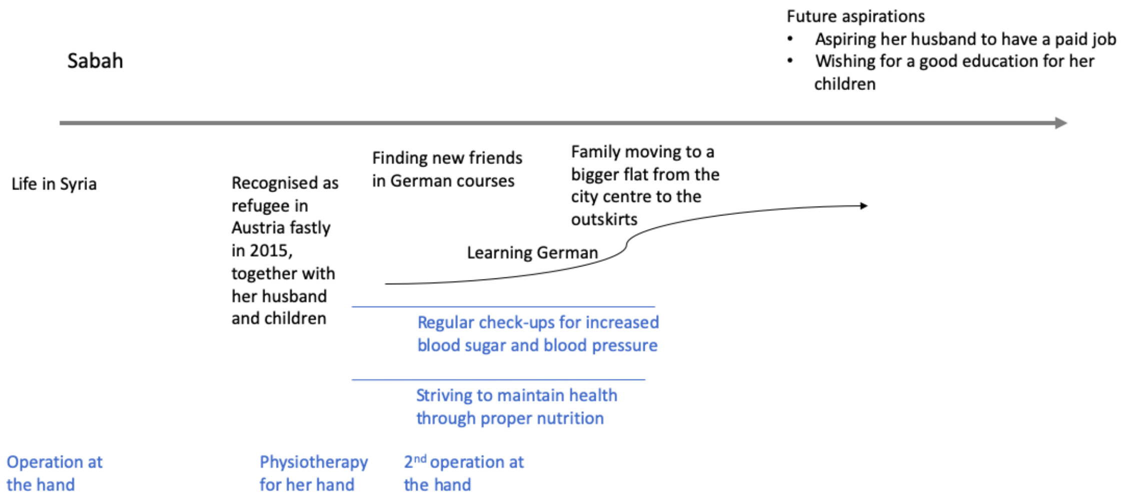

Figure 22. Sabah (woman at the beginning of her fifties, with family, including a husband and four children over the age of twelve, recognised refugee from Syria)

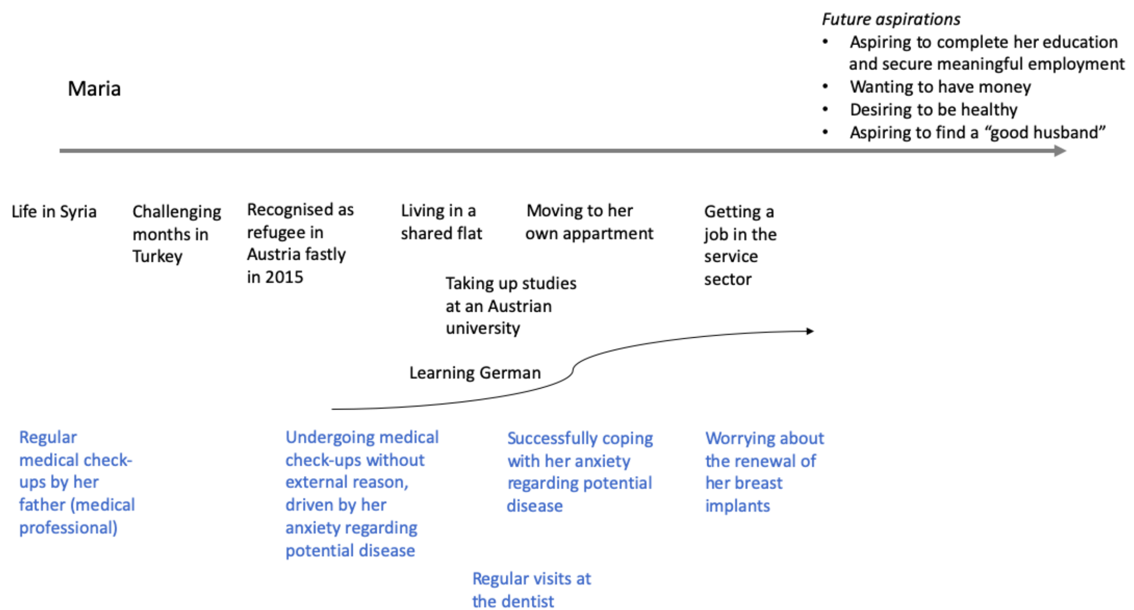

Figure 23. Maria (single woman in her thirties, recognised refugee from Syria)

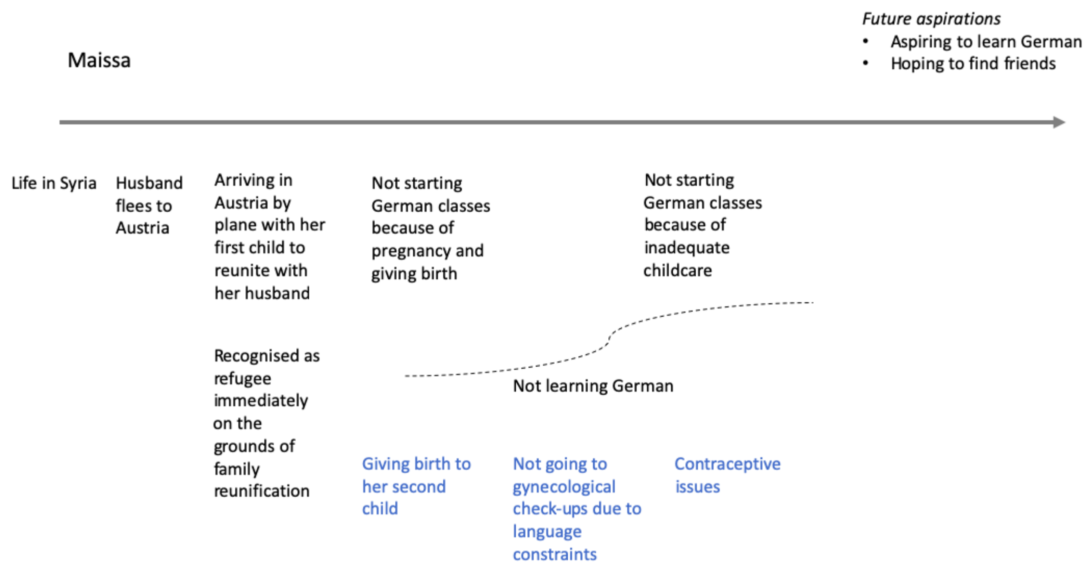

Figure 24. Maissa (woman in her twenties, with family, including a husband and two small children, recognised refugee from Syria)

5.3 Everyday Health Risks

In the subsequent sections of this chapter, refugee participants' health and migration trajectories (see Figures 18–24) are further examined to elucidate the intricate interplay between their everyday experiences and their health conditions, discussing quotations from our interviews. First, I discuss how asylum seekers' lived reality in legal limbo gives rise to distinct health challenges. This is demonstrated through an exploration of the emergence of health issues throughout the asylum procedures, the experiences of illness stemming from residing in asylum accommodations and the painful experience of receiving a rejected asylum application. Second, I illustrate how, even after their asylum application is approved, the everyday lives of refugees remain filled with stress and worries. These concerns stem from ongoing challenges related to bureaucracy, validating education in Austria, finding employment, language proficiency, and facing anti-Muslim racism. Third, this chapter discusses how refugees perceive Austrian citizenship as a source of security and connect it with well-being.

5.3.1 Developing Health Problems during Asylum Procedures

Muhammad, an Afghan man in his twenties, lay awake for several hours every night. He explained to me why:

> Maybe it is stress. I have not gotten the interview. .... I am here since five years. Waiting. They always said "No". I only hear "No". "Yes" I do not hear in Austria. They only say "No, No, No". .... Everything came in Austria. Pain. I used to be healthy. In Austria came the headache, also the leg pain came. And there is stress. (1st interview, Muhammad)

Muhammad had lodged an appeal against the initial negative decision made by the BFA regarding his asylum application. When talking to me about his insomnia, Muhammad shared that he had been awaiting an interview with the second-instance decision-maker, the Federal Administrative Court, for nearly five years. To him, the emergence of his sleeping problems, headaches, and health issues affecting his legs and back were a direct result of his time in Austria marked by a constant barrage of "No". This is significant given his history of both physical and psychological injuries endured in his home country and while fleeing, such as being detained in a Turkish detention centre for several months and being struck on the leg by the police in another transit country, Hungary. Despite these prior experiences, Muhammad interpreted his health problems against the legal limbo he had experienced in years of waiting during asylum procedures in his destination country. He directly compared life-threatening violence in the places he fled from

with the unbearable situation in Austria (1st interview, Muhammad), a link that other asylum seekers also make, as the following quote from a young man from a West African country shows.

> The legs are the problems from Austria (i.e., Paulin injured his legs while playing sports in Austria, which was followed by several operations and regular physiotherapy). They are from here. And another problem from Austria is the negative (*le négatif*; i.e. the negative asylum decision). On top of everything, this also, and many problems. But there are problems from Benin, but also from here. It is bad, many problems. In the night, I do not sleep a lot. (1st interview, Paulin)

Paulin's head was scarred by experiences of violence in his home country. But like Muhammad, he found the problems in his country of destination at least as burdening. His severe leg injuries in Austria as well as the insomnia and headaches that accompanied him while waiting for the asylum decision in the second instance wore him down. At another meeting with me, Paulin also explained that he suffered from insomnia in the Austrian capital, whereas he had been able to sleep well in Benin (1st observation, Paulin).

The years of waiting for an asylum decision often determine the self-perception of asylum seekers and prevent them from leading a healthy life. A health trainer offers courses for an NGO aimed at promoting the health of migrants. He talked about the exercise "life path", where a ribbon symbolises the life of the participating migrants from birth to the present situation. They can either put a flower on the ribbon if it is about positive experiences and events, or a stone if it is about negative events.

> And when I come to the present, what do I give? A stone or a flower? With asylum seekers it is always a stone. No security, no asylum, no asylum decision, and I will be deported at some point. (interview, NGO health trainer)

5.3.2 Staying Healthy in Asylum Accommodations

Residing in asylum accommodation provides both shelter and support for staying healthy, which includes facilitating connections between residents and migrant-friendly doctors within the public healthcare system and outreach care by social workers who remind residents of necessary follow-up medical appointments (see Chapter 7). Nevertheless, the collective strain of enduring the legal limbo within these accommodations can generate instances of violence. This shared experience of legal uncertainties occasionally culminates in small-scale rioting and physical clashes between residents. For instance, in Muhammad's accommodation, the residents would often set off the fire alarm without any fire-related reason or other external emergency for doing

so. They would break the glass enclosures housing the emergency switches on the walls for fire-related dangers, triggering the red button underneath.

> Muhammad: People also press this fire alarm themselves. Now it is less. Before, people used to press it six times in a week. In the middle of the night they also pressed it. ....
>
> Wanda: Ah, they broke the glass with the elbow. And then the fire alarm was pressed.
>
> Muhammad: Then they went away, to go sleep in their room.
>
> Wanda: But why?
>
> Muhammad: Playtime. .... They were in this flat for about three years, four years. It didn't get better. Always they were told, "no, no, no". So they might have started to feel stress. And they do it for fun. Or they go to the office and argue with the staff. (2nd interview, Muhammad)

For Muhammad, residents triggered the fire alarm due to their feelings of stress from waiting for an asylum decision and because they were facing constant limitations, always being told "No". As expressed by the social worker at the accommodation, "some simply become aggressive because they are so desperate" (interview, social worker large accommodation).

Setting off the fire alarm represented one of the few actions available to asylum seekers within their unbearable circumstances. However, the residents returning to sleep after this controversial "playtime" underlines their very limited ability to break free from the rigid system. Triggering the fire alarm ultimately remains an unsuccessful attempt to assert control over their own situation. The importance of making one's own decisions is shown by the impact of an organisational change: Especially at the beginning of the 2015 refugee policy crisis, in some accommodations, meals were served to residents in communal dining areas. Muhammad interpreted this arrangement as a form of everyday external control that led to heightened stress among residents. He detailed that incidents of the fire alarm being triggered significantly decreased when he and his fellow residents were given money to independently purchase and cook their own meals (2nd interview, Muhammad).[70]

Living in asylum accommodation has the potential to worsen pre-existing health issues. This is because sharing a room can lead to stress, residents worry about the police or social workers entering their rooms without their permission, restrictions on inviting non-residents exacerbate

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[70] Residents in asylum accommodations without meals receive €150-200 per month. Especially at the beginning of the refugee policy crisis in 2015, many accommodations provided meals to the residents and only paid them around €40 per month (Knapp, 2019).

feelings of exclusion, and the need to change accommodations can disrupt established medical support networks.

During the period of my fieldwork, it was commonplace for residents to share their room with at least one other person. Sanitary facilities situated in the hallways of repurposed office buildings, hospitals, or other vacant buildings turned into asylum accommodation were often utilised by inhabitants from entire floors. Sharing this private space occasionally triggered health-related challenges. For instance, Paulin recounted how his headaches worsened after he seriously injured his legs while participating in sports activities in Austria. He shared a room with three other residents in a former office building that had temporarily been turned into an asylum accommodation. The snoring emanating from his roommates behind the improvised curtains that they had set up around their bunk beds further exacerbated his difficulty in falling asleep (1st interview Paulin).

Few asylum seekers reside in single rooms due to specific circumstances, such as traumatic experiences. Social workers in accommodations distribute the limited number of single rooms available, which are in high demand. Asylum seekers interested in these rooms typically need to register and provide medical evidence, often in the form of a psychological report, demonstrating the necessity to live alone in a room. Muhammad, for example, felt great comfort in his lovingly decorated own room. He asked me to take off my shoes before entering and proudly showed me the devices he had collected such as a toaster and a rice cooker, which he picked up second-hand at a bargain price. He also drew my attention to a tablecloth with cut-out patterns and gold embellishments. Muhammad told me that the tablecloth was already worn out and that he would soon buy a new one of this model because he liked it so much (2nd interview Muhammad). Despite the comfort Muhammad felt in his room, the situation as an asylum seeker affected how he felt about his life and took away his sense of security, even in this safe space. He described often lying awake at night, imagining someone opening the door and entering his room without his permission. He explained that the accommodation staff sometimes entered and that he feared the police might come to his room while he sleeps.

> So much stress. Then I also have a little bit of fear with the police here. That the police come here to the door. That I am sleeping and they break open the door. (1st interview, Muhammad)

A social worker at Muhammad's accommodation later told me that the police generally do not have access, but that they may enter the building to enforce deportations (interview social worker large accommodation). She also explained how social workers themselves engage in room

checks to ensure a healthy standard of living. They try to prevent littering of the rooms and power cuts due to the unauthorised use of electric cooking appliances, help some previously homeless people to keep their rooms clean, distribute cleaning products and engage in activities aimed at support. While mentioning the good intentions and justifications for entering residents' rooms, the social worker at the same time saw the practice of room controls as ambivalent and emphasised that the staff normally asks for permission to enter private rooms:

> But that's not, well, we don't do that either, so don't get us wrong: we're allowed to go into the room, but we don't open any cupboards, or we're not allowed to rummage around in private things or anything; so basically we always wait until the clients open the door for us – only if there's somehow an emergency or there's already, as I said, smoke coming out from under the door, then we do go in [without being invited in]. (interview, social worker large accommodation)

Furthermore, asylum accommodations are highly regulated spaces that unauthorised persons are not allowed to enter. Larger facilities in Vienna usually have a reception desk at the entrance where the staff of the accommodation and sometimes external security personnel control access. For Muhammad and Abdi, this also meant that they could not invite people living outside their accommodation to their homes. Both described being unhappy over not being able to host friends. These feelings became particularly bitter when former co-residents, now recognised as refugees and living in private accommodations, were no longer allowed to enter the building. Their faces were marked with sadness when they spoke about this. The controlled rooms of the asylum seekers' home become symbols of the "state of limbo" (Hartonen et al., 2021; Isaacs et al., 2022; Jonzon et al., 2015) in which the asylum seekers find themselves while they wait for the decision. Their current home offers protection, but at the same time it separates them from a regular coexistence with other residents of the city.

Moreover, asylum seekers often have to change accommodation several times. A change may be necessary, for example, when rental agreements expire, particularly as asylum accommodations are often established in temporarily used buildings. Additionally, a decline in asylum applications during the period between 2015 and 2019 resulted in reduced demand for accommodation spaces, engendering closures (see Figure 7 in Chapter 3). Not only living in an asylum accommodation, but also the redeployment of residents to new accommodations can affect health. Despite the often years-long legal procedures, asylum seekers have only limited possibilities to decide on their place of residence within Vienna (a change of *Länder*, for example moving from Tyrol to Vienna, during the asylum procedure needed a permit which was difficult to obtain). For example, Abdi experienced six different residential addresses in Vienna over the

course of his asylum procedure that extended for more than four years. This continuous reassignment of accommodations also resulted in him severing ties with his previously established medical support network.

> Wanda: The doctor was nice and that was all ok?
>
> Abdi: Yes, very nice. He told me if you want help and stuff, come here to my doctor's office. He gave me his name and stuff. …
>
> Wanda: And then did you go again?
>
> Abdi: Then I came here. Haus Simmering (i.e., this is the anonymised name of the Abdi's new asylum accommodation) is very far. Hietzing (i.e. district of Vienna where Abdi's old accommodation was) is very far. .... When the tram is finished, another 15 minutes on foot and so, yes very far. I didn't go there again. (1st interview, Abdi)

He felt that his former general practitioner, with whom he had built up trust and felt comfortable, was too far away from his new place of residence. The long distance between the old and the new accommodation disrupted Abdi's trusting relationship with the empathetic doctor.

5.3.3 Painful Experiences due to the Rejection of the Asylum Application

Care providers in the asylum system are aware that refugees' living situation often limits their ability to lead a healthy life. For example, my interlocutor from the Vienna Refugee Aid (*Wiener Flüchtlingshilfe*; department of the Vienna Social Fund that coordinates basic care for refugees) explained how meeting asylum seekers' health needs is especially difficult. For her, this is the case because of long asylum procedures that cause frustration, the tabooing of mental health problems among many clients, the lack of access to the labour market, which often limits life satisfaction and the lack of prospects and despair in the case of a negative asylum decision (interview, employee at the Vienna Refugee Aid). Receiving a second-instance negative asylum decision can lead to profound health repercussions. Following the rejection of his asylum claim, Abdi developed a troubled psychological and bodily state. All the sense of normalcy and routine that he had established over his years in Austria suddenly disintegrated, leaving him feeling bereft of the opportunity to shape his own life, as these notes from our encounter illustrate:

> Visiting Abdi at his asylum accommodation a couple of months after he had received the court's decision, I witnessed its worrying effects. The three times I had met him before, I encountered an energetic young man with shining eyes who was eager to meet friends, to socialise over drinks, to learn how to skate, to have a girlfriend, to live. That day I faced a different person. The rejection was written all over his body. He was unkempt. His posture was bent, his hair was longer than

> usual and unwashed, his lips were chapped, his eyes were watery and blunt, and even his clothes seemed to have lost their posture, loosely hanging from his tall and thin body. Abdi explained to me that he had ended up in a position where he could not do anything. (notes of my 3rd interview with Abdi; he wished to not be recorded)

While Abdi continued to live in his room in the accommodation, hoping to receive the precarious legal status of a tolerated stay, others even decide to end their lives and commit suicide. Another common practice is to abscond. For example, Paulin simply disappeared after receiving a second-instance negative asylum decision, thereby also interrupting his medical treatment. He did not attend another operation for his legs, which had already been planned. Already before receiving the court's decision, Paulin had firmly expected he would not be able to stay in the country. To him, "that is life" (2nd interview Paulin). He had experienced rejections in Austria as his everyday normalcy.

Within asylum accommodations, emotional breakdowns following unsuccessful asylum applications become an integral facet of everyday life, as the social worker explained:

> Often the breakdowns take place somehow in the corridor or in front of the office – we then always try to go into a closed room where the other clients are not standing next to it and can see everything –something like that is exciting, then a crowd forms and everyone watches. (interview, social worker large accommodation)

When confronted with an acute crisis situation within an asylum accommodation, the immediate response of social workers is to provide a protective space for those experiencing a breakdown, separating them from other residents. The exposure to the distress of their peers contributes to the emotional breakdowns and the emergence of suicidal ideation that often accompany asylum seekers during the duration of their waiting period for an asylum decision.

5.3.4 Continuing Stress and Worries after a Positive Asylum Decision

The refugees I talked typically described receiving a positive asylum decision as a relief. Yet, recognised refugees often continue to find themselves in a situation that makes it difficult to take care of their own well-being and to live a healthy life. In practice, the transition from basic care in the asylum system to minimum social benefits in the general social system is a critical phase during which a lack of coordination between the authorities can lead to health insurance gaps on a practical level. Moreover, "the high (bureaucratic) threshold of the system is simply a horror" for their clients, as a counsellor for newly recognised refugees elaborated:

> This is a very vulnerable phase, this transition from basic care into recognition, where there is some relief because you have the recognition. But in reality until your livelihood (*Existenz*) is secured and normality prevails, so that the children can just go to school, the adults to the German course … [this takes more than legal recognition as a refugee]. That's why we always say that creating a normal everyday life is basically the challenge, isn't it? That I have enough security to be able to take care of other things than basic needs. (interview, director at an advice centre for recognised refugees)

Continuing difficulties after a positive asylum decision may hinder recognised refugees in having "a normal everyday life" with the "security to be able to take care of other things than basic needs" as the counsellor phrased the issue. This draws attention to how refugees' everyday lives make it difficult to take care of their own health. Worries associated with settling in in a new country, such as bureaucratic hurdles, getting education and training recognised in Austria, finding paid work, language proficiency, and experiences of anti-Muslim racism continue to form the health needs of recognised refugees to a considerable extent, as detailed in the following sections.

Sabah, Maissa and Rima take care of their family's household and do not have a paid job. The three Syrian women worry about their husbands finding paid work. For example, Rima's husband had been trained as tailor in Syria. Not knowing German and needing to get a certificate in Austria, the family had, by then unsuccessfully, tried to get his driver's license recognised to find work in another sector. Furthermore, Muhammad experienced an enhancement in his well-being upon embarking on a job as a newspaper deliverer, one of the limited income-generating avenues accessible to asylum seekers during that period[71]. Similarly, Maria's state of well-being improved when she assumed the role of a saleswoman. They explained that they had fewer sleep problems (2nd interview, Muhammad) and a better ability to concentrate (2nd observation, Maria). Both seemed relieved when they joyfully told me about their new jobs.

Maissa's case is particularly telling regarding how the ability to live a "normal life" is connected with personal health and well-being. The young Syrian mother of a four-year-old child and a baby literally equated her health with knowledge of German. After living in Austria for almost two years, she could barely speak more German than saying hello. She had followed her husband as a successful applicant for family reunification and had not attended a language course due to a

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[71] The employment ban for asylum seekers was lifted by the Austrian Constitutional Court in 2021. Since then, asylum seekers can obtain a work permit three months after they have applied for asylum (Ebner, 2023).

lack of or insufficient care for her baby. Being asked what she needed to feel healthy, she immediately replied, “I feel very good when I learn German and very happy” (1st interview, Maissa). She further explained that after her second child was born, she would have liked to have an appointment with a gynaecologist. However, due to her poor knowledge of German, she had been shying away from making an appointment for ten months. She was relieved when the interpreter and I offered to accompany her (1st observation, Maissa).

Moreover, anti-Muslim racism has increased in Austria in the last decade, especially during the refugee policy crisis following 2015 and the participation of the right-wing populist FPÖ in government from 2017 to 2019 (see Chapter 3). Religious discrimination poses a health risk that Muslim families must contend with as they navigate their daily lives in Austria. Among those most impacted by anti-Muslim prejudice in their everyday experiences are Muslim women wearing body coverings (Sauer, 2022), a topic that was also raised by the healthcare providers I talked to. For example, a general practitioner recounted an incident where a woman, who had been photographed on the bus en route to the doctor's office, experienced an emotional breakdown in the presence of her daughter during the consultation. An orthopaedist was visibly moved and angry when he explained how his patients suffered from physical attacks:

> When the father, this proud father, really [starts] to cry in front of you …. This enormous pressure that lies on these minorities, the others don’t even notice it. Do you know how often people, women with hijab are spat at in Vienna? (pause) Unbelievable. .... Patients tell me that, especially in this phase [i.e., the FPÖ’s participation in government], these attacks, yes – they were frequent, yes. Men whose wives had headscarves, (pause) were afraid for their wives, and there was more of a tendency to no longer use public transport, but to be taken by car, there and thereabouts. (interview, one doctor at the Viennese Medical Chamber)

5.3.5 Insecurity of not Having Austrian Citizenship

Furthermore, the legal status as recognised refugee still often involves a sense of insecurity in terms of rights. While recognised refugees are entitled to social rights, including minimum social benefits and access to the public healthcare system, they do not hold formal citizenship. For example, Rima’s family felt to only be safe with obtaining Austrian citizenship:

> It is important for them [i.e., Rima and her husband] that they speak German now and work [well], so that they get the citizenship. This is important if you want to stay in Austria. …. It is never safe, because every day the rules are changing. And it depends who will be there after September 29 [i.e., national election day in Austria on September 29, 2019]. And the rules that are coming now

are not ours; it became[72] more difficult. They can at some point in time, when they want, whom they want, send back. .… This is what is on our mind a lot. .… And always when a new law comes or something, then we are so (breathes in sharply), we talk about it. It is sometimes frightening. (2nd interview, Rima; interpreted by her adult daughter)

The quote illustrates how not having citizenship had a detrimental impact on Rima's mental well-being and cast a shadow over her family's everyday life. They would thoroughly follow Austrian news, worrying about the possibility of being forcibly returned to Syria. Despite being officially recognised as refugees, the family's sentiment was that political regulations were not for them, they were "not ours". The status of being a refugee, regardless of the extent of rights conferred by that status and how "secure" the status is overall, remains precarious in the eyes of many refugees. The quote from Rima's family highlights that refugees perceive true security only in the attainment of citizenship. This underscores the notion that, in the context of personal well-being, the focus needs to extend beyond formal status and its associated rights. The perceived security that accompanies the attainment of citizenship matters for well-being.

5.4 Healthcare Practitioner's Dilemma of Treating Health Problems with a Social Cause

Addressing everyday health risks within the healthcare system poses significant challenges. In the perspective of the employee at the Vienna Refugee Aid, the life situation of asylum seekers complicates the provision of institutionalised healthcare for them:

[I]n health matters, there are always areas that we cannot influence and where the work is difficult .... However, it is not sufficient that the people in basic care have the necessary information; we have made the experience that, conversely, for example, staff in various health areas sometimes also lack relevant knowledge and a corresponding sensitisation with regard to the needs of people in basic care. (interview, employee at the Vienna Refugee Aid)

In this quote, the Vienna Refugee Aid's employee implicitly expressed reservations about solely concentrating on disseminating health information to them, instead highlighting an inherent issue within the healthcare system. As per her perspective, numerous healthcare professionals lack the necessary capacity to effectively address the health requirements of asylum seekers, considering the broader context of their day-to-day challenges.

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[72] Rima's daughter is speaking in the past here. The quote should be understood against the background of Rima's and her daughter's rejection of the government of the time. During and after the interview, both expressed anger about the ÖVP-FPÖ coalition government, which brought disadvantages for them as refugees.

Care providers and healthcare professionals know that they cannot cure health problems that were formed by the experience of being a refugee, as described in this excerpt from my field notes:

> Sabah and I sit opposite her general practitioner in the treatment room. Between us is his large desk, on which there is a computer screen, piles of folders and notes and other desk accessories. The stern looking doctor, who will probably soon reach retirement age, tells Sabah something in Arabic, and she replies in the same language. The doctor then turns to me and explains in German, which Sabah understands only rudimentarily, that she suffers from high blood pressure, for which she should take her tablets and lose weight. He also explains that many other life circumstances can cause one to feel weak. Nodding into Sabah's direction, he says that especially for refugees there is a lot at stake. They have to think of their families and what they have left behind. For the doctor, these are important causes of high blood pressure and many other health problems. He goes on to explain to me that of course it is okay for refugees to come to the doctor, because that is their right. "Of course," as he says, he tells them what to do about high blood pressure, which is to eat well, take the pills, exercise. (2nd observation, Sabah)

Sabah's general practitioner explained her elevated blood pressure in the context of medicalisation, lifestyle and her lived reality as a refugee. He distinguished at least three levels of treatment for Sabah. As a medical doctor, he carried out blood tests, prescribed medication and informed her about healthy behaviour. As a patient, he expected Sabah to take the prescribed medication and follow his instructions in her lifestyle choices. On another level, Sabah's experiences as a refugee hindered both medical and personal efforts to adopt healthy lifestyles. The lived reality of many refugees, where everyday life is characterised by worry, poses health risks against which medical professionals are only partially equipped.

Also others involved in refugee care note the manifold social determinants that negatively affect the health of recognised refugees. For example, an Arabic speaking general practitioner explains that many different factors are relevant when treating Syrian patients (note that the vast majority of Syrians were quickly recognised as refugees after arriving to Austria around 2015, see Chapter 3), "from trauma to health problems, socially, economically" (interview, general practitioner). At a publicly financed advice centre for newly recognised refugees, the refugee experience is understood to cause physical health issues. Having talked about disability and mental health problems, the director started to talk about common physical health problems among their clients:

> Cardiovascular problems, I would say, as a consequence of the stress of flight. In my opinion, this is also very common in men who have cardiovascular diseases, high blood pressure .... How is a body supposed to integrate that, especially now with men who have fled ahead (of their family) –

> who then not only have the stress of fleeing, but also the stress of building up an existence for the family in some way, with everything they don't have? (interview, director advice centre)

The director pointed out that cardiovascular issues are notably prevalent among men who feel compelled to establish a future home for their family. Conversely, she perceives a higher tendency for women to develop migraines. To illustrate, she cited the experiences of two female social workers within the centre, who grapple with challenging histories of displacement and are seemingly trapped in a cycle of migraines. They do not get out of "this migraine spiral", as she formulated it.

> I always have the feeling, it's so very clear that health just suffers massively and that you know where that comes from, yes? (interview, director advice centre)

The director's daily interactions indicate a recurring occurrence of stress manifesting in orthopaedic complaints, such as back problems, intervertebral disc issues, as well as knee and joint discomfort. With her extensive experience counselling newly recognised refugees at a publicly financed advice centre, the director discerns an evident tendency for the somatisation of post-migratory stress, even if this cannot be medically pinpointed.

5.5 Conclusion

This chapter offered a nuanced account of health risks that the experience of being a refugee evokes in their everyday lives in a destination country, adding to a growing body of qualitative research on that topic (Nowak et al., 2022). I showed how refugees perceive personal experiences of health and illness through their everyday experiences during and after asylum procedures in Austria. Notions of the "everyday" have established as crucial departure point for understanding the hierarchical power dynamics of white male normativity in critical feminist and race studies (Essed, 1991; Smith, 2016; Smith, 1987). Also in scholarship on migrant health, notions of "everyday discrimination" and "everyday racism" have become important analytical lenses (Bourabain & Verhaeghe, 2021; Harnois, 2021; Hou et al., 2020).[73] In the anthropology of health, Berlant (2007) famously discussed the dire health consequences of everyday experiences, with what she called the "slow death" in the "ordinary environment":

> The phrase slow death refers to the physical wearing out of a population and the deterioration of people in that population that is very nearly a defining condition of their experience and historical

[73] Another field in which everyday aspects are also coming to the fore is security studies, using the concept of "everyday security" (Crawford & Hutchinson, 2016; Ismail, 2023).

> existence. The general emphasis of the phrase is on the phenomenon of mass physical attenuation under global/national regimes of capitalist structural subordination and governmentality. (p. 754)[74]

This chapter's analysis of refugees' narratives of health and illness align with this rich research. My findings help to understand how deeply embedded power structures negatively affect refugees' health in their everyday lives. The serious health consequences of refugees' everyday realities in Austria become "a defining condition of their existence", as Berlant (2007) put it.

I showed how asylum seekers' situation of legal limbo creates specific health problems for them. After filing an asylum application in Austria, asylum seekers have an interview with the BFA within a specified timeframe that is not to exceed six months (Court of Audit Austria, 2019, 2023a). In the event of a negative decision, they can file an appeal with the Federal Administrative Court (Court of Audit Austria, 2023b). Anecdotal knowledge suggests that processing sometimes takes more than five years. There are no legal requirements or statistics on this processing time (Knapp, 2019). By the end of 2018, 30,168 asylum decisions were still open, affecting 14,489 Afghans, 5,142 Iraqis, 1,724 Iranians, 1,243 Somalis, and 2,155 persons from other countries (Ministry of Interior, 2022). For often half a decade, asylum seekers' lives are determined by the potential outcome of this second-instance court's decision. Think about the Afghan Muhammad who explained how always hearing "no" in Austria caused him pain. Accounts from my fieldwork show how the many "noes" in Austria form a telling metaphor for a state of curtailed agency and insecurity that slowly instils itself in many refugees as insomnia and other conditions such as migraine. Continuously waiting for a court's decision determines everyday life for asylum seekers and can become a health risk in itself (see also Phillimore & Cheung, 2021). As shown, the living situation in asylum accommodations often exacerbates these problems.

Moreover, administrative decisions can lead to interruptions in healthcare. Think of Abdi, who had to change asylum accommodation several times and was cut off from his general practitioner, with whom he had built up a trust relationship. Rejected asylum decisions can have an even more drastic effect, as shown by Paulin's sudden absconding, which caused him to miss the next

[74] Foucault addressed a similar idea to that of Berlant's (2007) "slow death" as a precursor to death. In his 1975–76 lecture series *Society must be defended* he mentioned – without developing this thought further – that "killing" is to be understood in a differentiated way, as it also encompasses "every form of indirect murder: the fact of exposing someone to death, increasing the risk of death for some people, or, quite simply, political death, expulsion, rejection, and so on" (Foucault, quoted in Wiertz, 2021, p. 1385).

operation on his legs, which had already been planned.[75] Second-instance negative asylum decisions affect a large number of people and are unevenly distributed across applicants' home countries. Between 2015 and 2020, the vast majority of Syrians received a positive asylum decision within a short time. However, only between one third and half of decisions on Afghans were positive, with slightly higher figures for Somalis, such as Abdi who entered a worrying bodily state after the judicial decision. Additionally, the increased suicide rates among asylum seekers in the years following 2015 can be seen as having a particularly negative impact on health (only anecdotal knowledge available). The topic came up in several of my interviews and has attracted political attention. In November 2019, a position paper by several umbrella organisations in the field of mental healthcare in Austria included a call for preventive measures against suicide. It localised suicidal attempts and suicides especially after experiences of disappointments in Austria and rejected asylum applications (Danzinger et al., 2019). Moreover, in 2020, so-called stabilisation places in existing accommodations were created for asylum seekers in acute mental health crises.[76]

I showed how intertwined exclusions that create health risks also extend to recognised refugees, as was also found in other recent empirical studies (see for example Isaacs et al., 2022; Stewart & Mulvey, 2014). A change in status comes with legal certainty, more social rights such as the right to do paid work, and often an improved housing situation. Still, stress and worries persist and "creating a normal everyday life" is challenging and can negatively impact health and well-

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[75] Although Paulin did not exercise this right, rejected asylum seekers, in general, might have their deportation delayed due to a medical condition. Before deportees are put on a plane, they must be declared fit to fly by public health officers. The lack of medical treatment options in the home country and the associated need to visit a doctor in Austria are also factual reasons for postponing the date of deportation (Küffner, 2022; Rosenberger et al., 2018). These cases are not recorded statistically in Austria (in Germany, 141 asylum seekers were not deported for medical reasons in the first half of 2018) (Küffner, 2022). The other way round, health care access may also be hindered when medical facilities pass on information to asylum authorities. For example, an interview study with healthcare professionals in the UK for example suggested that recently introduced healthcare policing and restrictive policies hindered asylum seekers and refugees to access care (Asif & Kienzler, 2022). More research on how health problems influence asylum decisions and the right to stay in the Austrian context is needed. I inquired into the topic in my interviews with care providers and representatives of political parties, yet my interlocutors were not informed about the relationship between medical care and (delayed, cancelled or accelerated) deportation.

[76] In Switzerland, Schoretsanitis et al. (2018) examined the medical records of psychiatric consultations conducted in an emergency room between 2012 and 2017. Their study focused on 38 persons, mostly young, male, and single, who had received rejected asylum applications. Among these individuals, 40% sought psychiatric assistance due to suicidal thoughts. In comparison to asylum seekers awaiting a decision, this group exhibited elevated instances of acute stress reactions (21% versus 7.6%).

being, as the interviewed director at an advice centre for newly recognised refugees explained. The transition phase from being a recipient of basic care as an asylum seeker to receiving minimum social benefits when being a recognised refugee is critical and can delay medical treatment and create stress. At the time of my research, personal e-cards of newly recognised refugees were sometimes rejected by medical institutions. In these cases, the persons erroneously did not have valid insurance coverage, due to poor coordination between the authorities responsible for basic health care (the *Länder* implement the requirements via the Ministry of the Interior) and the authorities responsible for minimum social benefits (the *Länder* implement the requirements via the Ministry of Social Affairs).

After the transition phase from being an asylum seeker to being a recognised refugee with more social rights, everyday life as recognised refugee often continues to create difficulties. Finding work can be difficult because of language requirements and nostrification processes (for information on the difficult nostrification process for Syrian medical personnel in Austria, see Sieder & Farwati, 2017). Recognised refugees in Austria often continue to be excluded along multiple axes, such as religion, language proficiency, and ethnicity. Think about Rima's family who felt threatened to be removed from Austria as they do not hold formal citizenship. Their worries were exacerbated by a political discourse that marked refugees as a burden (Rosenberger & Müller, 2020) and general uncertainties about recognised refugees' rights were amplified by increasingly restrictive asylum policies in Austria. In 2016, the Asylum Act (§ 3 (4)) was amended with a potential reassessment and subsequent withdrawal of the status as a recognised refugee three years after the asylum decision, in cases of changes in the situation in the home country or of a conviction for a serious crime in Austria.

On top of that, Austria has a relatively strict naturalisation law (Bauböck & Haller, 2021) and was ranked 53th out of 56 countries when it comes to migrants' access to nationality in the Migrant Integration Policy Index (Solano & Huddleston, 2020). To become an Austrian citizen, one must have a clean criminal record, show proficiency in German at a B2 level, not claim social benefits, have sufficient income, pass a civic knowledge test, affirm Austrian civic values, and renounce any other formal citizenship. Furthermore, naturalisation is only possible after 10 years of uninterrupted stay in Austria (six years in special circumstances) (Marik-Lebeck, 2021). Other EU countries, such as Finland and Belgium, do not require demonstrating a specific income level for naturalisation (Stadlmair, 2018). Austria has a notably lower share of migrants who obtained Austrian citizenship in a comparison of 17 European destination countries. It stands at 37.19%,

contrasting with an average of 44.16% (average data 2008–2016). Countries with a lower rate encompassed only Cyprus, Estonia, Greece, Ireland, and Spain (Huddleston & Falcke, 2020).

Furthermore, the insights from this chapter indicate that health risks for refugees follow a specific temporality, throughout experiences of war and violence in the home country until formally obtaining Austrian citizenship in the sense of possessing the Austrian passport. Thereby, manifold experiences that refugees make can negatively affect their health, as visualised in Figure 25.

Figure 25. The temporality of everyday health risks for refugees in Austria

The preceding sections focused on how health risks are experienced in mundane situations, such as waiting for an asylum decision, learning German, and worrying about changes in law that negatively affect non-citizens. They unfold in time and are characterised by continuity. Everyday health risks are not self-contained in specific moments such as being on the run, but they overlap and can exacerbate and influence each other. Past experiences detrimental to health often continue to play a role in refugees' lived reality in destination countries. For example, previous experiences of violence in the home country can manifest in memory flashbacks that keep refugees awake at night in Austria. Living in asylum accommodation with little opportunity for retreat can exacerbate these sleeping problems. Consider how Muhammad and Paulin directly compared experiences of violence in their home countries and in transit countries with the stressful time of waiting for an asylum decision. For them, this intertwining of past and present health risks manifested itself in recurrent insomnia and headaches.

Understanding the exposure to health risks during experiences of war and violence in home countries, during migration, and in Austria as entangled, it is also particularly clear that specific health burdens continue to exist even after the recognition of the refugee status and possibly even after obtaining Austrian citizenship. Think of the mental and sometimes physical violence that women wearing a hijab experience within an increasingly hostile environment for Muslims

(Mattes, 2021; Opratko, 2019; Sauer, 2022; Sezgin, 2019; see Chapter 3). The healthcare professionals quoted in this chapter referred to the pressures of experiences of discrimination that need to be considered when thinking about refugee patients' health, irrespective of their legal status.

In sum, this chapter demonstrated how refugees' lived realities in the high-income host country Austria continuously create health risks such as stress, insomnia, headaches, and eruptions of violence that are reinforced by repeated experiences of daily exclusion. Moreover, refugees' experiences of these everyday health risks take place in mundane settings and follow a specific temporality in which past experiences such as violence in the home country continue to influence and exacerbate newer health problems such as insomnia in crowded asylum accommodations. I showed a continuity of health needs between the home country and the situation of seeking asylum that also expands to life in the host country as recognised refugee.

Chapter 6: Self-Care Practices

6.1 Introduction

The preceding chapter described how refugees experienced difficulties in their daily lives in Austria that materialised as dire health consequences for them. I now shift the focus to the personal strategies employed by refugees to meet their own health needs outside the formalised services of the healthcare system. These strategies aim to maintain their well-being amid the institutional and political challenges they face, as well as their experiences of insecurity. This chapter's focus is on practices that counteract the difficulties of refugees' lived experiences and promote their well-being and health. I refer to these practices as "self-care practices". This term distinguishes them both from the everyday health risks that affect refugees, such as the stressful wait for asylum decisions and experiences of insecurity (Chapter 5), and from the healthcare practices within the institutions of the healthcare system that are in the focus of the second part of this thesis' empirical findings (Chapters 7–9).

This chapter concentrates on the self-care practices that I understand to be particularly essential for the well-being of the refugee participants. I explore how these practices, outside the realm of institutionalised medical care, contribute to their health. This is illustrated through the examples of revisiting public spaces associated with well-being, using mobile phones, engaging in religious practices, pursuing paid work, and mutual support among refugees. Among the other notable self-care practices that held significance for the refugees in this study were: sports, preparing meals for themselves and those close to them, and routines such as apartment cleaning and grocery shopping.

6.1.1 Creating Safe Havens in Public Places

Amidst a general situation of insecurity, public places in Vienna functioned as safe havens for refugees. This feeling of security extended both to crowded areas where refugees felt a sense of belonging to the wider community and to quieter places that provided moments of peace.

> Vienna is a good place to live because there are so many nationalities. There you feel like all the others. It's not always like that, but most of the time it is. .... She likes, for example, when she goes to a park, to the Danube, to Stephansplatz something, she sees how the people are there. You can see so much and so on. And you feel calmer when there are so many people. (2nd interview, Rima; interpreted by her adult daughter)

For Rima, visiting bustling places of Vienna held great significance. She found relaxation there and experienced being part of an abstract “we”, “like everyone else” as she described it. In this context, the consistently crowded Stephansplatz had a special meaning for her. This renowned square, located at the heart of the city, surrounds Austria’s most iconic structure, the Roman Catholic St Stephen’s Cathedral. Other refugee participants similarly described how going to certain public places or routes within the city provided them with a sense of security, which they associated with their overall well-being. Repeatedly visiting these places became a part of their coping mechanism to manage the stress they encountered. When asked how he kept himself healthy, Muhammad explained that he took walks to both Stephansplatz and Praterallee, a renowned and busy avenue within a large park (3rd interview, Muhammad). By going to bustling places, the Syrian woman and the Afghan man experienced a connection with the crowds of people present in those places. This, in turn, fostered a feeling of belonging not only to the local crowd but also, as I would argue, to Austria’s entire population. Such activities helped alleviate tensions and counteract everyday experiences that negatively impacted upon their health.

Another self-care practice in public spaces involved frequent visits to peaceful locations and quiet places. For instance, Muhammad regularly went to a specific spot in a spacious park near his home to cope with his anxiety and insomnia. These are notes from my fieldwork:

> I picked up Muhammad at his accommodation on a sunny and warm day. When I asked if he knew a nice outdoor spot to sit, he hesitated briefly before saying yes, and we began to move. As we reached a bridge above a highway, his face lit up and he said that there was a really nice place on the other side that he enjoyed. We continued our way, passing a remote university building and strolling down a small path next to allotment gardens. Muhammad’s enthusiasm grew and he told me that he frequently visited this place because he enjoyed being there. He explained that he went there when he was tired, had something on his mind, or was having trouble sleeping. He always visited this place alone. As we followed the path, it opened up into a spacious meadow where we saw a wooden park bench next to a public picnic table. (3rd interview, Muhammad)

For Muhammad, the park bench became his favourite place when he experienced a headache or when sombre thoughts hindered his sleep, describing this state as feeling “tired”. In our encounters, he often employed the term “tired” to depict a sense of existential exhaustion.[77] In

[77] The feeling of tiredness was also expressed by other refugees I spoke to. For example, when Maria and Maissa described that sometimes everything got too much for them and that it was then particularly difficult to learn German, they used the word “tired”. See Schiocchet (2019) for a discussion of the close connection between the expression of tiredness as a marker for depression and malaise among Arabic-speaking refugees in Austria.

the preceding chapter, I detailed how living together in an asylum accommodation with other residents who shared the same state of waiting could contribute to tensions that exacerbated insomnia, headaches, and even occasional violent outbursts.

The significance of appropriating public spaces as a strategy for enhancing one's sense of security and well-being is further illustrated by Abdi's yearning for his previous accommodation in Vienna's 20th district. He favoured this location because it was close to the river and a shopping centre with a cinema.

> But the 20th district is really, really good. Very nice, yes really, I like it there. .... There is the Danube there. And the Danube Island .... You can swim. .... Twice I think, yes three times I went to the shopping mall nearby and I watched a film. This cinema, wow, is interesting really. Yes, good films .... Yeah, that's why I liked it there. But now I'm here and cinema and so, ah they are very far. (1st interview, Abdi)

Similar to many asylum seekers, Abdi had to relocate several times. Some of the asylum accommodations that were established around 2015 were subsequently closed, others were divided or combined, and some provisional housing arrangements were replaced by construction projects. Unfortunately, Abdi did not experience the same positive feelings in his new accommodation that he had in his previous one.

Not everyone possesses the opportunity to cultivate safe spaces in Vienna through repeated visits. Maissa, the young Syrian mother of two, largely confined herself to her home. Her movements within Vienna were primarily limited to taking her older child to kindergarten, grocery shopping, visiting a distant uncle every other month, and attending medical appointments. Her haven in Vienna was her thoughtfully adorned apartment, featuring numerous cushions and soft carpets that were shielded from outside view by drawn curtains.

6.1.2 Feeling Connected through Mobile Phones

Beyond physical places in Vienna, mobile phones emerged as significant sources of well-being for the refugees I accompanied. For example, Abdi recounted the distress he experienced when his mobile phone remained inoperative for two weeks due to a skateboarding mishap. During that period, he could not send texts, play games, or receive calls. He even likened his mobile phone to being a person. He said it was "like a friend" to him (3rd interview, Abdi). Maissa explained that she used Google Translate to enable her to communicate through text messages such as those

sent to me. Additionally, she found health advice and doctor recommendations in Vienna through Arabic-language Facebook groups (2nd interview, Maissa).

For some refugees in the study, the mobile phone held particular importance as a means of staying connected with their families in their home countries. Maria, for example, told me how deeply she missed her family and pulled out her mobile phone to share pictures of her parents and siblings. She detailed her daily routine of video calling her mother, sometimes until they both fell asleep. This practice helped alleviate her sense of loneliness as a single woman who arrived in Austria without her family. Given their daily conversations, it was not uncommon for Maria and her mother to sometimes find themselves with nothing left to talk about. On many occasions, Maria's mother simply kept her company through the mobile phone as Maria went about her activities, such as having lunch and studying for exams (lunch with Maria).

Furthermore, refugees used mobile phones to seek guidance on healthcare-related matters from trusted doctors and family members back in their home countries. For example, Maissa recounted how she called her mother for advice during her pregnancy in Austria and continued to do so after giving birth, particularly because she had not seen a gynaecologist post-delivery due to language barriers (2nd observation, Maissa). Maria regularly sought medical advice from her father, who is a doctor in Syria (3rd observation, Maria). Muhammad's mother also worried about his well-being and provided him with advice on maintaining good health, such as suggesting the use of oil for skin issues (2nd interview, Muhammad).

6.1.3 Practising Islam as a Source of Well-Being

Some participants described how engaging in religious rituals provided them with moments of joy, where they experienced a sense of safety and contentment. For instance, Sabah extended an invitation for me to join her family in their home during Ramadan. I found a warm and cosy atmosphere where all family members gathered to dine together. Everyone shared their joy in this tradition. Similarly, Rima described how this period had positive effects on her well-being, attributing it to both fasting as a form of bodily cleansing and the enriching social interactions and bonding moments it fostered. For the two Syrian women, the religious tradition held significance in terms of benefiting their physical health while also fostering emotional connections with their loved ones:

> You store up a lot of toxins per year if you take everything and stuff. And from a health point of view, according to new studies, you have to have a time when you don't eat so much, or when

> you fast, or go on a little diet. And with us it's important, because for example in Ramadan we all sit at the same table, then there's such a tradition. It's also fun for us, and it's also very good for our health, because you learn how, you see how our body changes when you don't eat and don't drink .... And you also invite everyone you know, and then you go to them, and everyone in the family always stays together for the meal ... – it's kind of nice. It's like Christmas in Austria. (2nd interview, Rima)

> Our body starts to regenerate ... and it [i.e., fasting during Ramadan] strengthens our immune system. (3rd interview, Rima)

Moreover, refugees who did not have families in Vienna found a sense of togetherness in the context of Islam. Invited by a fellow resident in his asylum accommodation, Paulin began to visit the mosque on Fridays regularly. He liked going there and appreciated being together with others: "It is big, it's nice. There are many people, a lot of young people. There are also children." (2nd interview, Paulin). Muhammad similarly felt comfortable in the mosque community. During a discussion on how he dealt with insomnia and his back and leg pain, he shared his passion for cooking. Each day, Muhammad would prepare meals for himself. He especially enjoyed preparing food for others during religious festivities at the mosque (1st interview, Muhammad).

6.1.4 Building Stability through Paid Work

Engaging in paid work was another self-care practice that contributed to well-being. For Muhammad, securing a job as a newspaper delivery boy brought him a sense of relief and aided him in managing his sleep issues: "Now it is better. Because of this work I am sleeping more because I am tired." (2nd interview, Muhammad). Maria also once told me excitedly that she had finally got a job as a shop assistant, a milestone achieved four years after being granted refugee status in Austria. I could feel that a heavy burden had been lifted off her (2nd observation, Maria). Both experienced a sense of relief after finally finding paid work and consequently working regularly. Taking up a job also led to a shift in their perceived social standing within Austria. Muhammad's enthusiasm for his new job particularly captures this change. He regarded the job as beneficial not only because of the physical exercise gained from cycling, but also it carried a symbolic significance as a literal door opener. Having been given a postal key that granted him access to the front doors of typical Viennese apartment buildings, the job had more meaning to him than just being a source of income.

> I can open everywhere with my key. My district is Hernals [i.e., one of the 23 districts in Vienna], I am working in 14 streets in this district. (2nd interview, Muhammad)

The district in Vienna where he delivered newspapers six days a week, early in the morning before most people were awake, became "his district", as he described it. He gained a new routine and structure, along with the financial means to support his mother's medical treatment in Pakistan, as he explained.

The challenge of finding paid work is not exclusive to asylum seekers; even recognised refugees like Maria faced difficulties, as her lengthy job search exemplified. As discussed in the preceding chapter, Sabah's and Rima's husbands also encountered hurdles in finding paid work primarily due to obstacles in having their previous work experiences recognised, their limited grasp of the German language, and unsuccessful endeavours to validate their driving licenses in Austria.

6.1.5 Mutual Support between Refugees

In order to stay healthy and maintain well-being, I found personal ties to fellow refugees to be an important resource. In an earlier section in this chapter, I described how refugees drew strength from communicating with loved ones in other countries through their mobile phones. Apart from the family, the closest reference persons for asylum seekers are often fellow residents in their accommodation. This creates bonds, often with people from the same home country who share a common language, as was the case with Paulin, for example:

> Wanda: Do you have friends here in the house (i.e., Paulin's asylum accommodation)?
>
> Paulin: Yes, there is one Beninese here …. We talk. (1st interview, Paulin)

Co-residents within the asylum accommodation offered mutual support in various ways, ranging from simple gestures in daily life to concrete help in solving problems. Examples included talking to each other, lending a listening ear, providing interpretation during doctor's appointments (for a detailed examination of solidaristic practices by fellow refugees within the healthcare system, see Chapter 7), borrowing items such as tomato sauce by knocking on each other's room doors, and aiding each other in securing employment, as was the case with Muhammad's newspaper delivery job.

Often, these bonds between co-residents persist even after they move out. For example, a friend of Muhammad's, who had been officially recognised as a refugee, continued to offer him emotional and material support even after he had left the asylum accommodation:

> We meet at his home, we take a walk, we talk a lot. Sometimes he buys clothes for me. We talk about what is happening. I tell him, it is ok, I have not taken any stress. I say it is ok, I did not get any stress. (3rd interview, Muhammad)

Also after having obtained a positive asylum decision, refugees continued to feel comfort through interactions with other refugees. For example, Sabah, told me with a smile that she has more friends in Vienna than in Syria because she made new Arabic-speaking friends in each German course she attended (1st interview, Sabah). The bonds between refugees are important resources for their well-being and their ability to navigate life in Austria. I would like to emphasise that these bonds were established on a selective basis and at a personal level. None of the refugees I spoke with considered themselves part of a "community of asylum seekers" or a "refugee community", a perspective also shared by a social worker at a large asylum accommodation:

> Wanda: Do you have the feeling that your clients see themselves as part of a group of, for example, asylum seekers, that they identify themselves with this?
>
> Social worker large accommodation: No, I don't have that impression. (pause) I mean, of course there are 200 other asylum seekers meeting here. So, I don't have the impression that they only see themselves as that – not at all, actually. (pause)
>
> Wanda: And that there is something like a cohesion (*Zusammenhalt*) here in the house?
>
> Social worker large accommodation: Oh, yes, there is ... there are people who have lived next door to each other for years, or they happen to be from the same village and so on. I mean, of course there is cohesion. And there are disputes. The nationalities may also stick together. (pause) So there are the loners in our house who really have contact with few people and don't want to have any contact with other people for very different reasons. And then there are clients who always cook together, who always eat together, who support each other very much; when one of them is in hospital, they go to visit him every day and bring him food and so on. But that is, I would say, quite individual. (interview, social worker large accommodation)

According to the social worker, residents of the accommodation tended to identify more with their home country, religion, or other positively associated categories than with the label of being a refugee. She explained that there was not a strong overarching sense of community among them. Instead, she felt that personal connections naturally formed among individual residents who shared mutual sympathies. Refugees make up a diverse group with varying backgrounds, including different home countries, languages, religions, marital statuses, genders, and levels of education, among other characteristics. Simply sharing the legal status of being an asylum seeker or a recognised refugee does not automatically create a sense of community. In fact, it can sometimes lead to negative feelings. For example, survey data from Austria found that Christian

Syrians expressed reservations about the welcoming culture towards Muslim Syrians in 2015 (Buber-Ennser et al., 2018).

Moreover, Muhammad's narrative about seeking assistance at a quango-run advice centre for asylum seekers illustrates refugees' reluctance to identify and be viewed as part of the group of refugees.

> In recounting his visit at a legal counselling NGO for asylum seekers, the young man from Afghanistan said that "many people come there, many (pause) asylum seekers, many people who wait for the decision about their asylum application". He went on to describe how he does not want to be at the NGO too long. (3rd interview, Muhammad)

Muhammad seemed to have felt uncomfortable being in the company of other asylum seekers while waiting for legal advice on his asylum application. He hesitated to use the word "asylum seekers" and then in the further course of the interview spoke of "people who wait for the decision about their asylum application". On various occasions, Muhammad also expressed his discontent with certain fellow asylum seekers, particularly those engaging in behaviours he perceived as undesirable, such as drinking, smoking, and speaking loudly.

The desire of refugees to set themselves apart from the broader labels "asylum seeker" and "refugee" is not surprising, given the shift from a welcome culture (Trauner & Turton, 2017; see Chapter 1) for the 2015 refugees to protectionist policies later in Austria (Gruber, 2017; Rheindorf & Wodak, 2018; Rosenberger & Müller, 2020; see Chapter 3) alongside the perpetuation of a narrative that delineates an Austrian "us" and a refugee "them" along the lines of race, values, and religion (Mattes, 2021; Myott and Vasileva, 2020; Scheibelhofer, 2017; see Chapter 3).[78]

6.2 Conclusion

This chapter provided insights into self-care practices that illustrate how refugees themselves stabilise their health and well-being amid the often-challenging circumstances of life in Austria.

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[78] The existing scholarship on un/deservingness could provide valuable insight into understanding Muhammad's reluctance to identify himself as asylum seeker in a more nuanced way. This field of study has demonstrated that certain refugees, such as pregnant women, might be seen as deserving of protection, while others, such as male asylum seekers, may not be similarly perceived (Holmes & Castañeda, 2016; Holzberg et al., 2018; Sales, 2002; see Chapter 2).

These practices serve as counter-practices to the everyday health risks described in Chapter 6, helping to alleviate stress, worries, and anxiety.

A particularly paradoxical example of this tension between experiencing everyday health risks and adopting self-care practices is evident in the context of practising Islam. When Rima spoke to me about how fasting during Ramadan and spending time with her family contributed to her well-being, her daughter added that Ramadan for her was like Christmas for Austrians. Despite the fact that a significant and increasing portion of Austria's population identifies as Muslim (8% in 2016 compared to 4% in 2001, and with a higher proportion of Muslims in Vienna, 12% in 2011), her daughter felt compelled to draw a comparison with the Christian tradition to help me understand the religious ritual's meaning. This comparison could be interpreted as a reflection of anti-Muslim racism and the legal constraints placed upon Islamic communities in Austria, which shape the context in which the practice of Islam occurs (Mattes, 2018, 2021; Opratko, 2019; Sauer, 2022; Sezgin, 2019; see Chapter 3). On the one hand, being a Muslim in Austria can result in stress and adversely affect the well-being of refugees, such as when women wearing the hijab face hostility in Vienna, causing entire families to feel despair (Chapter 5). On the other hand, experiencing Ramadan with their family and feeling a sense of belonging within the mosque community are important self-care practices for refugees, an aspect that was also found by research in Nordic welfare states (Bendixsen, 2020; Bendixsen & Wyller, 2019).

Moreover, this chapter focuses attention on refugees as active maintainers of their own health and well-being. I wish to emphasise how personal ties between refugees are important resources for maintaining good health. Refugees help and support each other, as family members, friends, and co-residents in asylum accommodations. Over the last decades, there has been a growing emphasis on community-building approaches as a means to address existing inequities, including in healthcare. Research shows that personal relationships among refugees play a significant role in promoting well-being, which might suggest the potential value of implementing such community-based approaches.[79] However, the refugees in Austria I talked to did not identify

[79] Nearly three decades ago, British sociologist Nikolas Rose, in his article titled *The death of the social? Re-figuring the territory of government* (Rose, 1996), cautioned against community-building approaches. He described an emerging mode of governance in the Global North, especially in the UK, characterised by the pervasive use of "community" in policies and language as a sign of a new form of neoliberal individualism that undermines collective societal responsibility. Rose (1996) argues that when society breaks down into smaller communities, it assigns them responsibility – for health matters in the context of my doctoral work – and thereby weakens the acknowledgment of broader societal responsibility, of "the social". In this vein, I would like to express caution when assigning responsibility to a "refugee community" in health

themselves as "refugees" and I did not find evidence of a distinct "refugee community". Rather, I found refugees wanting to belong as patients like all other patients in the shared waiting room (see Chapter 8), as parents, as pupils, as students, as skateboarders, as employees, etc. Moreover, the group of people who filed an asylum application around 2015 was heterogeneous and, beyond the organically formed bonds among well-intentioned and amicably connected people facing similar circumstances, commonalities were often rare.[80]

Collectively, Chapter 5 on everyday health risks and Chapter 6 on self-care practices underscore the necessity for understanding health as a personal, dynamic, and relational practice that is influenced by larger life circumstances and social determinants (Chapter 1). Greater acknowledgment should be given to the particular life situations of refugees which profoundly shape their health needs, and to the personal strategies refugees employ to maintain their health beyond the confines of the institutionalised healthcare system. These findings underscore the importance of heightened sensitivity towards the health needs of refugees' lived realities in high-income host countries. Both detrimental and health-promoting practices occur outside the institutions of the public healthcare system, and these practices should be recognised as pertinent within the realm of health policy. Gaining an understanding of what health needs and appropriate healthcare entail for refugees requires a comprehensive understanding of their health needs that considers bodily, psychological, and social aspects (Whitbeck, 1981; see Chapter 1).

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policymaking. The concept of "community" should be critically examined when future policies on refugee health are designed. The perception and construction of a supportive and resourceful "refugee community" can inadvertently shift responsibility away from other actors and social structures. For instance, think about situations where children serve as interpreters for their parents during medical appointments or where refugees pay more proficient German-speaking refugees to accompany them to the doctor. These instances should be recognised as systemic gaps in the healthcare system, and relevant policymakers should bear responsibility. Similarly, a recent study by Newman (2022) on mistrust in healthcare institutions among black communities calls for health policymaking to prioritise the establishment of trustworthy institutions instead of placing the burden of health responsibility solely at the personal level.

[80] Refugees might indeed be better viewed as "anti-community", following Rose's (1996) claim that some people are marginalised in "anti-communities" that threaten the existing order: "[T]he marginal … are not considered as affiliated to any collectivity by virtue of their incapacity to manage themselves as subjects or they are considered affiliated to some kind of 'anti-community' whose morality, lifestyle or comportment is considered a threat or a reproach to public contentment and political order. On this division between the affiliated and the marginalized are articulated two rather different sets of debates, and two rather different governmental strategies, neither of which seem to be undertaken from 'the social point of view'." (p. 340)

FINDINGS PART 2: REFUGEES IN THE PUBLIC HEALTHCARE SYSTEM

The first part of my findings (Chapters 5 and 6) described how refugees' health needs and some forms of healthcare provided to them unfold outside of medical institutions. The following three chapters, Chapters 7–9, focus on practices within the healthcare system. Refugees in Austria enjoy the same entitlements as other beneficiaries of the public healthcare system. Upon admission to the asylum procedure, asylum seekers promptly receive a national social insurance number, and shortly afterwards, they are sent an e-card holding their name (see Chapter 3). Furthermore, asylum seekers as well as recognised refugees without employment are exempt from co-payments, such as prescription fees.

Despite these comprehensive healthcare provisions, practical barriers to medical care for refugees persist in Austria, such as insufficient interpretation services and cultural competence among medical staff, delays in SHI registration, and co-payments for dental and psychological treatments (Kohlenberger et al., 2019; Leitner, 2018; see Chapter 2). In the next chapter, I show how care providers strive to address these persistent inequities through solidaristic practices (Chapter 7). Subsequently, attention is drawn to how the functions and practices within the healthcare system foster a personal sense of belonging among refugees (Chapter 8). In the last chapter on the findings, I discuss how refugees perceive the healthcare system as the "good state" and how the healthcare system shapes them as citizens (Chapter 9). Chapters 7–9 do not primarily address the medical function of the healthcare system. They direct attention towards a secondary function: Institutionalised healthcare in Austria engenders inclusion to society, as is discussed in detail in Chapter 10.

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Chapter 7: Lived Solidarity by Healthcare Practitioners and Other Care Providers[81]

7.1 Introduction

This chapter aims to answer the question of what forms of solidarity are practised in the healthcare of refugees in Vienna, with a focus on the institutions of and practices within the healthcare system. Despite refugees' comprehensive legal right to medical care in an inclusive healthcare system, practical barriers and structural exclusions exist for them (Kohlenberger et al., 2019; Leitner, 2018; see Chapter 2). This chapter shows how some care providers counteract these barriers and exclusions in their daily work.

Solidarity has received wide attention in the academic literature on health and migration (for a detailed discussion on the literature, see Chapter 2). The Austrian healthcare system, as other Western European healthcare systems (Hofmann & Spieker, 2022; Prainsack & Buyx, 2015; Ter Meulen et al., 2011), is based on the principle of solidarity. It has institutionalised reciprocal support on a national level and thereby provides a good example of "civic solidarity". The philosopher Sally Scholz (2008) uses the term civic solidarity to refer to "the obligations of civil society to protect citizens against vulnerabilities through the provision of healthcare, welfare, and consumer and environmental protection" (p. 5). Civic solidarity forms a specific relationship between the state and citizens and denotes a way in which welfare states distribute wealth. In Austria, people who have not previously paid into social security, such as asylum seekers and recognised refugees who have never worked in Austria before, are entitled to the same benefits as other beneficiaries of the public healthcare system.

In contrast, migration scholars tended to focus on another form of solidarity: "political solidarity" (Scholz, 2008) that foregrounds the political struggle for inclusion (Agustín & Jørgensen, 2019; Ataç et al., 2016; Schwiertz & Schwenken, 2020; Vandevoordt & Verschraegen, 2019). They

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[81] I developed the central argument of this chapter in collaboration with Barbara Prainsack, and parts of this chapter were published in our co-authored article *Lived solidarity in the Austrian healthcare system*, which was published in *EASST Review* (Spahl & Prainsack, 2021). In this chapter, I expanded upon our previous work by incorporating additional insights from my interviews and fieldwork data. Furthermore, I introduced new sections addressing the notion of "bridging solidarity" and the limited resources in the public healthcare system. A German-language version of the *EASST Review* article was published as a book chapter (Spahl & Prainsack, 2022).

primarily addressed emancipatory and normative claims on the provision of health and other social services to refugees and conceptualised solidarity either as a (desirable) feeling or attitude, or tied it to revolutionary practices and activism.

This chapter looks at the meaning of solidarity in Austria's healthcare system in the years following the refugee policy crisis in 2015. The focus is neither on institutionalised civic solidarity, nor on normative and explicitly activist stances, which are often the focal point of migration scholarship. The starting point for my reflections on solidarity was the work of Prainsack and Buyx (2011, 2012, 2017), originally developed in the field of bioethics and healthcare. They define solidarity as follows:

> Solidarity is an enacted commitment to carry "costs" (financial, social, emotional or otherwise) to assist others with whom a person or persons recognize similarity in a relevant aspect. (Prainsack & Buyx, 2017, p. 52)

Prainsack and Buyx's framework identifies three interconnected levels of solidarity: an interpersonal level, a collective level with a focus on group practices, and an institutional level, as exemplified by civic solidarity in the Austrian healthcare system. Their concept is valuable for conducting research on healthcare for refugees in several respects. They view solidarity as a practice, distinct from normative values or personal emotions of solidarity with specific persons or groups. The methods I employed, observation and qualitative interviews, enabled the empirical exploration of solidarity practices and provided a grounded perspective to comprehend various forms of lived solidarity within the healthcare system. This conceptualisation of solidarity also allows to understand formal and informal practices as interwoven. Healthcare can be examined at different levels, including the legal level of the institutionalised healthcare system and the practical implementation in everyday medical interactions. Prainsack and Buyx's multi-level approach offers a valuable lens for addressing practical challenges in delivering medical services to refugees and fruitfully incorporating the perspectives of both patients and care providers.

In addition, the concept "highlights the social process of 'making' similarity, and enjoins us to focus on what connects us to others over what sets us apart." (Prainsack & Buyx, 2017, p. 68) It offers an understanding of commonalities and differences that is not fixed but emphasises their situatedness within specific situations and their cultural construction. For example, the shared experience of being threatened by a forest fire can foster solidarity and obesity is only considered a disease because of a cultural construct, the body mass index (Evans & Colls, 2009; for details, see Chapter 2).

Prainsack and Buyx's approach to understanding what motivates solidarity can better account for empirical nuances than other concepts. Consider the widely used concept of "welfare chauvinism" as an example for other concepts that operate on a binary logic. It distinguishes between generous social benefits for one's "own" population and the exclusion of others from these benefits. Welfare chauvinism is grounded in the idea of equal citizenship, which is often associated with a particular ethnic understanding of population groups (see Chapter 2). In contrast to such an understanding that ties commonalities to the nation state, Prainsack and Buyx foreground situational commonalities as motivations for acting in solidarity. Health needs, in particular, tend to create a sense of similarity, as persons from various social backgrounds can identify with the same health vulnerabilities. For example, the difference in legal status between a citizen and an asylum seeker may become less significant when they share a common health issue such as toothache. In my research, I found that healthcare, in the context of refugees, stands out as a unique area. When utilising medical services, refugees tend to be treated as persons with distinct characteristics and personal concerns, rather than being reduced to their legal status. In this way, healthcare opens a window of opportunity to avoid essentialisation.

This chapter focuses on care providers who, in their daily work, confront practical obstacles and structural exclusions in the Austrian healthcare system while delivering appropriate care to refugees. First, I describe four forms of lived solidarity in refugee healthcare that I encountered in my doctoral work. These include the way healthcare professionals actively engage with refugee patients, by listening to their particular health problems as the mouths, ears, and arms of the healthcare system ("concretising solidarity"). I also explore how care providers compensate for structural gaps, exemplified by their efforts to overcome language barriers and fill insurance gaps ("compensating solidarity"). Additionally, I address the strategies employed by care providers to improve the healthcare system for refugee patients ("creating solidarity") and their role in connecting refugees with the various institutions and services of the healthcare system ("bridging solidarity"). Second, I discuss the motivations that drive care providers to practice solidarity, even in the face of time, financial, and emotional constraints. Third, this chapter reflects on the role of lived solidarity in the context of limited resources in the public healthcare system. I conclude with a summary and a critical discussion of the dynamic between the institutionalised healthcare system and the supplementary temporal, financial, and emotional burdens shouldered by care providers.

7.2 Forms of Lived Solidarity in Refugee Healthcare

7.2.1 Concretising Solidarity: Listening to Patients and their History of Forced Migration

Muhammad, a young man from Afghanistan who had been waiting for a decision on his asylum claim for years, was suffering from leg and lower back pain that significantly impacted his sleep and daily life. Since arriving in Austria, he had sought help from several orthopaedists, but none had provided relief. I accompanied him to three additional specialists, as described in this excerpt from my field notes:

> Muhammad had already sat down in a chair opposite the orthopaedic specialist. They were separated by his desk. Once I introduced myself as a researcher and sat down on one of the companion chairs next to Muhammad, the doctor started asking me about his health problems. When I clarified to him that I that I was there only to accompany Muhammad and he should communicate directly with the patient, the doctor asked him what had happened. Without giving Mohammed a chance to answer, the doctor then asked if he played soccer. Muhammad replied to that question, stating, “Yes, I used to play soccer, but not really anymore.” Cutting off his patient’s sentence, the doctor quickly asserted that his pain was certainly due to playing soccer. At the follow-up appointment in the same practice, another orthopaedist briefly reviewed previous medical results and, barely taking his eyes off his computer screen, referred Muhammad to a specialised hospital. Throughout both consultations, Muhammad remained quiet and resigned, although I had seen him as a cheerful and talkative young man on other occasions, including medical visits. After these two consultations he was unhappy and, in one instance, cried out bitterly in the street, expressing his frustration with the orthopaedists prescribing the same treatment without any improvement. He said that he could not take any more painkillers or injections.
>
> When I accompanied Muhammad to the specialised hospital a few weeks later, he was the last patient in the room after we had spent several hours in the waiting area. While seated, we overheard the orthopaedist venting her frustration to her colleagues about the large number of patients that day. Despite her initial, the consultation with her was different from the previous ones. The doctor first asked Muhammad if it was really okay for me to be present and then took the time to speak to him. While she was looking at his X-rays and medical findings, she listened as Muhammad explained that he had been in pain for a long time. She then took her eyes off the findings and looked at him directly. She told him emphatically that he was too young to have such pain and began to ask him personal questions. She wanted to know where he came from and since when his pain had started. She smiled encouragingly. Muhammad opened up to her and began to tell her about the police violence he experienced during his lengthy journey to Austria via Turkey and Hungary, which he had not mentioned to the other orthopaedists. The doctor ultimately diagnosed a soft tissue injury that required special treatment. (2nd, 3rd, and 4th observation, Muhammad)

The last orthopaedist put into practice the solidarity principle of the Austrian healthcare system – in the sense of realising it in a specific situation. Knowing that patients with a migration background have special problems and need particularly attentive care, she encouraged Muhammad to talk about more than just medical needs in the narrow sense. Based on his biographical information, she ensured appropriate care. In a similar case, I witnessed the development of trust and a relaxed atmosphere when I accompanied Muhammad to an optician. The eyewear specialist used humour and created a friendly atmosphere. This enabled him to address Muhammad's medical needs within the context of his life situation, also considering his limited financial resources when selecting the appropriate medical aid (5th observation, Muhammad).

Sometimes, being attentive in caregiving can be just as, if not more, important than sharing a common mother tongue and cultural background. For example, Maissa praised the Austrian nurse who attended to her during the birth of her second child at the hospital Despite their inability to communicate in a shared language, she recounted, "I understood, when she talked, […] for example through her movements or when she asked in simple words if I am tired or not." (2nd interview, Maissa)

The examples show how healthcare providers nurture a relationship of trust on the basis of which they can detect medical needs and adequately act upon them. Care providers such as the orthopaedist and the optician act as the mouths, ears, and arms of the healthcare system. They concretise the institutional solidarity of the Austrian public healthcare system in which the health needs of all beneficiaries should be met, irrespective of their societal position and personal starting position.

Being a refugee can sometimes result in an inability to assert one's patient rights when healthcare system errors occur. This is often linked to factors such as language barriers, experiences of discrimination, and a general mistrust in state institutions, including those within the healthcare system. For example, an Arabic-speaking pharmacist described an incident where a customer, who had fled to Austria from Syria with his family, expressed concerns about his daughter's treatment. She had been diagnosed with a genetic condition that required ongoing medical care. The father was worried about the quality of treatment at a Vienna hospital, citing previous experiences of discrimination in the Austrian healthcare system. However, he refused to contact the patient ombudspersons' office, the designated institution for addressing such issues within the healthcare system, as the pharmacist explained:

> I told him that if he was unsure, he should contact the patient ombudspersons' office. But there is an inhibition there too. He thinks that if he intervenes and reports them, they will treat his child even worse and sanction him because of this complaint. And apart from that, he says they treat us like the last ones when we are there. I don't just hear that once, I hear that very often, unfortunately. Also about doctors, but also about hospitals. (interview, pharmacist)

The Viennese Patient Ombudspersons' Office refused an interview on the topic of refugee health, explaining that refugees have not approached them for assistance. This suggests that refugees may be hesitant to assert their patient rights. The pharmacist mentioned earlier sees himself as a trusted advisor for Arabic-speaking clients, thanks to their shared language and repeated interactions. In this capacity, he aimed to empower refugees to claim their rights as patients, materialising institutional solidarity by ensuring the same quality of treatment for all beneficiaries of the public healthcare system.

> This is what I mean by the system of informing about (*Aufklärung*) the rights. This means that they (i.e., refugees in Austria, regardless of their legal status) are insecure. They also fear that if they demand too much, they will be negatively affected. Therefore, they attempt to restrain themselves, not to be too loud, so that they won't be punished. They believe that by staying quiet and contenting themselves with what they have (*sich dann zufrieden geben*), they can continue in peace, so to speak. They are afraid that raising their voices and engaging in legal defence would affect them negatively. (interview, pharmacist)

7.2.2 Compensating Solidarity: Filling in for Structural Gaps

For healthcare workers, practising solidarity may also involve the active closing of structural gaps. I illustrate this by discussing the examples of the absence of medical services in a patient's mother tongue in combination with infrequent utilisation of professional interpreters, and of insurance gaps for refugees resulting from systemic errors.

7.2.2.1 Solving Language Difficulties

Refugees in Austria often do not have the opportunity to access medical care in their native language. One common reason for this is the absence of doctors or medical practices contracted with SHI funds nearby refugees' place of residence that have doctors or other staff proficient in their language. Additionally, it can happen that patients are referred to specialists by their general practitioners or during hospital treatment, but these specialists may not have the necessary language skills. In Austria, there is a low-tech video interpreting system in place to address this

issue, but its usage remains limited, mainly due to a lack of regulations governing the cost coverage (Kletečka-Pulker & Parrag, 2018; Kletečka-Pulker et al., 2021). Even when social workers attempt to arrange interpreters for hospital visits in advance, this support is often not provided in practice.

> I once had a case in a hospital where I called and asked: "Do you have video interpreting?" The lady said, "Yes, we do." Then I said, "Very good, we need a video interpreter for Arabic on this and this day." .... We came there on that day. Of course, they didn't have video interpretation. I mean, they have, but they haven't used it, yeah? And then either the client is sent home with the request to come back with an interpreter. And often it is the case that family members or acquaintances step in. (interview, social worker special needs)

Care providers and refugees close the structural gap of language difficulties in practice. For example, a Farsi-speaking general practitioner regularly prescribed gynaecological medication because there were too few gynaecologists in Vienna with appropriate language skills:

> There are medicines that, for example, only a gynaecologist is allowed to prescribe, yes? I always approve it and add, "because of language difficulties"; or that [getting an] appointment with the gynaecologist, if she has fungus, would take three months. (interview, general practitioner)

The general practitioner went on to explain that many patients with limited financial resources choose to see private gynaecologists who speak their language, even though they must pay out of their own pockets since these services are not covered by insurance. On an interpersonal level, this doctor acted in solidarity with her patients. Although it took her time and effort, she was considerate of their living circumstances and went "the extra mile" to meet their needs.

In addition, issues related to interpretation were also addressed through solidaristic practices by other refugees. For example, during an interview, Maissa mentioned that she wanted a gynaecological examination but did not have anyone to interpret for her. The interpreter, who was also a Syrian refugee, offered to accompany Maissa to the doctor. A couple of weeks later, at Maissa's gynaecologist, she provided interpretation assistance. Meanwhile, I helped soothe Maissa's crying baby in the waiting room (1st observation, Maissa).

Often, it is the patients' children who serve as interpreters, as they typically learn German more quickly and easily than their parents. For example, Rima's daughter always joined her mother for doctor's appointments to interpret for her. This is an excerpt from my field notes:

> Rima, her daughter, and I were all sitting in the waiting room of a Viennese hospital, waiting for Rima to have her regular diabetes check-up. The daughter, who was soon to turn 20, started explaining to me that there were almost no medical staff in Vienna's hospitals who knew Arabic.

> That is why she had been accompanying her mother and father to all their medical appointments. She paused briefly and chuckled a little nervously before telling me that some refugees who were already proficient in German accompanied other Syrians to doctor's appointments and interpreted for money. They had this support paid for in cash at €25 per hour. To help family friends save on these expenses, the daughter had also accompanied some of them. She explained that she enjoyed doing this because she aspired to become a doctor herself and hoped to learn from accompanying other patients. (1st observation, Rima)

By accompanying her parents and other Syrians to medical appointments, Rima's daughter filled the structural gap of interpreting services in the Austrian healthcare system.

Her motivation to aid others in their healthcare needs without financial gain contrasts starkly with the profit-oriented approach of capitalising on refugees' language barriers. Some Syrians, proficient in German, were accepting payment for accompanying other Syrians who lacked these language skills to medical appointments. The aspirations of Rima's daughter present a potential informal yet effective solution to this challenge. Aspiring to become a physician herself, she could expand the limited pool of Arabic-speaking healthcare practitioners, thereby addressing the deficiencies in interpretation services. Often, minors and other relatives are reluctantly burdened with the intricate and weighty responsibility of interpreting during medical consultations.[82]

The next time I accompanied Rima to her regular check-up at the hospital, an attentive doctor relieved her daughter of the task of interpreting:

> During a check-up examination for Rima's blood sugar levels, the nurse turned toward Rima's daughter and me and told us that we do not need to remain in the room. We then relocated to the doorway. I observed as the medical professional asked for Rima's birthday, and how Rima immediately looked at her daughter for assistance, who wanted to intervene. However, the nurse continued to address Rima directly, adopting a patient and encouraging tone. Rima turned back to face the healthcare professional and conveyed her birthday, brightening up after saying the words in German. It was evident that she was excited and full of life, answering on her own. After that moment, she stopped to glance in our direction. (2nd observation, Rima)

The nurse's approach to Rima was more time-consuming compared to if the daughter had been present, demanding both empathy and patience. However, by compensating for the lack of

[82] At a later meeting, Rima's daughter told me that she did not pass the entrance exam for medical university (2nd observation, Rima). The examination process is strictly regulated in Austria, with places reserved for citizens of the country. Most of the remaining positions are secured by German citizens. This regulation exacerbates the problem: Despite being a young and committed woman who would contribute to better care for Arabic speakers in Austria, her non-native speaker status posed a hindrance that detrimentally impacted her prospects of pursuing a medical career.

interpreters in the healthcare system, the nurse alleviated the burden on the daughter and allowed Rima to act for herself.

7.2.2.2 Covering Insurance Gaps

Another case where care providers I spoke to were actively involved in filling structural gaps in the healthcare system regarding refugees involved compensating for insurance gaps. For example, a pharmacist regularly compensated for administrative deficiencies.

> And sometimes when they come [to the pharmacy], they don't have insurance because they are too new and they don't have money for the medicine. Or the insurance is interrupted. In such cases, I give them the medicine in advance until they are insured again and can bring it (i.e., payment) later. (interview, pharmacist)

The pharmacist was aware that systemic flaws sometimes result in insurance gaps and actively compensated for this by covering the cost of medicines until the insurance gap was eliminated. The experiences of the director of an advice centre for newly recognised refugees and her colleagues underscore how important such solidaristic practices are:

> The first phase (i.e., first actions regarding healthcare for newly recognised refugees) is actually to secure health insurance, because we have a change in the health insurance system. When people are in basic care, they are insured through basic care. And as soon as they have completed basic care and go into minimum social benefits, the insurance runs through minimum social benefits. However, this is often not done automatically. This means that there are often people who have a gap in between, because the two systems do not interact seamlessly. .... Many only find out when the doctor inserts the e-card that they are not insured. (interview, director advice centre)

Recurring instances where patients face challenges when transitioning from basic care for asylum seekers to minimum social benefits for the unemployed highlight a structural gap in the healthcare system. The director of the advice centre attributed this gap to a lack of coordination among responsible authorities (see also Chapter 5). Solidaristic practices by healthcare professionals, and the work of refugee support organisations, including the mentioned advice centre, help to fill in for this gap.

Moreover, some specific medical services may not be covered by the public insurance. In Austria, beneficiaries of the public healthcare system, such as asylum seekers and recognised refugees, receive medical services from public hospitals and SHI-accredited physicians. However, in cases where non-accredited specialists are required for certain health problems, patients are expected to cover the costs out-of-pocket. Many refugees, particularly in the early stages of their arrival in

Austria when they have not yet secured employment, may struggle to afford these additional expenses, as was the case with Sabah:

> When I had the nerve thing in my hand, he (i.e., Sabah's orthopaedist) also referred me to a doctor to check the nerves. This nerve specialist was private, he didn't take the e-card and he only treated me out of pity or love for us, because he said, "Okay, you don't know the language well, you fled, go to the health insurance fund and bring me a bill from there. Otherwise you have to pay." .... And that's what we did. Otherwise he wouldn't have been able to examine me. (1st interview, Sabah)

The nerve specialist acted in empathy for Sabah's situation as the mother of a newly arrived refugee family with limited financial means. I can only speculate about what Sabah had to apply for at the SHI fund. My assumption is that the specialist was an elective physician, where patients are partially reimbursed for their expenses. It appears that the doctor chose to cover the remaining portion of the costs from his own budget. To understand healthcare professionals' practices of solidarity with refugee patients, it is essential to recognise that Sabah's medical and personal hardships formed the basis for this doctor's decision-making in her treatment.

7.2.3 Creating Solidarity: Improving the Healthcare System for Refugee Patients

Some healthcare providers were trying to introduce new rules, practices, and norms to improve the situation of refugees and other migrants. For example, a self-organised group of Arabic-speaking healthcare providers aimed to establish a monthly information centre with a nurse, a psychiatrist, and other volunteers from the healthcare community to address the health needs of Arabic-speaking refugees (interview, pharmacist). This group of care providers sought to address the challenges related to language barriers and cultural insensitivity within the healthcare system by creating a suitable care structure themselves.

Solidaristic practices often manifest simultaneously both on an interpersonal and a collective level (Prainsack & Buyx, 2017). The healthcare professionals enacted solidarity person-to-person and within organised collectives as part of the medical community. This simultaneity is illustrated by the following experience of a medical specialist:

> In a voice quivering with emotion, the physician told me of a tragic incident involving a child who succumbed to pneumonia. He recounted how the child and her mother were discharged from the emergency room with painkillers, only for the child's condition to deteriorate. Upon their return to the emergency room, they were compelled to endure hours of waiting before receiving attention, and tragically, the child's life was lost shortly thereafter. "That's when we felt," he

> recounted, "I felt so guilty with this case at the time because I'm just part of the system. .... That must not happen, something like that must not happen with us, yes?" (interview, one doctor at the Viennese Medical Chamber)

The healthcare professional struggled to hold back tears, visibly moved by the situation. According to the physician's assessment, the tragic outcome resulted from a misunderstanding of the child's and the mother's needs by the emergency room staff. The child's mother, who wore a headscarf and spoke fragmented German, embodies a typical profile among Austrian migrants, often carrying past experiences of discrimination, leading to feelings of uncertainty and reserve, as explained by the medical specialist. Remarkably, the doctor took personal responsibility despite having no direct involvement in the family's unfortunate circumstances. He viewed himself as an integral part of a failing healthcare system and was motivated by a desire to effect positive change. The heartbreaking death of the child served as a turning point that solidified his commitment to improve healthcare for migrants.

Collaborating with fellow professionals, he embarked on a journey to reform the system, making it more responsive to the needs of marginalised migrant communities. For example, he and his network frequently referred patients to specific medical practitioners from whom they anticipated culturally and religiously sensitive care. They also organised informational events for doctors within the formalised structure of the Intercultural Cooperation and Integration Unit at the Viennese Medical Chamber (*Referat Interkulturelle Zusammenarbeit und Integration*). Finally, they advocated for the allocation of contracts to medical practices with diverse language skills by SHI funds. This approach was also recognised by political representatives as an effective means to address gaps in healthcare (interview, SPÖ politician).[83]

[83] The Viennese Medical Chamber offers a website (www.praxisplan.at) where you can search for doctors based on specific criteria, including your health insurance provider, location, and the doctor's gender. This website is accessible in multiple languages, including German, English, Turkish, Croatian, Bosnian, and Serbian. You can also filter doctors based on their language proficiency. For example, in the autumn of 2019, a search for Arabic-speaking physicians who accept patients with the SHI fund, which most refugees in Vienna are insured with (until 2020 WGKK, now ÖGK, as discussed in Chapter 3), yielded 48 medical practices in Vienna. General medicine had the highest number at 27, followed by laboratory diagnostics (4), eye care (4), paediatrics (3), and dermatological diseases (2). In the fields of gynaecology, orthopaedics, otorhinolaryngology, psychiatry, and radiology, only one Arabic-speaking doctor had a contract with the WGKK in each case. Another free service providing a similar function is offered by the private company DocFinder GmbH (www.docfinder.at).

7.2.4 Bridging Solidarity: Connecting Refugees with the Healthcare System

Care providers outside the healthcare system often play an important role in helping people access healthcare and act as intermediaries. I view this as another form of lived solidarity. The range of this supportive role, which I call bridging solidarity, encompasses both informal situations, where friends and acquaintances assist newly arrived refugees and more formalised practices, such as initiatives led by social workers to assist asylum accommodation residents in finding a doctor. This continuum extends to institutionalised practices by organisations outside the healthcare system that facilitate connections between their clients and medical institutions.

7.2.4.1 Informal Practices of Bridging Solidarity

One of the employees of the Vienna Refugee Aid told me about their experiences:

> In the Vienna Refugee Aid, we have made the experience, especially in the health sector, that the transfer of knowledge by language and culturally sensitive persons is very relevant from the beginning. .... In this area, the involvement of multipliers is also very important. For example, a young mother who has just had a pregnancy and has already gained experience with the Austrian healthcare system can act as a multiplier and share her knowledge with other pregnant women, thus providing great support. (interview, employee at the Vienna Refugee Aid)

This quote highlights how refugees who have been in Austria for an extended period, learned the German language, and became familiar with the healthcare system, play a crucial role in helping other refugees access available healthcare services. Another example of refugees aiding their peers in accessing medical care is their use of social media. For instance, Maissa, who was not proficient in German and knew almost nobody in her new home, often relied on Arabic-language Facebook groups. Within these online communities, Syrian mothers living in Vienna shared health-related information and recommended doctors to each other (2nd interview, Maissa).

Informal assistance provided by fellow refugees can present challenges, especially when it comes to health and finances. Similar to Syrians accepting payment for interpreting at medical appointments mentioned in an earlier section, Sabah faced difficulties while trying to manage her diet due to high blood sugar levels. A Syrian friend in Vienna had recommended a nutritionist often visited by Syrian women. However, Sabah found the cost to be quite high and had doubts about the dietitian's professional expertise (1st observation, Sabah). This situation highlighted a situation where some persons seemed to be taking advantage of refugees who were still in the process of settling in and had limited understanding of the Austrian healthcare context.

Moreover, there are Austrians who support newly arrived refugees in connecting with medical institutions. This commitment was exemplified by a particular family. When I asked Rima what she did when she fell ill after arriving in Austria, she began to recount their journey through family reunification. Two of her children had already been living in Austria for over a year under the care of an Austrian family. This family played a crucial role in helping the Syrian couple access the healthcare system during the initial weeks following their arrival, and they accompanied Rima to the hospital when she needed a cardiac assessment (1st interview, Rima).

Informal connections between healthcare professionals and institutions within the healthcare system play a significant role in facilitating the delivery of appropriate care. Many dedicated healthcare providers serving the needs of refugees utilise informal networks of colleagues to whom they refer patients, often because of their language skills or cultural sensitivity (interview, two doctors at the Viennese Medical Chamber). These referrals can include contacting a cardiologist acquaintance to secure an earlier appointment for a patient (interview, general practitioner). In some cases, they involve writing a personal note to request special attention for a patient. For instance, an orthopaedist explained that she wanted to ensure the best treatment for an Afghan patient and referred him to a trusted colleague. She concluded the medical referral with "warm regards" and her first name (interview, orthopaedist). Additionally, I came across business cards and promotional materials of other medical practitioners in certain refugee-friendly medical practices, such as at the reception of an Arabic-speaking dentist (1st observation, Maria).

7.2.4.2 Social Workers' Practices of Bridging Solidarity

Often, social workers within asylum accommodations take on the responsibility of organising healthcare services for their clients and establishing connections with medical facilities. The transition from a reception centre to an asylum accommodation is a crucial moment in this process. A social worker at an accommodation catering to people with special needs explained: "When the clients move in with us, there is a medical history interview (*Anamnesegespräch*)" (interview, social worker special needs). During this interview, she elaborated, healthcare professionals assess health needs and make referrals to medical facilities as necessary. For example, at Austria's largest reception centre in Traiskirchen, a girl was initially given a wheelchair that was unsuitable for her condition. Social workers in the asylum accommodation later directed her to specialised medical experts to ensure proper medical care (interview, social worker special needs). In general, experts and professionals identify problems during the compulsory initial

medical examination in reception centres as frequent. Often, social workers later compensate for these problems in their daily work (see Chapter 3).

Identifying health needs was equally vital for another social worker at a relatively large accommodation exclusively for men. Alongside some other colleagues, she held responsibility for overseeing the health needs of the residents, recounting their procedures when residents move in newly:

> It starts with the basic check-ups (*Vorsorgegrunduntersuchungen*). Many clients have not yet been to the dentist or something, appointments like that. When they have their move-in interview (*Einzugsgespräch*), for example when people move in, we do something such as a staff questionnaire (*Personalfragebogen*), let's say, where we ask them about the most important things. (interview, social worker large accommodation)

Social workers in asylum accommodations compensate for inadequate care that occur during the reception procedure and in the residents' home countries, such as a lack of dental care. The residents are "examined by the house", as the social worker explained, through formalised procedures such as the move-in interview and staff questionnaire. As part of these procedures, asylum accommodations gather and manage residents' medical information. This comprehensive approach was further explained by another social worker in a smaller accommodation, emphasising that the facility houses "all the information about previous medical findings, what medication this person is currently taking – just their health history" (interview, social worker special needs). Once this medical data is compiled, social workers also facilitate its transmission to healthcare facilities when necessary, especially during emergencies. For instance, in the event of a client experiencing an epileptic seizure, social workers inform the ambulance service about the person's medical background and ensure the prompt transfer of this medical information to the hospital (interview, social worker special needs).

Moreover, social workers take on the responsibility of scheduling medical appointments for their clients. When I accompanied Muhammad to his ophthalmologist appointment, he held onto a piece of paper – a printed online confirmation of the appointment – containing his complete name, social insurance number, the ophthalmologist's location, and the appointment time. A social worker from his accommodation had highlighted the doctor's name, address, and appointment time in yellow. With this paper in one hand and his mobile phone displaying a web mapping platform in the other, Muhammad guided us to the doctor's office (5th observation Muhammad). In asylum accommodations catering to those with special needs, social workers go

a step further by providing additional assistance, such as accompanying clients to their appointments.

> It was about the fact that one of the clients, who also has an alcohol disorder, wanted to go to inpatient rehab. And to ensure that it really works, it is often good if someone accompanies them. This way, it can be easily explained at this institution, as it is often difficult for the clients to express themselves. So, it can happen that the institutions don't know what to do with them, or they are sent away again. (interview, social worker special needs)

The social worker supported a resident, who grappled with alcoholism and faced challenges in connecting with medical institutions due to his addiction. These problems were additionally increased by communication barriers. The social worker recounted how she helped transition this client from an outpatient addiction counselling centre to an inpatient facility. In her explanation, she underscored those misunderstandings between health institutions in such cases, which could lead to the person seeking assistance being turned away, disrupted the medical treatment continuum. In navigating this intricate process for the resident, who grappled with alcoholism, the social worker not only aided with the general process but also stood outside the door during a private doctor-patient conversation, "to provide a bit of security", as she described it. In cases where the task is simply to accompany clients within the city due to illiteracy or unfamiliarity with the German script, social workers save time by involving community service workers (*Zivildiener:innen*).

In some asylum accommodations, I noticed lists in the communal areas. Social workers had put up these lists, which included names of doctors with whom residents had negative experiences, such as facing discrimination during medical visits. These lists also featured names and contacts of doctors who had been supportive and understanding, either because they were skilled in the residents' or their willingness to offer additional assistance in various ways. A social worker provided more insight into this practice:

> As far as doctors are concerned, we now have a list of dentists, neurologists, physical therapists – all kinds of doctors with whom we have worked and who we know are good. In some cases, we have specifically looked for doctors who speak Farsi or [any other language shared by residents]. And we refer residents to them. We have a pool of doctors for making appointments, where we know that they deal well with our people, and everything fits. .... And, of course, there are also doctors with whom things don't go well at all. (interview, social worker large accommodation)

Furthermore, in cases involving increased medical complexity, social workers may dedicate significant time to ensure and orchestrate appropriate medical care in collaboration with specialists. This can involve numerous follow-up phone calls and the development of informal

connections with necessary specialists. For example, a social worker recounted a situation where she had to make multiple calls to a hospital and use resourcefulness and creativity to facilitate treatment for a child with mobility challenges. Additionally, she familiarised herself with specialised medical information related to the child's health needs, ensuring that her interactions with healthcare professionals were treated seriously:

> When you call the hospital, it's also difficult to explain it to them because they tend to turn you away, don't they? That means that you must make sure that you acquire a bit of professional [medical] competence, so to speak, so that when you call the hospital, you simply have more vigour for your inquiry. .... So, I was once so bold and simply wrote to a doctor at a private practice by e-mail. I got a tip that this was a doctor with whom the company that makes the wheelchairs works well. And that's how it slowly got going. .... Sometimes you must be a bit cheeky (*dreist*), I say, and try everything you can. (interview, social worker special needs)

The social worker explained that organising and orchestrating appropriate treatment can be "very labour intensive" and requires a significant amount of effort on her part. Next to the steps outlined in the quote, this also involved coordinating with the child's paediatrician and navigating the complexities of the hospital's challenging operation procedure.

Other bridging functions, which social workers perform, include organising interpretation services for doctor visits, connecting with volunteer health navigators, overseeing follow-up treatments, asking doctors to provide free medical certificates, and staying in regular communication with residents to monitor both existing and new health needs. They also ensure that asylum seekers receive the medical aids they need, even for items that are not covered by their SHI, such as hearing aids. In such cases, the social workers take on the responsibility of arranging reimbursements (interview, social worker large accommodation) or make inquiries over the phone to determine if alternative versions of prescribed splints are covered by the SHI (interview, social worker special needs).

In addition, social workers routinely take the initiative to reach out to clients who may have undiagnosed health needs. This proactive approach helps addressing some residents' lack of connection to the institutional structures of the healthcare system:

> Then I have one or two clients who are very mentally ill. But they don't have a diagnosis because they don't want to go to the doctor, which is very difficult. Then we try to do outreach work because some of them don't leave the room very often, and you wouldn't see them. .... We also have a group of, so to speak, a list of people whom we try to visit at least once a month in their room. That's our focus group, where we have the feeling that we must pay a little more attention

> to them because otherwise, they don't arrive at us at all. (interview, social worker large accommodation)

The quote highlights the prevalence of unnoticed mental health issues among refugees in Austria during my fieldwork, a topic that was also raised by the psychologist I talked to (interview, NGO psychologist). In Austria, mental healthcare is generally under-resourced and faces greater accessibility challenges compared to other medical services (see Chapter 3). Ideally, social workers can bridge the gap by connecting residents dealing with mental health problems to specialised professional services, such as the NGO Hemayat. This organisation is specialised in assisting war victims and provides treatment in their native languages, funded by both private donations and public contributions (interviews, social worker special needs; social worker large accommodation; observations during fieldwork).

7.2.4.3 Institutionalised Practices of Bridging Solidarity

At a more formalised level, organisations specialising in overall refugee care often take on a bridging role to connect their clients with the healthcare system. For example, counselling centres for newly recognised refugees serve this purpose (interview, director advice centre). The Austrian Integration Fund holds a unique position in this context. It tasks NGOs and quangos with conducting standardised courses for orientation and on Austrian values for newly recognised refugees in the nine Austrian *Länder*.

According to the Integration Act of 2017, newly recognised refugees must participate in these orientation courses on Austrian values to be eligible for social benefits (Taubald, 2018; see Chapter 3). The mandatory comprehensive overview course for all newly recognised refugees includes a section dedicated to the healthcare system. This section covers the pivotal role of general practitioners as gatekeepers, the e-card's role as a door opener to medical services, and the funding structure of the healthcare system based on solidarity through the general tax system. Additionally, those interested can partake in an in-depth course specifically focusing on health-related matters. During my observations in both an overview course and a health-specialised course, I witnessed engaging sessions with around ten participants each, some of whom shared personal experiences and showed their interest by posing questions. One course instructor explained to me how she directs participants with specific health concerns or personal inquiries to the institutionalised healthcare system, for example by referring them to general practitioners (interview, integration course trainer).

In certain instances, a dual bridging role becomes apparent. So far, I elucidated how persons or institutions outside the healthcare system identify a medical need and establish a connection with the institutionalised healthcare system. However, actors within the healthcare system can also guide patients toward establishments beyond the healthcare domain. These two dimensions of the bridging function can intricately intertwine and work in tandem. For example, the Vienna Child and Youth Welfare Service (*Stadt Wien – Kinder- und Jugendhilfe*) referred a client to an NGO specialising in war trauma. Subsequently, this NGO assisted the mother in engaging with the youth welfare office. A psychologist from this NGO shared this account with me, highlighting the collaborative nature of the process:

> One client had her child taken away by the youth welfare service. But she had a very nice social worker at MA11 (i.e., Vienna Child and Youth Welfare Service) who referred her to us. At the beginning, there was, of course, always networking in the sense of: okay, the woman has now landed with us - what is the situation? What is the situation with the child? What must happen now so that she can get the child back? (interview, NGO psychologist)

The psychologist and her colleagues bear a significant responsibility in establishing connections with various organisations and institutions that address social needs, as illustrated by reuniting the child with their mother. Other instances of these social needs include finding suitable housing, understanding bills, and comprehending written reminders of medical appointments (interviews, NGO psychologist; general practitioner). Another doctor outlined how she built a network with representatives from institutions outside the healthcare system. Frequently, she and her assistants engaged in social work on behalf of refugee patients requiring additional assistance. This encompassed communicating with their children’s schools and coordinating both bureaucratic and further medical appointments for them (interview, general practitioner).

7.3 Motivations for Lived Solidarity

Solidaristic practices are guided by specific motivations. In the theoretical framework adopted for this chapter, solidarity is defined as “an enacted commitment to carry ‘costs’ (financial, social, emotional or otherwise) to assist others with whom a person or persons recognize similarity in a relevant aspect.” (Prainsack & Buyx, 2017, p. 52) These similarities can be situational, such as the experience of pain after an injury, or more enduring such as a shared immigration history, being a woman, and being a parent. I now focus on the motivations of the care providers that I encountered during my research.

As mentioned earlier, informal networks exist among healthcare providers in Vienna who themselves have a migration history. Many of the health professionals focused on in this chapter themselves migrated to Austria. When accompanying refugees to medical appointments in Vienna, I often encountered healthcare practitioners whose mother tongue matched the language of the patients or who shared a cultural background with the 2015 refugee cohort. However, in the interviews with such care providers (optician, pharmacist, general practitioner, NGO health trainer, two doctors at the Viennese Medical Chamber), the shared language and their common cultural background was just one motivation among others for them to act in solidarity.

> These are things that, of course, also seem totally alien to us here as healthcare providers in Austria at first glance, if one were not familiar with the cultural background, as I am. I take an insane amount of time and that is also the time that no one pays me for, but it is a great concern to me. (interview, pharmacist)

In the quote, the pharmacist from an Arabic-speaking country pointed out that having a shared cultural background with many of his refugee clients makes it easier for him to understand and address their needs. Yet, when expressing his motivation, he talked about how it is important to him that everyone receives the care they need. Similarly, a general practitioner, who arrived in Austria as a child from a Farsi-speaking country, based her actions on her role as a mother:

> I am a mother myself - and when I call [the school] and say "my child is sick", it means my child is sick. Up to three days, the parents can do it themselves [without needing written confirmation from the doctor]. No parents would call if their child was not sick. I mean, what's the point, yeah? Sometimes it's really annoying, yes, because it's unfair, I think. (interview, general practitioner)

Being a mother herself, the doctor empathised with parents who had to go the extra mile because schools wanted them to pay for doctor's confirmations for their children. To address this perceived injustice, she acted in solidarity with affected families. She reached out to the schools by phone to question the need for written confirmation for a particular child. Despite the emotional and time-consuming effort, she issued free confirmations, opposing the medical association's fee requirement. Her stance was that certain social groups, due to language barriers, past experiences and traumas, cultural differences, low assertiveness, or financial constraints, require more support and attention to meet their health needs effectively (interview, general practitioner). The shared experience of parenthood also motivated the assistant in a doctor's practice I spoke to during my fieldwork. Working in an Arabic-speaking doctor's practice, she faced challenges in understanding patient requests, prompting her to start learning Arabic. She

expressed that, as a mother herself, when she encounters worried mothers, her aim is to assist them as much as possible.

Furthermore, a sense of personal responsibility can be a strong motivator in the healthcare sector. Some professionals I interviewed felt a duty to address what they saw as unjust or flawed in the system. For example, one specialist felt guilt over the death of a migrant child in an Austrian intensive care unit (interview, one doctor at the Viennese Medical Chamber). Similarly, the Farsi-speaking general practitioner felt responsible for compensating for structural deficits. Seeing herself as a representative of the healthcare system, she aimed at ensuring equal attention to all beneficiaries (interview, general practitioner). Another specialist grew increasingly frustrated witnessing the inadequate care provided to certain persons, which drove her to take on extra work to counteract these disparities:

> And I see that with these people, from the war traumas, from the Yugoslav, from the Yugoslav war, from terrorist attacks in Madrid as I said the one, and systematically through the bank of headscarf wearers, no matter, even if they come to terms with their fate from an age, because that is their culture or also [seek it], who simply develop the whole body pain at some point, because they are simply treated like shit; and that is a cultural aspect and therefore by no means okay. (interview, orthopaedist)

7.4 Lived Solidarity on the Background of Limited Resources in the Healthcare System

Limited resources play a pivotal role in understanding the described solidarity-based practices. The Austrian healthcare system does not (yet) follow the efficiency-focused approach of for example the NHS in the UK, which commentators labelled as "care crisis" (Dowling, 2021). Yet, many care providers I spoke to criticise a declining quality of care within the Austrian system as well. They linked their role as rectifiers of systemic deficiencies in healthcare for refugees to overall resource limitations. Economic factors heavily influence and shape the services provided, escalating the financial, emotional, and time costs for healthcare workers in delivering adequate care. These factors significantly impact the need for solidarity-based practices and the capability to meet the requirements of refugees and other patients, as exemplified in the multiple lived solidarity instances detailed in this chapter.

The pharmacist explained that the additional time spent caring for certain clients is not compensated (interview, pharmacist). Many therapists would like to have "much more support from social workers" (interview, NGO psychologist) and a health course trainer at the Austrian Integration Fund mentioned that "at some point ... [they] are no longer the right contact persons"

(interview, integration course trainer). This trainer mentioned that certain participants in the course came to her with ongoing social and health concerns, but she could not assist them due to time constraints. The general practitioner pointed out that the calculation system for health services of the Austrian SHI does not allow her to dedicate the necessary time to her patients. Despite this, she invested extra time but faced losses in her SHI-accredited general practice. To compensate, she was additionally working as a company doctor in the private sector (interview, general practitioner). The empathetic orthopaedist who took time to listen to Muhammad's complicated injury story and worked in a public hospital, explained that the medical quality suffers due to general austerity measures in the healthcare system. She expressed frustration with the cuts, which hinder providing quality care to patients and make her unhappy with her job. The doctor felt the impact of austerity measures across all areas of her work, from hospital staff amenities to the medical equipment used in patient care.

> It started with them taking away lemons from us and replacing them with citronate. They take away our Sonnentor tea (i.e., a comparably expensive biological Austrian tea brand) and replace it with Teenina, so this is not even the cheapest Teekanne tea (i.e., a tea brand in the lower price segment). It's a copy of Teekanne. These are the little things, that's how far these effects are. .… From, to – we now only get cheap needles, even for the intrathecal ones; I get a cheap lump, shit. (interview, orthopaedist)

Over the past decade, increasing limitations have also impacted organisations dedicated to refugee support in Austria. Specifically, critical and diversity-oriented civil society groups in the fields of migration, women's issues, labour market, development, and arts faced political delegitimisation and financial reductions between 2014 and 2019 (Simsa et al., 2019). For example, a health trainer from an NGO specialising in migrant and refugee health told me that their organisation experienced financial strain, engendering job insecurity for the trainers (interview, NGO health trainer). Similarly, the director of the advice centre for recognised refugees highlighted the issue of limited resources:

> We always have ideas for projects, but just no, really no resources, or little. Our funding is also always at the limit, of course. That's clear. The City of Vienna is also saving, but yes. We just try to make what is there, which is a lot in Vienna, accessible to people. That is our approach. (interview, director advice centre)

Moreover, the social workers I interviewed told me that they would like to offer more health services to their clients, but often lack the means to accompany them to medical appointments. The social worker at the large asylum accommodation described the challenge of supporting the health needs of 70 to 90 residents due to insufficient staff. Acknowledging the impossibility of

adequately attending to everyone amidst their current workload and the high care ratio, the existing conditions hindered her from working as she wished (interview, social worker large accommodation).

The practical difficulties in meeting the medical needs of refugees, as well as of other patients, can lead to frustration among solidaristic care providers. For example, the optician shared his distress over being unable to fully cater to the needs of his clients within the constraints of the existing system – illustrated by the example of the need for a certain type of glasses. He emphasised the importance of considering his clients' financial capacities and addressing their specific needs rather than prioritising the most profitable products (interview, optician). I was able to observe this approach during a prior visit to the optician's workplace while accompanying Muhammad. With an encouraging posture and a warm smile, he respectfully guided the young Afghan to the special offers and openly discussed price differences. However, as the glasses Muhammad required were not covered by his public health insurance, the optician could only provide an alternative model that would not help his condition in the best possible way (5th observation, Muhammad). Reflecting on this and similar situations, the optician explained during our later interview:

> So I provided him with this emergency care (*Notversorgung*) with these glasses, which were part of the health insurance tariff and [were] without an anti-reflective coating. Meanwhile, I feel uncomfortable because I know that these reflections worsen his eyes. It won't bring improvement, it's a merely temporary solution, yes? .... He can't afford more, but at least, he can see better than without. Personally, for me, that part is the most painful: when you come home after work and you're like, "Ah, it's been a tiring day". This fatigue usually stems from these moments, when I take on or am confronted with this energy from people. (interview, optician)

The optician provided Muhammad with an affordable but not medically ideal pair of glasses. He told himself that this was better than nothing. These moments, when he must prioritise financial feasibility over medical necessity, drain him a lot of energy. His quote illustrates how material conditions can impede the drive to act in solidarity. The optician explained that his ability to act is greatly limited by institutional requirements mandating additional payments for certain types of eyewear. Nonetheless, he strove to address medical needs as effectively as he could. Both his and other care providers' experience reveal a recurring pattern, highlighting the emotional and mental strain that negatively impacts the well-being of those providing care.

7.5 Conclusion

This chapter showed how care providers, including healthcare practitioners and social workers, engage in various forms of lived solidarity that compensate for practical barriers that persist for refugees in practice. It discussed four different forms of solidaristic practices that fulfil the promise of justice within Austria's solidarity-based healthcare system (see Table 3): In the first form (concretising solidarity), healthcare workers act as the mouth, ear, and arm of a solidarity-based healthcare system. They shape solidaristic institutions through their everyday practice. Think about Muhammad's search for treatment for the pain in his leg. Two orthopaedists primarily focused on his physical symptoms, failing to consider his personal history. However, the third orthopaedist, who took the time to listen to Muhammad's story, accurately determined his medical needs.

	What does the (health)care provider do?	*Example*
Practice 1: **Concretising Solidarity**	Healthcare providers concretise institutional solidarity, shaping medical institutions through their everyday practice	Medical specialist also inquiries about other areas of life to adequately answer to medical needs, for example, patient's history
Practice 2: **Compensating Solidarity**	(Health)care providers compensate the lack of institutional solidarity, by filling gaps left open within the healthcare system	General practitioner takes on gynaecological examinations due to the scarcity of Farsi-speaking gynaecologists and - against the guidelines of the medical association - issues free certificates for cash-poor parents
Practice 3: **Creating Solidarity**	(Health)care providers try to create new rules and practices	Advocacy for more multilingual doctors within the public healthcare system
Practice 4: **Bridging Solidarity**	Care providers help in entering the healthcare system	Other refugees or Austrians support newly arrived refugees (informal); social workers build connections to medical institutions (formalised); Austrian Integration Fund courses about the healthcare system (institutionalised)

Table 3. Forms of solidaristic practices (source: Spahl & Prainsack, 2021; complemented by bridging solidarity)

In the second form of solidaristic practice (compensating solidarity), healthcare practitioners fill gaps within the healthcare system, such as language difficulties and insurance gaps. Think about the pharmacist who extended medications without immediate payment, waiting for refugees' insurance coverage to be reinstated. Through such practices, solidarity becomes an inherent corrective to the system. A third form of lived solidarity (creating solidarity) takes a more

proactive stance by aiming to create new rules and regulations that alter the existing norms and instruments (for example, new laws or revised resource allocation criteria). Lastly, care providers outside the healthcare system help in initially accessing services (bridging solidarity), for which I found different levels of formalisation. Informally, refugees and other persons committed to mitigating persisting inequities for refugees for example offer support by sharing information about supportive healthcare providers. On a more formal level, social workers in accommodations establish connections between residents and institutional medical services, ensuring comprehensive care by identifying healthcare needs and ensuring continuous treatment within the healthcare system. Institutional bridging solidarity takes place in specialised organisations such as NGOs dedicated to refugee support and the Austrian Integration Fund.

Furthermore, this chapter discussed the diverse motivations of care providers to enact solidarity with refugees. Shared characteristics, such as a common language or cultural background, as well as shared life experiences, such as motherhood, guide their actions. These commonalities allow for a broader understanding of persons beyond just shared immigration or ethnicity. Care providers practise solidarity with refugees not only due to their shared refugee status but also driven by other factors, such as shared parental roles. In contrast to the theoretical assumptions on solidarity by Prainsack and Buyx (2012; 2017), which form the basis of this chapter, I also found motivations based on differences. Care providers supported refugees as persons not receiving standardised care within the healthcare system. Some expressed a sense of responsibility as healthcare practitioners with a professional ethos in a flawed system.

The forms of solidarity discussed here often go unnoticed and are mostly unpaid. Besides creating solidarity, which aims at institutional change, and institutionalised forms of bridging solidarity, this largely involves additional, unpaid work that exhausts care providers, pushing them to their limits. In a healthcare system already strained by limited resources, this extra effort becomes particularly burdensome. It extends beyond medical work in the narrow sense, encompassing activities such as listening to refugee biographies, and consumes healthcare practitioners' time and energy. This becomes especially challenging given the already demanding nature of their professional lives. Think about the optician's profound fatigue when providing Muhammad with an affordable pair of glasses that were not the best fit medically.

Recognising material conditions as either facilitating or impeding solidarity practices is crucial. Ideally, the emotional, financial, and temporal burdens should be institutionalised, not placed solely on solidaristic care providers. In the realm of "epistemic solidarity", defined as supporting patients as knowers, Pot (2022) suggests institutionalising associated costs to support and sustain

this vital practice. She proposes integrating the practice of attentively engaging with patients into formal healthcare protocols, giving it a status similar to that of biomedical interventions such as diagnostic tests.

Some care providers advocate for institutionalising solidaristic efforts to bridge gaps through novel regulations (creating solidarity). Recent studies conducted amid the COVID-19 health crisis researched the relationship between solidarity and its institutionalisation (Kieslich et al., 2023; West-Oram, 2021). They suggest formalising interpersonal and collective solidarity within institutions to ensure continuity and address existing voids. Based on qualitative interviews, Kieslich et al. (2023) find that formalising interpersonal and collective solidarity within institutions is vital for these practices to continue. When applied to the findings of this chapter, this argument suggests that if care providers bear the sole emotional, financial, and temporal burdens of their solidarity efforts, their determination to continue such actions might diminish over time. Similarly, West-Oram (2021) contends that institutional solidarity is a critical foundation for interpersonal solidarity. He argues that relying solely on individuals consistently practising interpersonal solidarity is insufficient for public health endeavours. To foster interpersonal solidarity, governments should express solidarity by furnishing epistemic, institutional, material, and financial support.

This chapter demonstrated that limited resources, both within and outside the healthcare system among those practising bridging solidarity, present a challenging environment for solidarity-based practices that facilitate adequate healthcare for refugees. Relying solely on the solidarity efforts of dedicated service providers to meet the health needs of all individuals in Austria is not a sustainable long-term solution. The valuable work of health professionals engaged in solidarity must be institutionally supported to prevent discontinuation due to frustration or overwhelming demands in their daily professional lives.

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Chapter 8: Developing a Sense of Belonging through the Use of Medical Services[84]

8.1 Introduction

The previous chapter concentrated on the ways in which solidarity-based practices of care providers fill gaps in the public healthcare system (Chapter 7). While refugee participants in my doctoral work acknowledged these practices, this chapter focuses on how they had acquired the skills to navigate the healthcare system and what this meant to them. The narratives of refugee patients showed that emancipation from support held more meaning for them than the support itself. To refugees, the healthcare system offers the opportunity to be regarded as patients among fellow patients, rather than being perceived as marginalised "others" (see Chapter 2).

This chapter shows how some experiences by refugees when utilising healthcare services in the public healthcare system and finding their way around medical facilities such as hospitals and doctors' offices engender a personal sense of belonging for them in their new home. First, I discuss how self-managing healthcare becomes a moment emancipation from needing support. Second, the familiarity established with healthcare providers and institutions empowers refugees, enabling them to undertake independent actions often curtailed within the asylum system. Then, I show how the personal electronic health card, the e-card, serves a role beyond merely functioning as administrative technology. Lastly, this chapter addresses how refugees value the solidarity-based Austrian healthcare system and actively seek to participate in reciprocal support, exemplified by their consistent attendance at medical check-ups and voluntary blood donations. To conclude, I argue that these notions of public healthcare collectively foster a sense of belonging for refugees in Austria.

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[84] Note that I conceptualised large parts of the empirical data presented in this chapter elsewhere with a different focus. Instead of this chapter's framing of belonging, my previous article *Being a patient among other patients: Refugees' political inclusion through the Austrian solidarity-based healthcare system*, published in *Bioethics*, focused on my data's relevance for theories on solidarity, uniting claims from migration and healthcare scholarship (Spahl, 2023). Specifically, I argued that the solidarity-based Austrian healthcare system in the case of refugees is both an example of "civic solidarity" and of "political solidarity". I showed how medical encounters not only provide medical care, but also enact political inclusion. I summarised the *Bioethics* article in a blog entry for Eurac Research (Spahl, 2022).

8.2 Emancipation from a Position of Need

> Muhammad held an online confirmation of his appointment with the ophthalmologist in one hand that a social worker at his accommodation had printed out for him, when we were on our way to the doctor's practice. They had highlighted his name, the ophthalmologist's address and the time of the appointment in yellow. Muhammad held his mobile phone with an open web mapping platform in his other hand, to guide us to the doctor's practice. Taking a glance at the navigation system, I was sure that we just needed to continue on the street for half a block. Muhammad suddenly stopped and turned to the left and to the right. I expected him to be lost and asked if I should help him. He firmly declined my offer and eagerly kept to watch out for the doctor's practice himself (5th observation, Muhammad).

For persons who have lived in Austria their whole lives, establishing contact with medical institutions and finding out where to get help with a specific medical problem can be challenging. For refugees, this step of entering the healthcare system is even more difficult and – at least at the beginning – often accompanied by support. In Chapter 7, I described various ways of how care providers connect refugees with the healthcare system's institutions and services, which I called bridging solidarity. I described one instance illustrating this practice in my observational note of Muhammad's ophthalmologist visit, where social workers printed the practice's location and appointment details on paper to assist him in accessing necessary healthcare. However, from Muhammad's perspective, autonomously managing his own healthcare was more important than the experience of having had support. His focus was not on the support itself, but on his emancipation from needing the support – accordingly he declined my offer to help him with finding the doctor's practice.

When I accompanied Muhammad to a dental appointment, I observed a similar display of Muhammad's ability to navigate the healthcare system by himself:

> As we entered the large dental centre housing multiple doctors, Muhammad swiftly checked in at the reception desk. He confidently led us through the intricate layout of the building to the waiting area. When I needed to use the restroom, he showed me the right way between the grey doors that looked the same. After his consultation with the dentist, he nearly ran back to the reception to promptly arrange another appointment. As we left the building, he turned to me, firmly stating: "This is not my first time." (1st observation, Muhammad)

Muhammad's statement about not being at the dentist centre for the first time underscores a certain pride about knowing his way in the healthcare system and his comfort and experience within this particular healthcare environment. Already in our very first meeting, the young man had already emphasised that he does not need anyone to accompanying him to his medical appointments, stating that he knows his way. Navigating the healthcare system by themselves

was also important to other research participants. Abdi, for example, expressed the wish to be an active participant in the healthcare system in the healthcare system without being dependent on others, such as social workers. He proudly highlighted that he had learned how to search for doctors by himself and had particularly wished to not being accompanied.

> Last year, my counsellor explained to me [how to get medical appointments]. She showed me how I can search when I need the doctor. I went to the [asylum accommodation's] office to look for a doctor and so on. But now I can look for a doctor myself. I write "doctor" on the internet. Yes, it's very easy for me (laughing). (1st interview, Abdi)

Moreover, civil society volunteers also support refugees in finding doctors and accompanying them to medical appointments. These volunteers, often referred to as "health navigators", play a vital role due to the resource constraints faced by asylum accommodations. Even within accommodations designed to cater to the needs of clients with extensive medical needs, social workers rely on these volunteers' assistance (interviews, social worker large accommodation; social worker special needs). However, Muhammad and Paulin had a different perspective on these voluntary health navigators compared to what the social workers conveyed. Rather than appreciating their support as much-needed assistance, both young men distanced themselves from the notion of being accompanied. They explained that this support was offered to them without their request. Muhammad emphasised that he not only did not require assistance at the moment but also hinted that he had not needed someone back when he first arrived, "at the beginning" (1st interview, Muhammad). Similarly, Paulin was introduced to a French-speaking woman by someone in his asylum accommodation, who would accompany him in case of medical issues. When I asked him about that, he stated with resignation "it works a little bit, it works a little bit, it works a little bit" (1st interview, Paulin).[85]

It is not only social workers and health navigators that provided support from which refugees sought to emancipate themselves, but refugees also supported each other. Abdi explained that a friend with advanced German skills accompanied him to doctor's treatments when necessary, such as when he broke his arm whilst skateboarding.

> I know that my German is not very good. When I need help and stuff, I call one of my friends, he speaks better. He knows the language well. Some words I can't say because I don't know them. I

[85] What might contribute to Muhammad's and Paulin's restrained enthusiasm about the voluntary health navigators – next to their wish for autonomy – is that none of the women were speaking their native language, thus not being able to adequately interpret.

> forgot them and stuff. But if it's not something big, I can go myself and I can speak the language myself. .... But I hope that I will learn [German better] later. (1st interview, Abdi)

Abdi expressed admiration for his friend's proficiency in German and told me that he wanted to improve his own language skills. Interestingly, in his narrative, he did not place much importance on his friend's assistance with his medical issues. Abdi did not bring this up, nor did he convey his gratitude for his friend to me. In a similar vein, Maria received support by "friends and acquaintances" in letting her know how the Austrian healthcare system works. She stressed that she had acted for herself after having asked them how everything works:

> But I did all of that that alone. …. I only asked and then I went there. Because the public transport here is very good, you really can't get lost. Everything is always the same. Now I know, it is also me who can do everything. It's very easy. (1st interview, Maria)

To Rima and her family, acting autonomously in the healthcare system was important and allowed them to emancipate themselves from a position of need. She and her husband had arrived in Austria via a family reunification policy. Two of their children had already been there for over a year, living with and cared for by an Austrian family. This family took over an intermediary role in connecting Rima with the right places to go within the healthcare system. She explained that they went to the hospital with her, as she needed to check-up on a pre-existing medical issue. In the interview, Rima then went on to talk to me about the various forms of examination and the operation. In Rima's narrative, the Austrian family no longer played a role from the moment she was connected to the healthcare system. While she acknowledged that this family assisted her to establish contact with medical institutions, she placed greater emphasis in her narrative on how she herself then navigated these institutions within the healthcare system (1st interview, Rima).

The time factor is pertinent in all these accounts of struggling for and practising autonomy through managing their own health, in the sense that the research participants explained that they have developed independence over time. For example, Muhammad recounted:

> When I came here, many people helped me, for example. When I arrived in Austria, I had a lot of stress. What happens? The new people, I can't speak the language. .... Here I learned English, German too, at the vocational school. Then it got better for me. If there is a problem for me now, I go myself. I don't take anyone here from the flat to the doctor or to therapy. I don't take people with me, I already go myself. Speak for myself. (1st interview, Muhammad)

Muhammad explained how in his early days in Vienna he relied on help from other residents in his accommodation, from social workers and from health navigators. After his strenuous way to Austria, he suffered from severe exhaustion and, according to his own account, slept for two

months. With time, and learning English and German, he found his feet in the new place, going to medical appointments and speaking for himself. Equally, Paulin emphasised how he does not need volunteer health navigators to accompany him anymore and Rima highlighted how she managed her medical issue by herself. Similarly, Abdi explained emphatically and at length how he had become independent from social workers in finding doctors and making medical appointments: "Now I can look for doctors myself." (1st interview, Abdi) The healthcare system offers ways of seeking healthcare not as refugees in need of support, but as self-reliant patients among other patients in the public healthcare system. Healthcare practices can enact emancipation in the true sense of the Latin word of "to be taken out of someone's hands".

8.3 Empowerment through Familiarisation with the Healthcare System

Next, familiarity with healthcare providers and institutions empowered refugees. It was part of regaining control over one's life and create a feeling of safety, both of which refugees often are deprived of. For example, when I accompanied Maria to her general practitioner, she experienced visiting him and his practice as a familiar and pleasant event.[86] She told me about her strong admiration for the doctor. Sitting in the waiting room, she greeted the passing assistants warmly and pointed to some framed staff portrait photos hanging above one of the tables with magazines and information brochures, in order to explain to me that she knows them and that one of the assistants was the doctor's wife. During the medical consultation the doctor acted with familiarity towards Maria, greeting her warmly and calling her "princess" (4th observation, Maria). I could feel the familiarity between her and the general practitioner. They had already shared a trustful doctor-patient relationship. I also observed such a relationship at an appointment with Paulin and his physiotherapist. The therapist greeted him with a warm smile and asked about his progress and if the doctor was content. In a relaxed and harmonic atmosphere during the therapy, both laughed and she praised his progress (1st observation, Paulin).

Such familiarity with the medical staff mattered to the research participants: Maria for example joked with her dentist, who at first did not seem to recognize her, but then switched to a colloquial and familiar mode of conversation (1st observation, Maria). Sabah explained to me that

[86] This chapter focuses on healthcare experiences that refugees perceived as pleasant and safe. Note that this was not always the case. Participants were sometimes in a bad mood when I accompanied them to medical appointments and reported being treated badly or not wanting to go to a specific doctor again.

the receptionist is the wife of the doctor while we were in the waiting room (2nd observation, Sabah). The young daughter of Sabah proudly told the medical specialist that she had gone to him since she was in kindergarten (1st observation, Sabah). Rima's grown-up daughter always accompanied her mother to regular diabetes check-ups in order to interpret for her. At the hospital she explained to me that the receptionist whom we just had encountered was unfriendly but that the other receptionist – who was not there at that time – was very nice. Watching medical personnel pass by when sitting in the waiting room, she explained to me some of their positions and the specific tasks they performed at the hospital unit (1st observation, Rima).

Finally, medical staff may be one of the few contacts that refugees have, especially when newly arrived, and thus play a special role for them. Maissa for example arrived via family reunification and has not really met other people yet. Due to childcare obligations, she has not attended a German language course or any other vocational training. She explained:

> All doctors are very good to me. And generally, I do not know so many people here. Also, I do not leave the house too often. (1st interview, Maissa)

Next to familiarity with the medical staff, familiarity with healthcare facilities was important to the research participants. This points to a relationship not only between patients and healthcare practitioners, but also between patients and medical institutions. What also mattered was the institutions' rooms and corridors, the routes to get to them and away from them, and the procedures that take place in them and technologies that belong to them. For example, Maria displayed an affective history with her general practitioner's treatment room while we were waiting for the doctor, pulling out the scale hidden beneath the examination table and helping herself to colourful sweets from within a large jar (3rd observation, Maria). Others expressed the importance of familiarity with healthcare facilities through explaining and showing to me how everything functions: They commented on the waiting time when entering the waiting room, informing me about the 'usual waiting time' to expect (1st and 4th observation, Muhammad; 1st observation, Rima). They also eagerly explained to me where to find the restroom (1st observation, Muhammad), or that the empty waiting room during the Christmas holidays is normally full of people (1st observation, Rima). Finally, familiarity with medical institutions might even be something that you are proud of: Muhammad's face lit up when he heard that I had never been to a hospital in the outskirts of the city and was happy to show me around (4th observation, Muhammad).

Furthermore, knowing ways of getting to and away from healthcare facilities mattered to research participants. In order to go to Paulin's physiotherapy, we met at the asylum accommodation in which he lived. He confidently led the way to the hospital, explaining the various public transportation possibilities that would take us there, showing me a place where I can sit in the tram and confidently walking down the hallways of the large and confusing building (1st observation, Paulin). The same is the case for Rima who had regularly visited the hospital for diabetes check-ups. When arriving a couple of minutes too late, her daughter immediately started to explain to me that this specific tram line always runs a little bit differently. Then they entered the building with nonchalance and purposefully walked towards the elevators in a corner at the end of the big hallway (1st observation Rima). Maissa emphasised that it is important to her to make her way to medical appointments on her own. She explained how she went to the paediatrician without her husband on the subway:

> It was very difficult because I was alone. But I wanted to go there alone because I want to learn that. (1st interview, Maissa)

Maissa wanted to learn to get to doctor's appointments on her own. Especially for refugees from countries with characters other than the Latin alphabet navigating public transport can be difficult and it can take time to be able to find one's way:

> I once was in charge of an Arab family where it was extremely difficult linguistically. And of course the Arabic script has different characters than the German language. This means that it is of course difficult to orientate oneself by means of underground stations. So it really took a lot of accompaniment, sometimes even to hospitals. (interview, social worker special needs)

Knowing healthcare facilities and the way to get to them takes time. Doctor-patient relationships grow over time and emotional attachments to medical institutions form through repeated visits. Over time, these aspects of being a patient empower refugees and help them to regain control in a context that is often characterised by dependency and uncertainty. With regard to the temporal component, follow-up treatments (1st observation, Paulin; 1st and 2nd observation, Rima) and repeated appointments with the same doctor or at the same institution (2nd and 3rd observation, Maria; 1st and 4th observation, Muhammad) play an especially crucial role: Being familiar with healthcare practitioners and institutions created feelings of empowerment for refugees.

8.4 Material Object of Belonging: The Personal Electronic Health Card

Asylum seekers in Austria receive an e-card only a couple of days after being admitted to asylum procedures. This electronic health card contains a personal insurance number, with which they basically have access to the same facilities and services as all other beneficiaries in the Austrian public healthcare system.[87] Receiving the e-card is the first administrative step for newly arrived refugees that is neither connected to the determination of their legal status, nor to other asylum matters. During admission procedures in Austria, everyone receives an initial medical examination within 24 to 72 hours after filing an asylum application, generally within large reception centres run by the Ministry of Interior (see Chapter 3). Getting the e-card however means belonging to the majority group of beneficiaries of the healthcare system. Research participants perceived this as easy and "without problem" (1st interview Maria). In their narratives, the e-card seems to be an entry ticket to the regular healthcare system in which they are treated as "normal" patients among other patients in Austria. In Paulin's words: "If I am sick, I have an e-card. I will go to the doctor with my e-card." Later in the same interview he explicitly related getting to Austria with receiving the e-card: "If you go to Austria, you will be given the e-card." (1st interview, Paulin) Being asked about her experiences in the healthcare system, Sabah directly mentions the e-card as door opener:

> It (i.e., the healthcare system) is a good thing. About 20 days after I arrived, I got the card, and since then I go regularly to the doctor, to the hospital, and I can buy medicine. (1st interview, Sabah)

After talking about something else, Sabah continues to refer to the e-card's inclusive notion when recounting her first experiences in the healthcare system:

> Sabah: When I got the e-card, I did some tests. I went to the doctor …

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[87] The introduction of the e-card in 2005 marked the beginning of the Austrian e-health infrastructure (Bogumil-Uçan & Klenk, 2021). With regard to digitalization in healthcare, Austria ranked on the 10th place compared to 13 other Western European countries and Australia, Canada and Israel, leaving it in the lower midfield (Thiel et al., 2018). ELGA, the Austrian electronic health record, answered to calls for digitalisation and bureaucratic simplifications. ELGA is financed by the Federal Health Agency. Nationwide dissemination of e-cards and the advancement of e-health infrastructure in Austria, such as e-medication, e-prescription and e-reports, is implemented by the private company ELGA Ltd., jointly governed by the federal and the *Länder* governments as well as the SHI funds. The measures aim at better management between health organisations, such as between hospitals and established physicians, and improved coordination of care. For example, ELGA aims at preventing harmful polypharmacy. Finally, patient empowerment is in the focus, through the possibility to administer the own medical history in the online tool (Bachner et al., 2018).

> Wanda: And your children, when you came to Austria, were they examined by a doctor in any way?
>
> Sabah: Yes, normal. So after they got the e-card, they also went to the doctors. (1st interview, Sabah)

Rima was directly given her insurance number during the initial medical examination in Austria, even before she received the physical e-card. A healthcare worker gave her the phone number of a hospital and told her to go there. With her insurance number, as she explained, she received the care needed (1st interview, Rima).

Healthcare practitioners also highlight the e-card's role in including refugees as equals with all other insured persons. The e-card does not provide them knowledge about their patients' legal status with regard to their residence permit. For example, a physician commented, "I only know if he is insured or not, that is the only thing" (interview, general practitioner). Thus, the e-card does not mark or set aside asylum seekers or people with asylum status in any way. In addition, the e-card is a present symbol of the public healthcare system in doctors' offices. In almost all medical practices, slips of paper on the desk of the doctor's assistant remind patients to have their personal e-card handy, and posters with pictures of e-cards hang on the walls of the health facilities.

The e-card is an anchor in otherwise often arduous asylum procedures (see Chapter 5). Abdi recounted that he had lost his e-card and had not received a new one for more than four months. Even though the SHI fund had provided him with a paper note confirming his entitlement to receive healthcare services, having his own e-card was important to him. He asked for his mail at the accommodation every day and visited the WGKK's office in Vienna to settle the matter (1st interview Abdi). Also, a social worker at his asylum accommodation explained that the e-card means a lot to the residents. In the case of Abdi, she was critical that the SHI fund had taken so long to send a new card:

> Just send Abdi the card. It was so important to him. I always think to myself: yes, all your people here also have a health insurance card. I always imagine it like that, you know, like when you're a student. All your fellow students have a student card and only you don't have one. (interview, social worker large accommodation)

Moreover, the social worker recounted how another resident's social insurance number on the e-card was changed due to an administrative procedure. The original number meant a great deal to him, being one of the few things that were his own during his lengthy asylum process. The social worker stressed that the point was not about losing entitlement to healthcare services with

the changed number on the new card, but that it was about their own e-card with their own personal number that "is just often the little they can really influence" (interview, social worker large accommodation).

8.5 Valuing the Solidarity-Based Healthcare System

I found certain healthcare practices to hold additional meaning, transcending the mere provision of medical care. They emphasised the importance of fostering support for fellow patients within a shared public infrastructure. Some of the refugees actively and deliberately participated in the solidarity-based healthcare system; for instance, they regularly underwent health screenings, showcasing their commitment to the well-being of the broader community. An exemplar of this proactive engagement is Abdi's perspective on mandatory tuberculosis screenings within asylum accommodations. He supported this practice, acknowledging its wider societal significance. He shared an incident in which social workers instructed all residents to undergo tuberculosis screenings at the municipal authorities due to a confirmed case in their accommodation. When discussing that incident with me, he opened his purse and took out a folded piece of yellow paper. It was a medical screening record for tuberculosis. Abdi explained that due to the relatively large number of residents in his accommodation, he had participated in a tuberculosis screening every year so far. He viewed the tuberculosis screening as a safeguard for "everyone's" health, reasoning that if one person contracted tuberculosis, it would affect everyone. Abdi found this medical assessment to be a sound idea, as he believed that the collective well-being of everyone was at stake: "If everyone is sick, it is a disaster" (3rd interview, Abdi). To him, participating in the screening meant caring about others as fellows. This is particularly noteworthy because, after residing in Austria for five years, Abdi had recently received an unfavourable asylum decision, effectively closing off legal pathways to refugee status for him. Once an asylum application is rejected for the second time, as in Abdi's case, there are no further legal means to become recognised as a refugee in Austria; a person can legally stay in the country only by postponing deportation, which involves obtaining the legal status of a tolerated stay (see Chapter 3). Despite this legal setback, Abdi still valued solidarity within the healthcare system.

There are instances where refugees are excluded from supporting others in the solidaristic healthcare system. Attending one of the Austrian Integration Fund courses about the healthcare system mandated for newly recognised refugees (see Chapter 3), I observed a lively debate among participants concerning blood donations. A man in his mid-30s explained that he had wanted to support others with his blood donation, but he found this challenging for refugees.

After enduring a long wait at a donation centre, he recounted to the fellow course attendees that he was turned away (observation, Austrian Integration Fund). This incident was not isolated. In March 2016, approximately 100 residents of an asylum accommodation in Vienna expressed their intent to donate blood as a gesture of solidarity with the victims of a terrorist attack in Brussels at the time (Völker, 2016). However, the Austrian Red Cross, the primary blood donation organisation, declined their contributions. While refugees are not prohibited to donate blood in principle, certain requirements pose barriers, including proficient German language skills. Furthermore, refugees from specific countries are excluded due to the higher prevalence of diseases such as malaria in those regions. The example illustrates that regulations surrounding blood donations exclude refugees from engaging in acts of solidarity within the healthcare system. Despite their genuine appreciation for the system's basis in solidarity and their eagerness to actively support it, these regulations hindered their ability to do so.

8.6 Conclusion

This chapter discussed how emotional connections to and familiarity with medical personnel and healthcare facilities can empower refugees and be a help in finding their own way in their new home Vienna. These connections evolve gradually over time. They are often the result of routines established through repeated visits, such as building a trusting relationship with a general practitioner, becoming familiar with routes to medical facilities, and knowing how to find a specific department within a large hospital. Subsequently, the chapter showed how the personal e-card is more than an administrative tool. Receiving the same e-card as all other people in the Austrian healthcare system shortly after submitting an asylum application, this card not only grants access to medical services but also carries significant personal meaning for its holders. Furthermore, it was shown that refugees express their appreciation for the solidary basis of the healthcare system in their actions. They participated in health check-ups not only for their own well-being but also to contribute to the protection of others, and showed disappointment when confronted with exclusions from this mutual support network. Think of their frustration over restrictions on blood donations for people from specific countries.

I posit that these four notions of healthcare create a personal sense of belonging for refugees in Austria. When I refer to belonging, I view it as an open and conceptually flexible term that varies in interpretation, focusing on "the texture of how it is felt, used, practised and lived" (Wright, 2015, p. 392). Belonging was established over time. It was only through regular visits to healthcare providers and facilities that refugees became familiar with them. Autonomous management of

their own health evolved gradually. Abdi, Paulin, and Muhammad, for instance, explained that they had initially needed help to schedule and attend medical appointments. They later found satisfaction and content that they had developed the knowledge and capability to manage these appointments independently.

I further showed how a sense of belonging is established through the spatial dynamics of certain places. Proficiency in navigating Vienna's hospitals and doctors' offices, with their labyrinthine corridors and distinct room layouts, was important for refugee patients. They formed emotional connections with these healthcare facilities and took pride in their spatial knowledge, which not only facilitated access to medical services but also fostered a sense of familiarity with the city itself. The aspect of spatial belonging has garnered increasing scholarly attention (Wright, 2015). Antonsich (2010), for example, underscored the significance of place in his conception of "belonging as a personal, intimate, feeling of being 'at home' in a place (place-belongingness)" (p. 646).

At a conceptual level, the findings of this chapter resonate with perspectives of the material turn and posthumanism (Coole & Frost, 2010), such as agential realism (Barad, 2007, 2017) and vital materialism (Bennett, 2010). These frameworks question the ontological primacy of the human subject, positing that not only individuals but also objects and spaces act and generate meaning (Bennett, 2010; Harman, 2018; Latour, 1996). To paraphrase the feminist theorist Karen Barad, matter has begun to matter (Barad, 2007). This chapter showed that spaces such as hospital corridors and doctors' waiting rooms, as well as objects like the jar of sweets from which Maria helped herself, hold special meaning for refugees. It is within the interplay between their identity as patients and the spaces and materialities of the healthcare system that belonging is established. In a same vein, Caronia and Mortari (2015) elaborated on how objects and things in an intensive care unit, such as posters promoting hand washing and dispensers for antibacterial soap, shape human behaviour. Their perspective regards actions like handwashing as "interaction(s) where non-human and human subjects participate" (Caronia & Mortari, 2015, p. 404). Research on belonging reflects the material turn with an interest in delving into the "more-than-human aspects that may act to generate feelings of belonging" (Wright, 2015, p. 401).

In particular, this chapter's section on the positive bond between refugees and their e-card resonates with the material turn and posthumanism. Beyond inner experiences, the personalised plastic card serves as tangible proof of refugees' frequently disputed belonging: With each visit at a doctor's office or hospital, their personal e-card undergoes digital scanning through a standardised card reader. This process subsequently verifies their existing insurance

arrangement, thereby solidifying their role as a patient within that specific facility. The card enacts belonging. Consider how refugee participants perceived the e-card as a door opener that unlocks access to the broader healthcare system's services.

Taken together, this chapter directed the focus toward the perspectives of refugees regarding their interactions with the healthcare system and how these interactions – with healthcare professionals and with non-human aspects of the healthcare system such as waiting rooms, routes to hospitals and the e-card – create a personal sense of belonging among them. In Chapter 10, I address how this sense of belonging holds the potential to contribute to countering legal, practical, and discursive exclusions, which refugees face in other aspects of their lives in Austria.

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Chapter 9: Citizen–state Relationships in the Healthcare System

9.1 Introduction

This chapter discusses medical services as a mode of governance. It explores how healthcare for refugees in Austria shapes citizen–state relationships, showing how practices in the healthcare system represent the "good state" and produce the "good citizen". Refugee participants in my doctoral work perceived the healthcare system as an instantiation of the "good state". In turn, healthcare practices within these institutions required them to adapt to tacit and formal rules.

The understanding of the terms "citizen" and "state" in this chapter differs from the legal understanding and use of these terms. I focus on how the notions of citizen and state are lived in practice. By way of refugees' entitlement to healthcare services in the public healthcare system as well as claims based on bodily needs, the definitions of state and citizen are loosened. Rather than understanding them as clearly delineated legal categories, this chapter demonstrates how they are practised in healthcare and how they change over time. My understanding of citizen–state relationships is inspired by and builds upon the literature on "social citizenship" that was helpful in making sense of this chapter's findings.

In his seminal essay on citizenship, Marshall (1950) introduced social rights as one aspect of citizenship since the development of the welfare state in the 20th century. Behind the immigration to European welfare states since the Second World War (for details about the Austrian context, see Chapter 3), the notion of social citizenship was established to understand the meaning of people becoming entitled to social rights in their country of residence without being required to hold formal citizenship in this country. Social rights allowed for new lines of stratification between citizens to emerge (Baldi & Goodman, 2015; Morris, 2002; Sainsbury, 2012). In this line of thought, citizenship is defined not only by political rights, such as the right to vote, but also by identity criteria, which entail for example a common language and shared values, and social rights. Social citizenship includes the entitlement to healthcare and the use of medical services without the legal status of citizenship (Joppke, 2007). Thereby, the entitlement to healthcare and the provision or denial of medical care for refugees establishes (or prevents) their status as social citizens. For example, Österle and I showed how "healthcare policies are political

means that can include or exclude" (Spahl & Österle, 2019, p. 14) refugees.[88] Considering refugees' comprehensive legal entitlements and their practical inclusion in the Austrian public healthcare system, I understand them as social citizens.

In the following sections, I first describe how refugees perceive the healthcare system as the "good state", contrasting with their numerous adverse encounters with other Austrian state institutions. Second, I show how refugee patients maintain this positive perception of the healthcare system despite facing negative experiences during medical treatment, viewing the healthcare system as an entity that shapes the "good citizen". Third, I present a discussion about medical examinations as practices through which "the state" literally gets under the skin of refugees with invasive medical technologies. Fourth, I address how the healthcare system functions as the backdrop for implementing integration measures. Fifth, I problematise the expectations placed on refugees to adapt to the Austrian healthcare system and discuss how the idea of the "good citizen" can evolve into a different direction within this system by embracing a diversified understanding of Austrian citizenship. Lastly, I summarise my findings on the particular role of the healthcare system in shaping citizen–state relationships for refugees in Austria.

9.2 Experiencing the Healthcare System as the "Good State"

9.2.1 The Healthcare System as the "Good State"

The refugees I talked to for my doctoral work considered the Austrian healthcare system as an instantiation of the "good state". This valuation was based on comparisons with healthcare systems in their home countries, an abstract appreciation of Austria as a country possessing high-quality medical care, and positive experiences of receiving medical services against the background of the difficulties that characterised their lives in Austria. Refugee participants consistently stated that the healthcare system and services they received in Austria were superior to those in their home countries.

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[88] Our study focused on healthcare access for refugees in Ankara. At the time of my fieldwork in Turkey in 2016, the largest groups of refugees in the Turkish capital were Syrians, Iraqi Turkmen, and Afghans. We argue that the Turkish healthcare system forms stratified memberships for different groups of refugees along the lines of legal status, social rights, and identity requirements. The article shows how the legal categories (temporary protection for Syrians and international protection for refugees from other countries), but also other factors such as gender, culture, language, and economic situation, were vital for shaping them as citizens in Turkey (Spahl & Österle, 2019).

> You cannot go to the doctors there. It is not like Europe. You do not do it like in Europe down there. (1st interview, Paulin)

Paulin mentioned the disparities between the public healthcare system he encountered in Austria and the poorly developed healthcare infrastructure he was accustomed to in his homeland, Benin. Syrian refugees similarly expressed their perception of the Austrian healthcare system as being superior to the medical provisions they had previously experienced. For example, Sabah described a problem with her hand in Syria that remained unresolved despite a previous operation. Because of this, she was initially doubtful about having a second operation in Austria and tried physiotherapy instead. However, when the physiotherapy did not improve her hand problem, she ultimately underwent hand surgery in Vienna. Based on her personal experience, she highlighted the superior quality of care in Austria compared to Syria:

> It is a totally different system here and in Syria. The operation was way faster in Syria, here one is more precise and needs more time. (1st interview, Sabah)

Rima, another woman from Syria, found the Austrian healthcare system to be positive due to its insurance-based nature. In Syria, where over fifty per cent of per capita healthcare expenditure required out-of-pocket payments, she had often worried about whether she and her family would be able to receive adequate medical care. Her worries were alleviated since her arrival in Austria. Rima explained that having health insurance in Austria ensures access to healthcare services and medication. This brought her a sense of relief compared to the worries she had experienced in Syria:

> And what is particularly good here in Austria, is that you are insured. And you do not need to worry about what you should do now, and how you get this medication now? It used to be like this before, but now you do not have this risk. (2nd interview, Rima)

The healthcare system in Austria gained refugees' appreciation and gave them confidence in their ability to receive the medical care they need.

Second, beyond the direct comparison of the healthcare systems in their home and host countries, refugee participants also valued the healthcare system in Austria in an abstract sense. Maria, for example, expressed a sense of security during the COVID-19 pandemic due to the well-functioning Austrian healthcare system and the relief of not residing in another country at that time: "I have safety like this. I was happy that I was in Austria" (4th interview, Maria). Similarly, Rima's family valued the Austrian healthcare system:

> The interpreter and I visited Rima in her neat and cosy flat. Together with her husband and two of her children, we were sitting in the living room. As we started the interview, the teenagers left the room. When I asked if she feels healthy, Rima responded, "yes, alhamdulillah", and said that she had no problems and everything was fine. After she explained the special importance of health in life, I asked her about her experiences within the Austrian healthcare system. After a long answer in Arabic, the interpreter interpreted her words: "This is one of the most important things. They stayed here because of the healthcare system. .… It was kind of a plus to stay here. (Rima adds a couple of sentences in Arabic). One of the most important things for staying here, is the healthcare system. She always feels, in case that there is something happening, she just goes to the doctor. In this way she gets everything, she receives good treatment." (1st interview, Rima)

Rima positioned her family's choice to remain in Austria, rather than pursuing migration to other countries as many refugees do, as a deliberate and conscious decision due to the exceptional quality of the healthcare system. This dynamic offers a reversal of the prevalent asylum logic, as it is expressed by politicians and in the general discourse in Austria and beyond: Opposed to being placed in a position of seeking help, this Syrian family critically measured host countries against their existing health care provision. Rima's husband furthermore lauded the Austrian healthcare system within an international context. He emphasised that Austria was "one of the best countries" in terms of healthcare provisions, noting that even countries such as Switzerland did not possess an insurance system of comparable excellence (1st interview, Rima).

The family's emphasis on the high quality of the healthcare system shows how their relationship with the Austrian state was crucially mediated by their perceptions and experiences of healthcare practices and institutions as high-functioning. Rima and her family perceived the "good state" in the healthcare system. This perception was formed against the background of other unpleasant experiences with state institutions and Austrian bureaucracy. Earlier, in Chapter 5, I described the family's concern about potential more restrictive measures affecting them as recognised refugees and their unsuccessful attempts to have the father's driving licence recognised, which would have expanded his work opportunities in Austria.

In a later interview, amid the COVID-19 pandemic, Rima reaffirmed her view of the healthcare system as a trusted institution. She saw the Austrian healthcare system as a source of security, a place that alleviates her worries:

> We used to also in the past (i.e., when the family was still living in Syria) think that the AKH was the biggest and best hospital in Europe. And everyone, for example, people from other countries, always got cured there and went to doctors. But the system (i.e., the healthcare system during the outbreak of COVID-19 in 2020) was super, and the intensive care unit, yes, the tests, the service

> people, and so on. .... In the health sector, you don't have big anxieties, and you have the feeling that you are in a safe place (*in Sicherheit*). (3rd interview, Rima)

Rima's narrative portrayed the healthcare system as an instance of the "good state". Her perception was based on the abstract appreciation described so far, but also on her lived experience of high-quality medical care: This introduced a third aspect in which the healthcare system was perceived as the "good state" in practical terms. Rima explained that she had been receiving the necessary treatment in Austria. This sentiment echoed her frequent affirmation that "everything is fine" concerning healthcare services in Austria, a sentiment consistently shared by other refugee participants as well. After several meetings with Rima and others, they continued to describe their good relationships with healthcare staff and spoke highly of the services they had received. For example, when asked about encountering difficulties while seeking healthcare, Sabah stated that neither she nor her friends faced any issues:

> No, there are generally no problems. .... I visit all doctors, also the dentist and everything, no problem. .... There are generally no problems, all of them (i.e., Sabah's friends) have not really encountered problems. (1st interview, Sabah)

In addition, the role of the healthcare system as an instantiation of the "good state" was evident in the comments of a dedicated Arabic-speaking pharmacist on what he perceived as the frequent consultation of healthcare professionals and institutions by refugees, even when they had no medical need. He explained that healthcare services represent a welcoming and safe place amid insecurity for newly arriving refugees:

> They (i.e., refugees) go to the doctor and to the hospital for every trifle, ... I suppose it's an insecurity because they don't want to take any risks, because they feel clumsy here in Austria, that's why they try, the best place to go from their point of view is the hospital. (interview, pharmacist)

The portrayal of the healthcare system as the "good state" was also evident in the experiences of other refugee participants. Paulin recounted a football accident, detailing the enduring pain he had experienced. Among other issues, an initial misdiagnosis resulted in delayed healing and an unexpected operation. When asked about his opinion of the hospital, he responded, "[i]t's good. It is my operation that is not finished yet", mentioning ongoing pain and the need for future surgery. Despite his lengthy and painful medical history, he showed appreciation for the hospital and its medical staff:

> They (i.e., the hospital staff) are fine, no problems. Ok, ok. It was good. When I saw them, and they looked after me, we talked. I don't know, no problems. (1st interview, Paulin)

When I accompanied Paulin to a physiotherapy session at the same hospital, his favourable impression of this medical institution and its staff became evident. He entered the premises in a relaxed manner and was enthusiastic about leading me through the numerous corridors and floors of the large building. Upon meeting the physiotherapist, Paulin and the therapist exchanged warm smiles and shared hearty laughter (1st observation, Paulin).

Maissa perceived the healthcare system's facilities as a haven of safety in Austria. She had arrived in Austria through family reunification, directly flying to Vienna with her first child and later giving birth to her second child in her new home. During our meetings, she had limited knowledge of the German language, was breastfeeding, and only knew very few people in Vienna. Maissa experienced a sense of isolation and mostly stayed at home, venturing out primarily for shopping, taking her eldest child to kindergarten, or attending medical appointments. This sense of insecurity was noticeable when she declined the interpreter's and my invitation to join us for a café outing after we had accompanied her to a doctor's appointment (1st observation, Maissa).

> I like the doctor. And I only go to the kindergarten and to the doctor. Only that, I only go there. …. All the doctors are very good with me. And normally we don't know so many people here. I don't go outside that much. (1st interview, Maissa)

In Maissa's case, healthcare professionals held a special role. Since she hardly knew anyone in Austria aside from her husband and children, she valued these professionals as friendly and supportive people with whom she had contact.

9.2.2 Sustaining the Image of the "Good State" against Negative Experiences

Remarkably, participants upheld their positive perceptions of the healthcare system despite their frequent and occasionally painful experiences of rejection. For example, Abdi persisted in valuing scheduled medical screenings for future appointments even though he faced imminent deportation.

> During a phone call, Abdi told me that he had just received his annual tuberculosis check-up (i.e., mandatory examinations for asylum seekers in large-scale accommodations[89]). He explained that

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[89] The responsible municipal department fur tuberculosis screening in Vienna, Municipal Department 15, Public Health Services, did not agree to be interviewed for my study. In the interview with the employee at the Vienna Refugee Aid, reference was made to a standardised tuberculosis examination as part of the initial medical examination for asylum seekers and to the legal possibility of further examinations: "At the beginning of the asylum procedure in Traiskirchen – or in the reception centres in general – there is a so-

> he had received an "okay", and that the doctor had given him a confirmation indicating that he was "all clear". The young Somali further explained that the next check-up was scheduled for a year later. It was only after this that he informed me that he had received a negative asylum decision for the second time and was facing deportation (for the devastating consequences of this decision on his health, see Chapter 5). (phone call, Abdi)

Though Abdi faced rejection in the asylum system, he obtained medical confirmation from the healthcare system. He anticipated the upcoming health check in a year, despite being denied this time frame as a rejected asylum seeker facing imminent deportation. Hoping for a deferment of his deportation, he applied for an additional year of tolerated stay, but the outcome remained uncertain at the time of the interview.

Moreover, participants displayed the ability to separate their negative experiences with individual doctors from their overall appreciation for the healthcare system, thereby sustaining a positive perception of the system. Refugee participants highlighted practical issues affecting all beneficiaries of the Austrian public healthcare system, such as extended waiting periods and limited consultation time with physicians, causing them frustration in accessing healthcare services (see Chapter 3).[90] A crucial aspect in comprehending how negative experiences were

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called health route (*Gesundheitsstraße*) where persons applying for asylum have to undergo certain examinations, including an X-ray examination of the lungs, to exclude tuberculosis. An initial medical examination already takes place here. In addition, some regulations provide for serial examinations (*Reihenuntersuchungen*) after the persons have been assigned to one of the nine Austrian *Länder*, which is coordinated by the MA15 (i.e., Municipal Department 15, Public Health Services) in Vienna. In any case, the initial examinations carried out in the reception centres (for details, see Chapter 3) are standardised." (interview, employee at the Vienna Refugee Aid). Moreover, the interviewee from GÖG, the Austrian Public Health Institute, criticised how tuberculosis received heavy political focus when considering adequate care for refugees in Austria: "But this (i.e., tuberculosis examinations among refugees) was especially important at the very beginning. When the platform (i.e., a national coordination platform for providing psychosocial support to refugees and helpers, commissioned by the Ministry of Health in 2016; see Chapter 1) was launched, ... it was mainly about infectious diseases. And it was very much about tuberculosis, and we always said: let's not only talk about tuberculosis but also about psychological problems." (interview, member of the coordination platform at GÖG).

[90] It should be noted that discrimination and bad experiences in the healthcare system were not big issues for the refugee participants in this study. My explanation for the lack of such experiences among them is, first, that they make an effort to fit into the Austrian healthcare system and adapt to its functioning from the beginning (as learned, for example, in special courses for refugees). Second, although there is no parallel health care system for refugees in Austria (as in Finland; see Tuomisto et al., 2019), there are informal mechanisms that create a refugee-friendly system (for example, lists posted in asylum shelters sharing the names of doctors with whom other residents had good experiences; informal recommendations from fellow residents and friends; selection of doctors in the mother tongue, if available).

rationalised as exceptions within the otherwise positively perceived system is the assignment of blame to specific individuals. These individuals, often emphasised as non-Austrian, were held responsible for treating them poorly. This allowed them to uphold the healthcare system as the "good state", as shown in the following statements made by Rima and Maria.

> Rima explained: "The doctors are very good, but not the assistants. Some are good, but one Chinese or Asian assistant, I am not exactly sure which nationality, she was not [good]." Following these words, the Syrian woman recounted how she was alone in the hospital bed after a heart surgery she had received after she arrived in Austria. Still weak and lying in the hospital bed, she could not reach the mobile phone that she used to call her children who were interpreting for her. She then asked the medical assistant to hand her the mobile phone. She refused and indicated that this was not part of her job. While sharing this story, Rima again placed this assistant outside the Austrian state: "She was not Austrian, she was an Asian woman." (1st interview, Rima)

Maria described a situation where two different doctors held divergent viewpoints regarding a skin ailment and the suitable treatment approaches. While her dermatologist recommended hormone therapy, she opted against it due to her overall scepticism about such treatments and also because her gynaecologist advised against its usage.

> [The dermatologist] did not talk so much. And he was not the main protagonist, he was an other [employee], a partner. I think he is not Austrian. He is not Austrian. (1st interview, Maria)

In the narratives shared by the two Syrian women, their negative healthcare encounters were attributed to healthcare practitioners from outside Austria, externalising their experiences. Both women emphasised that the healthcare practitioners who treated them poorly were foreigners. They viewed the medical staff involved in these problematic situations as "not Austrian". Furthermore, their stories contribute to the reconstruction of hierarchies within the medical system, where senior doctors hold a higher position of esteem, whereas younger colleagues or other staff, such as nurses, are regarded with less esteem. Maria emphasised that the dermatologist she found problematic was not the main doctor in the practice, and Rima mentioned that her negative experience was with an assistant, not a doctor. Despite extensively discussing their negative experiences, they still praised specific aspects of the healthcare system. Rima began her account by asserting that, in general, all doctors were good, and Maria expressed her confidence in her gynaecologist.

9.3 Forming the "Good Citizen" in the Healthcare System

Refugees' perception of the healthcare system as an instantiation of the "good state" was mirrored by institutional expectations of the "good citizen". Interacting with health institutions requires patients to adapt to certain rules. The next sections focus on what this adaptation means in the refugee context. For newcomers, changing their health habits also means becoming social citizens in Austria. After showing how "the state" gets under the skin of refugees during medical examinations, I analyse the perspective of the state. Here, formulations in relevant policy texts and interviews with health experts and politicians are helpful to understanding how refugees are (supposed to be) made into "good citizens" when receiving medical care.

9.3.1 Getting "The State" under your Skin

Medical services in the healthcare system form relationships with the Austrian state. With blood samples and other examinations, refugees get the "state" under their skin as the following experience by Rima illustrates:

> I accompanied Rima to her regular blood sugar check at a hospital. Since living in Austria, whenever she had a medical appointment, her adult daughter accompanied her to interpret. The three of us were seated in the waiting room when Rima was called into the adjacent room where the nurses take blood samples. Her daughter and I wanted to follow her. At the door, a friendly and determined nurse asked us if we were with Rima. We nodded, and she explained that we did not need to be present during the blood draw. Rima cast a helpless glance at her daughter as she sat down on a chair amidst blood samples, syringes, and other busy nurses. The young woman started to step across the threshold to stand by her mother. Then the firm nurse turned directly to Rima with a smile and asked her for her name and date of birth. Rima shifted her gaze from her daughter to the nurse. Her German was sufficient to answer these questions herself. She visibly relaxed, and the nurse began taking blood samples. Her daughter and I took seats in the waiting area outside. (2nd observation, Rima)

The nurse initially asked Rima's daughter to wait outside, leaving her mother feeling helpless and uncomfortable. However, as the healthcare professional then focused on Rima as a patient, the blood collection became a rare moment of independence for her. In this instance, the Syrian mother did not rely on another person to interpret the healthcare professionals' words. While blood collection can be stressful for many, this moment held meaning for Rima. It made her feel included as a patient and belonging in the Austrian medical institution (for a detailed discussion of how a personal sense of belonging emerges from practices in the healthcare system, see

Chapter 8). Furthermore, the routine blood test exemplified the adaptation of adapting one's health-related behaviour to Austrian standards.

Abdi had never been to a doctor's office or hospital in his home country and experienced medical examinations in Vienna as new. The young Somali was eager to have a blood test, to find out his blood type, and to take care of his health like everyone else by having regular tissue examinations:

> It (i.e., giving a blood sample) is totally normal. (laughing) Every year, or every two years, it is better if you go to the doctors and then they watch a little bit, what new things there are in the blood and so on, yes. (2nd interview, Abdi)

Abdi emphasised that the medical intervention was initially new to him but had become "normal". This normalisation can be interpreted as his adaptation to Austria and indicates his developing sense of belonging through regular medical check-ups, which are recommended for everyone in the country. Similarly, for Maria, getting used to the Austrian healthcare system involved an increased focus on measuring her body indicators, which, to her, reflected the bureaucratic aspects of Austria. Through this perspective, she directly linked the healthcare system with "the state":

> For example, in Syria, they can just say, you have this, take this. Without a blood test. (laughing) Without tests. They just do it and it works. Here it is safe. [They do] so many procedures, so many things until they tell you the results for example. It's more bureaucracy, also in doctors, you know more bureaucracy. In Syria, it's more spontaneous, easier. Everything has advantages and disadvantages. Here there is more security. But there it's faster. And it works [in Syria]. Really. (1st interview, Maria)

In Maria's case, having her blood drawn regularly became a symbol of her adaptation to the Austrian healthcare system and Austria in general. In her narrative, drawing blood functioned as a vivid example of the differences between a security-oriented and bureaucratised Austria and a more spontaneous Syria. These examples from Rima, Abdi, and Maria show how taking blood is part of the process of learning about and adapting to the Austrian state.[91]

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[91] In Chapter 3, I discussed the rather top-down medical practices refugees are subjected to upon arrival in Austria. Think of the obligatory initial medical examinations within a maximum of three days after filing an asylum application. Other examples are X-ray procedures for age determination of unaccompanied minors in the absence of identification papers and compulsory tuberculosis examinations for residents of some large asylum accommodations (for details, see footnote 89).

9.3.2 Difficult Adaptation in Practice

Politicians and healthcare professionals I interviewed in my doctoral work stressed that refugees must adapt to the tacit and formal rules of the healthcare system. In formulating their expectations, they often used the word *Aufklärung*. *Aufklärung* can be translated into English as "information" or "education" – and also "enlightenment".[92] Many of my interviewees used the word *Aufklärung* in their explanations of refugees' health needs to refer to the functions and instances of imparting knowledge about the healthcare system. They explained that refugees need to be *aufgeklärt* (i.e., informed) about the Austrian healthcare system in which fewer medications are prescribed than Syrians are used to in their home countries (interview, pharmacist) or in which the hospital is not the first contact point in case of illness (interviews, integration course trainer; SPÖ politician). They also recommended that refugees be *aufgeklärt* about mental healthcare to destigmatise the topic (interviews, integration course trainer; pharmacist), healthy lifestyle habits such as reducing stress and eating a healthy diet (interview, integration course trainer), and contact points such as NGOs specialised in refugee (mental) healthcare (interview, SPÖ politician). In addition, *Aufklärung* in schools for children was seen as the best solution for educating students for their own knowledge and for them to disseminate this knowledge to their families (interview, general practitioner). Moreover, the Viennese guidelines for basic care stipulate that "asylum accommodations are responsible for *Aufklärung* about health-related topics or referral to health-specific services" (Vienna Umbrella Association of Social Institutions, 2018, p. 15 [own translation]).

Aufklärung requires refugees' adaptation to the norms and rules of the Austrian healthcare system. This is neither quick nor easy and is to be understood as a process, as demonstrated by Sabah's hesitant transition toward her acceptance of the family doctor as a gatekeeper for specialists. She explained:

> In Syria this is different. There you do not go to the general practitioner, you only go there with really minor issues. If a child is sick, I am going to the paediatrician. If I have something else, I go to the specialised doctor, not to the general practitioner. And here you need to go to the general [practitioner] first." (1st interview, Sabah)

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[92] In the connotation of "enlightenment", as in the age of reason, *Aufklärung* carries more weight than simply imparting information; it implies prior ignorance in an almost existential way. I would however refrain from emphasising this meaning, which would put refugees in a particularly othered position, in my research. In Austria, the term *Aufklärungsgespräch* (literal translation: *Aufklärungs*-conversation) is used for "informed consent" in the medical context.

Like all refugee participants from Syria, Maissa was accustomed to being prescribed more medication in her home country. She described how difficult it was to get used to the Austrian healthcare system and how after a while she "got used to it" and adapted.

> It was very difficult because in Syria it is different. For example, here doctors don't write medicine so much. And in our country (laughing) it's easy to write medicine. I got used to this atmosphere [in Austria]. (1st interview, Maissa)

Not all refugees are able or willing to adapt to the Austrian healthcare system in the way that policy documents and decision-makers expect them to. Especially regarding the increased consumption of medicines in Syria and other home countries when compared with Austria, an Arabic-speaking pharmacist problematised refugees' difficulties in adapting:

> Of course, it is not easy when someone has been taught for 50 years that I need 5 medicines for this illness and you come to Austria and the doctor says: "This is a trifle, go home and take only one medicine." Explaining to him why that is and that what he has learned so far is not necessarily right. This cannot be done overnight and has to be done again and again. Many are stubborn and unteachable by conviction. You can say what you want, but that's the way it is. Then my or our means are exhausted at some point. You can't convince them, so they have to live with reality. Many are reasonable and understand this to some extent, and here and there you have success. (interview, pharmacist)

The pharmacist explained that it takes time to change one's behaviour to align with the expectations of Austrian authorities and institutions. In his experience, some customers refuse to adjust their behaviour. In a way, this makes them "the others" (see Chapter 2), by demonstrating behaviours outside of what is expected from the state.

9.3.3 Enacting Integrational Measures

The department of the Vienna Social Fund that coordinates basic care for refugees, the Vienna Refugee Aid, follows the principle of "Integration from Day 1" (*Integration ab Tag 1*) (Vienna Social Fund, 2022). I found that this principle of integration also being applied in the healthcare system. For example, the introduction of the healthcare system in the values and orientation courses of the Austrian Integration Fund implies refugees' responsibilities to integrate.[93] The

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[93] The Austrian Integration Fund courses are compulsory for recognised refugees in order to receive the full amount of social benefits. In addition to two specialised courses, where one can choose the topic of health among others, health is also part of the compulsory one-day overview course.

section on health in the official information brochure approved by the Ministry for Europe, Integration, and Foreign Affairs for 2014–2020 and available in German, Arabic, Farsi/Dari, Pashto, and Russian, highlights three aspects related to health:

> Austria has a very good healthcare system, which only works if people work in Austria and finance this system with their taxes and contributions. The first point of contact in the healthcare system in Austria is usually the general practitioner. It is important to familiarise yourself with the healthcare system. It is important to take responsibility for one's own health and to go for regular check-ups. (Ministry of Europe, Integration, and International Affairs, 2016, p. 39 [my own translation])

With regard to health, the information booklet implicitly asks refugees to contribute to the financing of the healthcare system, actively encourages them to adhere to the family doctor system, and expects them to participate in preventive measures. As part of the Austrian Integration Fund courses, these practices enact state-approved integration measures.

The SPÖ politician interviewed for this study saw the “good state” in the welfare state. She explained that the state and the *Länder* are responsible for informing refugees about adequate health services and connecting them with counselling centres. In doing so, she praised the Austrian healthcare system’s important role in integration and spoke of its importance in educating refugees to become citizens:

> I believe that Austria has integrated its migrants very well with its healthcare and social system and with this provision of public services (*Daseinsvorsorge*) that are there for everyone. (interview, SPÖ politician)

The NEOS politician also emphasised integration as a secondary goal of the healthcare system. In his opinion, the current structure of the system prevents this goal mainly due to insufficient reimbursement of patient consultations by the SHI funds and major bottlenecks in the area of mental health.

> So if we were to invest more, especially in the issue of coming to terms with the past (i.e., with refugees’ past traumatic experiences), in this psychosocial component, then integration and so on would also be much easier later on. (interview, NEOS politician)

These quotes illustrate how representatives of political parties imagine the public healthcare system as enabling refugees to become citizens through its integration functions. This is also expressed in ideas about active and self-determined use of medical services as a prerequisite for exercising rights as social citizens. The director of a publicly funded counselling centre for refugees explained:

> Health is always a central topic in counselling because there are health issues that are so severe that it is not even possible to go to the social welfare office – in inverted commas, I am dramatising now, yes? .... We have to initiate everything that the clients need in terms of health benefits from our healthcare system. .... One example would be that we have quite a few families with chronically ill children or chronically ill adults, with disabled children, who receive an asylum decision. And then you practically have to go from looking for a school to the application office, to the diagnosis via the outpatient clinic for developmental support[94], … to the application for care allowance, to the application for increased child benefit, family allowance, to, I don't know, looking for a day centre for a disabled adult son, for example. (interview, director advice centre)

This experienced counsellor's comments regarding refugees with special health needs, such as chronic illnesses and disabilities, highlight the necessity for medical treatment of their conditions. Moreover, they underscore the importance of official recognition of these ailments within the healthcare system to access various social benefits. These insights showcase how the healthcare system serves as a gateway to access other social services.

Furthermore, healthcare practices play a role in the process of refugees actively integrating themselves into the city as citizens. Against the backdrop of insufficient psychosocial services and limited preventive measures (for a discussion about the general problems of the Austrian healthcare system, see Chapter 3), the head of the counselling centre described their efforts to address these shortcomings in their counselling approach. As an example, she mentioned that her team encouraged their clients to explore the city and utilise its recreational areas through activities such as taking walks:

> Especially with new arrivals in Vienna, we always discuss what possibilities there are to go out with the children on weekends. And for a long time we also got the – see, I have to get this from the City of Vienna again - the [plans with all the] parks, the city maps, where you can tell them where it's nice, from the Lainzer Tiergarten to the Wiener Wald (i.e., recreational areas in Vienna) .... Once we even had a health project ... where we initiated clients to look at different places in Vienna, almost a bit like a puzzle. (interview, director advice centre)

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[94] So-called "centres for developmental support" (*Zentren für Entwicklungsförderung*) offer specialist diagnostics as well as interdisciplinary treatment and therapy services for children, as part of the quango Vienna Social Services (*Wiener Sozialdienste*).

9.3.4 Reshaping the Meaning of "Good Citizen"

The social service providers I spoke to were generally aware that the demand for adaptation can sometimes conflict with how refugees prefer to access healthcare. While the pharmacist quoted above problematised those who are unwilling to adapt, the subsequent quote describes how the city's integration policy would also allow for an alternative perspective. Although refugee care in Vienna primarily aligns with the integration paradigm, it also adheres to the principle of self-determination, as expressed by an employee at the Vienna Refugee Aid stated:

> It is also essential that the concerns and uncertainties of the people concerned are taken seriously and that the clients have the opportunity to make self-determined decisions about the issues that concern them from the very beginning. Consequently, these decisions must also be respected. If, for example, a person does not currently want to attend a check-up appointment at the dentist or ophthalmologist for personal reasons, even though this would be medically indicated, the reference care must inform the client in order to achieve the connection to existing services, but ultimately the decision is to be respected. (interview, employee at the Vienna Refugee Aid)

The quote illustrates how the value of patient autonomy can contrast with the expectations placed on refugees to adapt described in the previous sections. The interviewed employee at the Vienna Refugee Aid prioritised "self-determined decisions" of their "clients", also in the health sector. She emphasised that refugee patients' independently made decisions held greater importance than, for instance, medically prescribed check-up appointments. This approach shifts the focus from informing refugees to engaging with them as autonomous patients.

Ironically, the expectations placed on refugees to adapt to the Austrian healthcare system reflect critical weaknesses within the system. Issues such as a lack of coordination between the intramural and extramural sectors, the weak role of general practitioners, a poorly developed prevention system, and few mental health services are challenges that extend beyond the refugee population and also affect the general population (see Chapter 3). Thus, much of what is expected of refugees is not adequately fulfilled by the broader population. These existing deficits characterise health as "a difficult issue, even among the majority population" (interview, director advice centre). The perception of a "general lack of health literacy in the Austrian population" (interview, NEOS advisor in the National Health Commission) reframes the suggested need to educate (*aufklären*) refugees on navigating their health needs. It shifts the responsibility from refugees to officials, urging them to address the structural deficiencies of the healthcare system. Instead of solely focusing on molding refugees into "good citizens", it raises the question of how the healthcare system can offer improved care.

Rethinking the integration paradigm in health also means focusing on the need for the healthcare system to be more adaptive to the needs of a changing population. The healthcare system was not initially designed to serve the present-day's diversified population. For example, quality circles at the Viennese Medical Chamber aim at *Aufklärung* not for refugee and other migrant patients, but for healthcare professionals, as one of the organisors explained:

> The goal is not only that we educate ourselves. The goal is communication; that we, at least we doctors from other countries, or those with a migration background and Austrian doctors, communicate with each other, exchange ideas, share our experiences. That is one thing, and the other is that we naturally help patients with a migration background and also refugees to get on with their health problems. (interview, one doctor at the Viennese Medical Chamber)

Initiated by practising doctors who migrated to Austria, a section of the Vienna Medical Association aims to enhance the health of refugees and other migrants. The primary focus is not on integration immigrants into the healthcare system but rather on sensitising doctors to the health challenges faced by immigrants, such as the specific needs of Muslims. In this manner, the healthcare system becomes an active agent in redefining Austrian citizenship. The efforts of the Medical Association mirror the reality of a changing patient structure, where the "good citizen" encompasses Ramadan practising patients or refugees with past war-related traumas. Moreover, the organisors illustrate, through their personal migration experiences, how the diversification of Austrian society is reflected within healthcare providers. For example, the SPÖ politician highlighted the shifts in the Viennese population, with the citizen increasingly being the migrant: "[O]ver 60 percent of the medical staff in the hospitals, and in nursing, are multilingual." (interview, SPÖ politician)

9.4 Conclusion

This chapter showed how refugees' utilisation of healthcare services and the objectives outlined in refugee health policies contribute to shaping the relationship between refugees and the Austrian state. It highlights how the healthcare system's inclusivity fosters refugees' perception of it as the "good state", especially when contrasted with negative experiences within other Austrian institutions such as asylum courts and welfare agencies. This was for example illustrated in how Rima and Maria maintained their view of the "good state" by segregating negative experiences and attributing them externally to the Austrian healthcare system: They identified problematic healthcare providers as foreigners. This underscores how refugees, through their

recurrent interactions within the healthcare system, cultivate their perception of it as the "good state".

The second part of this chapter addressed how refugees' perception of the healthcare system as an instantiation of the "good state" aligns with the shaping of "good citizens". This "good state" shapes refugees into a certain type of citizen, rejecting exclusionary logics that designate refugees as non-citizens. I showed how managing the body as expected by the healthcare system translates to an internalisation of the state. It acquires the meaning of "getting the state under one's skin", as I termed it. Think about Abdi and Maria for whom blood tests and other bodily measurements were novel experiences. Integrating these practices into their lives played a substantial role in their adaptation to life in Austria. These insights also elucidate how the biopolitical concept of "normalisation" gains significance in the context of refugee healthcare.[95] The healthcare system "normalises" refugees, guiding them to comply with the implicit and explicit demands placed on beneficiaries.

Next, this chapter shifted from detailing refugees' experiences to exploring pertinent documents in the field of asylum and insights from representatives of political parties and healthcare practitioners. It illustrated how these entities embody the integration paradigm and the associated expectations imposed on refugees to conform. The healthcare system's services are predominantly tailored to a specific demographic excluding refugees. Despite refugees being entitled to Austrian healthcare as social citizens (Baldi & Goodman, 2015; Joppke, 2007; Morris, 2002; Sainsbury, 2012), the structure and functioning of the healthcare system is geared toward the "imagined community" (Anderson, 2006 [1983]) of the nation state's population. Within this system, refugees are expected to adapt to tacit and formal rules, often requiring them to unlearn previously acquired health practices from their home countries.

Inclusion within the positively perceived healthcare system presents its own set of challenges. Adapting to the rules of a new healthcare system is time-consuming and not always straightforward. Failing to fully adapt may lead to refugees being perceived as problematic cases,

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[95] In thinking about how people are governed via social policies, biopolitics has proven to be a fruitful concept. In its original meaning as developed by Michel Foucault in the 1970ies, biopolitics referred to the disciplining of individuals and the regulation of the population. The Foucauldian concept and its numerous actualisations by subsequent scholars have substantially discussed how healthcare – in a broad sense comprising institutionalised medical care in the healthcare system, hygiene measures, educational books, public health measures, etc. – govern people (Foucault, 2003 [1976]; Lemke, 2011). For more information, see Chapter 2.

deviating from the ideal "good citizen". For example, I discussed how disparities in prescription practices between Syria and Austria prompted a pharmacist to highlight the resistance of certain refugee clients to embrace the Austrian approach, which involves fewer medications. Implicitly framing them as problematic, such instances potentially categorise refugees engaging in different healthcare behaviours as "others" (see Chapter 2) them.

Lastly, the concluding section of this chapter directed attention towards alternative conceptions of the "good citizen" that diverge from the idea of a refugee "other" required to integrate. In contrast to the homogenising paradigm of integration, this diversified approach does not enforce expectations on citizens to conform to predefined "good" behaviours. Instead, it advocates for the healthcare system to adapt to the needs of new citizens. Policy documents and decision makers often call for refugees to be *aufgeklärt* (i.e., educated) on various aspects of the healthcare system, including practicing preventive healthcare, consulting general practitioners as gatekeepers, reducing hospital visits, and prioritising mental health. These align with the general weaknesses of the Austrian healthcare system, such as an underdeveloped prevention system, a lack of coordination between hospitals and established physicians, the weak role of general practitioners as gatekeepers, and poorly developed mental health services (see Chapter 3). Rather than portraying refugees as ignorant or culturally averse to mental health treatment, these weaknesses should be understood as inherent to the system, affecting the general population as well. Shifting the focus from personal demands on refugees to structural problems within the healthcare system could significantly enhance medical care overall.

Chapter 10: Discussion

10.1 Introduction

This chapter focuses on the implications of my findings for the understanding of refugee health in a European high-income destination country and for theory-building on that topic. My doctoral work shows a twofold dynamic of exclusion and inclusion concurrently experienced by refugees in Austria: They encounter various forms of exclusion in their everyday lives, which can exacerbate health problems, or create new ones. However, a notable contrast emerges regarding their entitlement to healthcare services and the utilisation of medical services. I demonstrated how, beyond its primary function of providing medical care, the healthcare system also engenders societal inclusion for refugees. This twofold, simultaneous dynamic – the coexistence of exclusion in everyday experiences and inclusion facilitated by institutionalised healthcare – demonstrates how healthcare practices enact, negotiate, shape, and reconfigure refugees' personal, social, and political positions in Austria.

In this chapter, I discuss the theoretical import of my findings for both the social studies of health and refugee studies. These fields have evolved in inter- and transdisciplinary terms, regarding both the broad methodological basis and their institutionalisation in multi-disciplinary research centres.[96] My research, which is at the intersection between political science and anthropology, complements these approaches. In the following sections, I first position my findings in the broader social science scholarship on refugee health. The predominant focus of the existing research has been on normative inquiries regarding legal entitlement to medical services and discussions of persisting barriers and factors that facilitate the fulfilment of refugees' health needs. My findings extend beyond these insights by focusing on other dimensions of refugee health as well that are often overlooked (see Table 4). Chapters 5 and 6 contribute to scholarship at the interface of research on the social determinants of health and studies on post-migration stressors by showing how refugees' lived realities in destination countries shape their health needs. Moreover, drawing on Chapters 7, 8, and 9, I situate my findings on the inclusive function

[96] In recent decades, there has been a growing trend of establishing research centres that adopt an inter- and transdisciplinary approach to studying health. The same development can be observed in refugee studies. An example of a centre that focuses on the intersection between health and (forced) migration is the Danish Research Centre for Migration, Ethnicity and Health at the Department of Public Health, University of Copenhagen. In 2021, I had the privilege of being a guest researcher at this institution.

of the Austrian public healthcare system in scholarly debates on solidarity, belonging and citizenship.

I then discuss how my findings on the simultaneous experiences of inclusion and exclusion align with empirically nuanced approaches to biopolitics (Aradau & Tazzioli, 2020; Fassin, 2018). I also complement existing studies on simultaneous inclusion and exclusion in refugee studies (Ataç & Rosenberger, 2013; Hynes, 2011; Inhorn & Volk, 2021; O'Reilly, 2020). While these studies explored this double movement in areas such as borders and housing, health remains an under-researched issue in this corpus. Second, this chapter discusses the methodological strengths and weaknesses of my research design at the intersection between political science and anthropology. Third, I address the policy implications emerging from my findings, before closing with a brief summary.

Location	*Dimension*	*Explanation*
Outside the healthcare system	Everyday health risks	Legal, practical, and discursive exclusions of refugees result in health problems (Chapter 5).
	Self-care practices	Health needs are met through practices outside institutionalised care structures (Chapter 6)
Within the healthcare system	Healthcare services	Provision of medical services in the institutions of the healthcare system ("key" function of healthcare systems).
	Solidaristic practices	Lived solidarity by care providers compensates for practical barriers refugees encounter in accessing healthcare services (Chapter 7).
	Belonging	Utilising healthcare services cultivates a sense of belonging among refugees (Chapter 8).
	Citizen–state relationships	The healthcare system shapes refugees as citizens (Chapter 9).

Table 4. Overview of the different dimensions of refugee health discussed in this thesis

10.2 Positioning the Findings in the Research Landscape on Refugee Health

Social science studies on refugee health in high-income destination countries often address legal entitlement to medical services or focus on practical barriers to and facilitators of receiving

medical care (see Chapter 2).[97] These are important aspects for understanding how healthcare systems fulfil their key function of providing healthcare in refugee context. Regarding questions about legal entitlement, studies highlighted the exclusion of undocumented refugees from receiving medical services in the healthcare system (for the situation of undocumented migrants in Austria see Ataç et al., 2020; Rosenberger et al., 2018; Stiller & Humer, 2020) and formulated normative claims with regard to comprehensive legal inclusion (Durham et al., 2016; Illingworth & Parmet, 2015; West-Oram, 2018a). Regarding barriers encountered by refugees who are legally entitled to healthcare services, studies for example identified the lack of interpreting services, insufficient knowledge about how to access medical services, financial barriers such as top-up payments, and stereotyping and discrimination by healthcare personnel as obstacles to medical care (Asif & Kienzler, 2022; Chase et al., 2017; Filler et al., 2020; Jallow et al., 2021; Kocot & Szetela, 2020; Nowak et al., 2022; van Loenen et al., 2018).

In Austria, documented refugees, including asylum seekers, have access to the same facilities and services as other beneficiaries in the public healthcare system, including public hospitals, SHI-contracted general practitioners and specialist practices, and psychological care (with a few exemptions for asylum seekers, such as top-up payments for some dental care; Knapp, 2019). I argue that this comprehensive entitlement renders normative questions on legal access largely redundant. Regarding barriers to and facilitators of healthcare access, insights regarding the 2015 refugee cohort in Austria largely correspond with international studies' insights, with language difficulties and a lack of psychological support identified as the most urgent issues (Kohlenberger et al., 2019; Leitner et al., 2019; Mayrhuber et al., 2016; see Chapter 2).

These insights into persisting barriers in refugee care and the strategies to overcome them focus on the healthcare system's primary role of delivering medical services. This thesis adopted a distinct perspective, drawing attention to other dimensions of refugee health. My initial objective was to study the health needs of refugees in Austria and how these are met, or not met. However, as my fieldwork and analysis progressed, I increasingly recognised the interconnection between refugees' socio-political environment and their health needs. This led me to explore questions

[97] This thesis finds its place within the broader body of research on health policies concerning refugees, primarily drawing from the fields of political science and anthropology. Notably, this topic has garnered interest in various other disciplines as well, such as medicine and economics. For example in the Austrian context, El-Khatib et al. (2019) showed prevalent diseases among refugees in an Austrian reception centre and economists compared public healthcare expenditure for (forced) migrant patients and Austrian citizens (see, for example, Hofmarcher & Singhuber, 2021; Schober & Zocher, 2022).

addressing refugee health beyond legal entitlement and healthcare institutions' ability to offer adequate medical services: How are refugees' health needs formed by their living situation in a high-income destination country? What does utilising services in a publicly funded healthcare system mean for refugees, apart from receiving medical care? What role do healthcare professionals and other care providers play in ensuring that refugees' health needs are met? How do medical services reconfigure who belongs in a nation-state? How do they form citizen–state relationships? The following sections present the answers to these questions, in dialogue with relevant research from the social studies on refugee health.

10.2.1 Refugees' Health Needs in the Context of Their Lived Realities in Destination Countries

Chapter 5 discussed how refugees' living situation in Austria creates new health problems and amplifies existing ones. In doing so, it adopts a broad understanding of health that extends beyond biomedical approaches to "disease" and beyond studies focusing on legal and practical access to institutionalised healthcare. Instead, it draws attention to subjective experiences of "illness" (Schramme, 2012) and contributes to research on the social determinants of health, such as housing conditions, education, and a person's position in society (Marmot, 2005; Venkatapuram, 2013). Generally, research on refugee health and forced migration has primarily focused on health problems resulting from experiences involving violence, war, and flight and neglected the impact of living conditions in destination countries (Agyemang, 2019; Nowak et al., 2022). While studies on the interrelationship between refugees' everyday living conditions in high-income host countries and their health needs have increased in recent years (for example, Isaacs et al., 2022; Mayblin et al., 2020; Tomkow, 2020, in the UK and Chase et al., 2017; Newbold & McKeary, 2018, in Canada), research focusing on the Austrian context remains scarce.

My findings contribute to the empirical knowledge base on how being a refugee in a high-income destination country shapes health needs. Listening to refugees' narratives of health and illness allowed me to gain insights into their lived reality. Austria's socio-political context of a shift to the political right (Liebhart, 2020; Wodak, 2018) and increasingly strict asylum laws (Gruber, 2017; Merhaut & Stern, 2018; Welz, 2022), combined with reception conditions for asylum seekers and the associated personal challenges for residents, create what I termed "everyday health risks" for refugees. Courts that deny asylum claims, magistrates that fail to acknowledge foreign driver's licenses, and public discussions that characterise forced migration as a burden have been discussed as examples of how refugees are continuously excluded in legal, practical, and discursive terms. Refugees' personal health experiences showed how these forms of exclusion

materialise in their bodies. They manifest as insomnia, headaches, stress and worries. You may remember Muhammad who attributed his insomnia[98] and persistent headache to always hearing "No" in Austria (Chapter 5). These findings corroborate existing research on post-migration stressors that were found to detrimentally affect the health and well-being of asylum seekers and recognised refugees.

For asylum seekers, research conducted in countries other than Austria also found that asylum procedures with an uncertain legal status and often hostile living conditions are particularly detrimental to refugee health and well-being (Gleeson et al., 2020; Juárez et al., 2019; Li et al., 2016; Nowak et al., 2022). A meta-ethnographic analysis of the meaning of the state of limbo for asylum seekers (17 articles comprising qualitative, ethnographic studies from mainly Western host countries, with publication years ranging from 2003 to 2019, qualitative, ethnographic studies; Hartonen et al. 2021) showed how this group's specific situation often deprives them of their capacity to act and leads to increased stress, depression and other detrimental conditions:

> In a stage of limbo, individual negotiation of agency is affected by ontological insecurity and spatial–temporal inconsistency that can hyper-realise the present, producing excessive anxiety, fear and sadness. Due to the lack of controllability of the outcome of the situation, liminality can increase emotionally focused coping, which is often observed as affect intensity and emotional arousal as individuals try to resist the stress caused by liminality. (p. 25)

Moreover, Chapter 5 showed how recognised refugees' lived reality continues to detrimentally affect their well-being. For instance, consider Rima's family; they were promptly recognised as refugees, as was the case for the majority of Syrians. They diligently followed the news to stay informed about any new regulations. The family was afraid of the right-wing 2017–2019 ÖVP–FPÖ coalition and expected that its policies would lead to more exclusionary measures that would affect them. Their expectations ranged from reductions in social benefits for foreigners to the potential deportation of even those who had obtained refugee status. Austria's comparably strict naturalisation (Bauböck & Haller, 2021; Stadlmair, 2018) exacerbated the Syrian family's sense of insecurity.

These findings corroborate prior research from European and international destination countries on the adverse effects on health and well-being that persist even after refugees receive a positive asylum decision. These effects were attributed to challenges such as navigating bureaucracy,

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[98] See Hisler and Brenner (2019) for a discussion on how experiences of everyday discrimination are mediated by sleep and impair mental and physical health.

losing the support structures in their home country, experiencing discrimination, and encountering restrictive policies related to, for example, language requirements for receiving social benefits (Isaacs et al., 2022; James et al., 2019; Juárez et al., 2019; Kikhia et al., 2021; see Chapter 2). Within the Austrian context, I wish to highlight two qualitative interview studies that underscore the impact of hostile living conditions on health and well-being: Schiocchet (2019) found Arabic-speaking refugees who arrived in Austria 2015 to closely link their own health to their everyday lives. They described to often have feelings of fatigue and a sense of powerlessness, which Schiocchet (2019) interpreted as indicative of depression. The other study focused on Kenyan women who had resided in Austria for periods ranging from four to 30 years, with the majority being employed. Nevertheless, post-migration stressors continued to impair their well-being. These stressors included troubled relationships with their families, feelings of alienation, unfulfilled expectations about their lives in Europe and experiences of racism (Stuhlhofer, 2021).

Chapter 6 showed how the self-care practices of revisiting public spaces associated with well-being, using mobile phones, engaging in religious practices, pursuing paid work, and experiencing mutual support were important in helping the refugees stay healthy when faced with everyday health risks. The link between self-care practices outside the healthcare system and the health of refugees who applied for asylum in European countries around 2015 has garnered attention due to recent empirical studies, which Chapter 6 contributes to. For example, a qualitative interview study conducted in a refugee reception centre in the Netherlands highlighted the significance of sports for overcoming boredom, temporarily escaping daily challenges, and alleviating social isolation (Waardenburg et al., 2019). Similarly, a single-case study involving an Afghan asylum seeker in his mid-20s in Austria found that "sport practices can enhance human agency to cope with health issues and distressing past and present experiences during the asylum-seeking process" (Ley et al., 2022, p. 4140). In addition, research has indicated the importance of food-related practices in promoting well-being and creating a sense of home (Al-Sayed & Bieling, 2020; Vandevoordt, 2017). Regarding religious practices, a qualitative interview study involving Syrian refugees in the UK identified practising their faith, spending time outdoors and "becoming their own doctor" as crucial for dealing with challenges related to loss, separation, cultural and community disconnection, and the well-researched barriers to healthcare often encountered by refugees (Paudyal et al., 2021).

Moreover, the findings in Chapter 6 on mutual support among refugees as a form of self-care resonate with research from other contexts that identified a social network and support as a key

positive factor in refugee health and well-being (Nowak et al., 2022) and identified refugee health as a relational phenomenon between refugees and their context in destination countries (Moe & Ytterhus, 2022). For example, a study on Syrian refugees who had resettled in Sweden between 2011 and 2013 operationalised social support as “someone available to the participant who will listen, give advice, show love/affection, help with daily chores, provide emotional support and can be confided in” (Gottvall et al., 2020, p. 507). In the Swiss context, insights into the primary care structures for Eritrean asylum seekers and refugees suggest that – apart from formal assistance provided by general practitioners, hospitals, social workers and specialised organisations – informal support from family, friends, acquaintances (often fellow Eritreans), volunteers and, to a lesser extent, relationships in the home country were important (Wallimann & Balthasar, 2019). To improve refugee health, studies also suggested actively involving community facilities in the medical care process (Filler et al., 2020; Hawkins et al., 2021).

10.2.2 Inclusion via Healthcare

I propose the term “inclusion via healthcare” to refer to how healthcare for refugees – defined by their entitlement to healthcare services and their utilisation of medical services in a public healthcare system – extends beyond its primary function of providing medical care. It also operates as a broader personal, social, and political mechanism which includes a marginalised group into society. This secondary function of the healthcare system can, at least in part, counteract the multifaceted exclusions experienced by refugees in various spheres of their lives in destination countries. Ultimately, based on a practice-based understanding of “citizenship as a social activity of living together” (Pols, 2016, p. 188), this function of healthcare includes refugees as citizens.[99]

[99] I termed this secondary function of the healthcare system as “personal, social, and political inclusion to society”. The personal aspect refers to refugees developing a personal sense of belonging by navigating the healthcare system, while the social aspect emphasises how this inclusion involves social interactions with care providers. This secondary function also carries political significance: The forms of inclusion enacted in the healthcare system counteract the legal, practical, and discursive exclusions, which refugees face, through restrictive asylum policies and in many other aspects of their lives. I distinguish the inclusive function from integration. Münch’s (2018) analysis of post-2015 political discourse in Germany shows how integration was framed as the individual responsibility of refugees, even by previously less conservative actors who had previously advocated for the term “inclusion”. Unlike integration policies aimed at migrants, the healthcare system’s inclusive function lies in treating this group equally among all it beneficiaries.

The relationship between health and social/political rights has received attention in previous social science scholarship. For example, the concept of biological citizenship suggests that disease can be a basis for asserting one's social rights (Petryna, 2004; Rose & Novas, 2005; see Chapter 2), and empirical research has shown how bodily evidence, such as traces of torture, can be used to make claims for citizenship in asylum courts (Fassin & D'Halluin, 2005; Heinemann & Lemke, 2014; Ticktin, 2011; see Chapter 2). These concepts suggest that a person's health and physical condition might afford them additional rights. However, my argument about inclusion via healthcare differs from this perspective.

In Austria, refugees are legally and practically included in the public healthcare system along with all other beneficiaries (see Chapter 3). Inclusion into society based on health considerations is not primarily determined by refugees' health status or vulnerability. Instead, the forms of inclusion at play are grounded in established legal rights to healthcare, which are integrated within the same healthcare system accessible to all residents. Unlike other examples mentioned earlier in this section, such as claims for citizenship in asylum courts based on bodily evidence of vulnerability (Fassin & D'Halluin, 2005; Heinemann & Lemke, 2014; Ticktin, 2011; see Chapter 2), this inclusion is not about additional rights that refugees may acquire when having a disease; rather, healthcare drives inclusion in a broader personal, social, and political sense. This differs from many other empirical contexts in which refugees lack comprehensive access to healthcare or receive medical services through less comprehensive parallel structures (for a preliminary international comparison, see the later section in this chapter on that topic).

In the following sections, I discuss how inclusion via healthcare emerges in multiple practices within medical institutions, including care providers' solidaristic practices (Chapter 7), personal feelings of belonging (Chapter 8), and the healthcare system's role in shaping citizen–state relationships (Chapter 9).

By using "inclusion to society", I emphasise a broader social participation that extends beyond ties within religious communities, associations (*Vereine*), or similar likeminded groups. This helps steer clear of invoking nationalist elements associated with the term "inclusion to Austria" (for an in-depth discussion on how public healthcare systems may harbour nationalist, racist, and exclusive elements, see Cowan's (2021) and Fitzgerald et al.'s (2020) analyses of the British NHS).

10.2.2.1 Solidarity

This thesis shows how inclusion via healthcare is enacted by two forms of solidarity. First, the lived solidarity of care providers described in Chapter 7 illustrates how healthcare practices within medical institutions may be practices against exclusion. Second, in Chapter 8, I showed how refugees asserted their place within the Austrian society by valuing the solidarity principle of the Austrian healthcare system. In this section, I contextualise these findings based on the wider literature on solidarity.

Based on a practice-based understanding of solidarity (Prainsack & Buyx, 2012, 2017), Chapter 7 showed how the lived solidarity of care providers contributed to meeting refugees' health needs. The described forms of solidarity differ from what is usually described in the literature on solidarity and healthcare, which tends to focus on the institutionalised solidaristic basis of public healthcare systems (Hofmann & Spieker, 2022; Prainsack & Buyx, 2015; Ter Meulen et al., 2011). This understanding of solidarity in healthcare systems can be described as "civic solidarity" (Scholz, 2008; see Chapter 2), as the institutionalised obligations between citizens.

In contrast, in Chapter 7, I described how the solidarity-based Austrian healthcare system forms the background for solidaristic actions aimed at addressing ongoing exclusions that impact refugee patients. Practical barriers continue to exclude them from receiving adequate care in Austria (Kohlenberger et al., 2019; Leitner et al., 2019; Mayrhuber et al., 2016; see Chapter 2). The solidaristic practices of care providers challenge these ongoing exclusions and play a vital role in ensuring that refugees receive equitable care. The literature on refugees and solidarity facilitates a better understanding of these practices than the literature on civic solidarity. The former focuses on forms of "political solidarity" (Scholz, 2008) that aim to alter existing inequities, for example, through demonstrations and protests against restrictive asylum policies and for refugees' legal inclusion (Agustín & Jørgensen, 2019; Ataç et al., 2016; Schwiertz & Schwenken, 2020; Vandevoordt & Verschraegen, 2019; see Chapter 2).

Gould (2018) criticised the existing literature on healthcare and solidarity for prioritising institutional infrastructures, i.e. civic solidarity structures such as public healthcare systems, without adequately addressing structural injustices or ways to fight them. In the context of the Austrian healthcare system, as this thesis shows, solidarity extends beyond mere civic solidarity to also encompass political solidarity. The system in Austria operates on a foundation of civic solidarity, in which higher contributions from high-income groups offset the low contributions made by groups without paid employment, such as asylum seekers and recognised refugees. At the same time, political solidarity is evident within medical institutions, as discussed in Chapter

7. The everyday practices of care providers constitute direct efforts to mitigate inequities and address injustices. Thus, I interpret the lived solidarity of care providers as a struggle for refugee inclusion: They actively work against what they perceive as the unjust exclusion of refugees.

Moreover, solidarity plays another role when thinking about the healthcare system's function of inclusion. I showed that refugees asserted their sense of belonging by actively supporting the value of solidarity within the healthcare system. According to the political scientist Nira Yuval-Davis' (2006; see Chapter 2) influential concept of belonging, personal attachment to values forms an important basis of belonging. She conceives belonging as a personal dimension arising from (i) an attachment to social places, such as race and place of birth, (ii) an identification with collectives, such as culture and religion, and (iii) an alignment with ethical and political values. The Austrian healthcare system is underpinned by the value of solidarity, which refugees willingly shared: In Chapter 8, refugees' personal commitment to the principle of solidarity in the healthcare system is illustrated by how Abdi valued regular check-ups to prevent infectious diseases. He saw this as a contribution to the well-being of the broader community. Notably, Abdi expressed this support shortly after his asylum claim had been rejected, which meant he was excluded from continuing to reside in Austria.

Other refugees also asserted their sense of belonging against the exclusionary notions of the healthcare system. They expressed a desire to donate blood, despite certain requirements regarding German proficiency and their home countries that posed barriers to it. This underscored their commitment to the healthcare system's solidaristic basis. You may remember the disappointed course participant from the Austrian Integration Fund who was turned away from a donation centre and the group of asylum seekers whose attempt to donate blood as a gesture of solidarity with terrorism victims proved unsuccessful. The man's disillusionment and the group's communication with a newspaper about their rejection due to donation restrictions manifested as a direct contestation of refugees' belonging, challenging the exclusion they faced.

Wittock et al. (2021) recently addressed blood procurement as a citizenship regime. While my findings describe refugees' active practices against exclusion from donating blood, Wittock et al.'s (2021) starting point was the low participation of minorities in blood donation in Europe. Their article advances an understanding of blood procurement based on two logics: gifting and safety. The former is closely tied to the concept of a nationwide, solidaristic citizenship, whereas the latter is associated with the disproportionate exclusion of minorities, often due to the prevalence of specific diseases in their home countries. Wittock et al. (2021) conclude that the

> [r]ecognition of the need for systemic changes in order to include ethnic minorities in blood donation could help to establish and maintain relationships of solidarity between minority and majority populations. (p. 547)

This argument on the relationship between blood procurement and citizenship aid in interpreting my findings about refugees endorsing the value of solidarity within the healthcare system. This endorsement can be viewed as a struggle over belonging and "membership in the solidary community of intimate strangerhood" (Wittock et al., 2021, p. 546). Ultimately, this effort aims to redefine who is part of the citizenry by fostering solidarity-based relationships between refugee and non-refugee patients.

10.2.2.2 Belonging

Other practices within medical institutions that engender societal inclusion include the development of a personal sense of belonging by refugees when utilising institutionalised healthcare services. In several instances, the issue of belonging is a subject of contention within destination countries (Mattes & Lang, 2021; Thelen & Coe, 2019; for details, see Chapter 2). Chapter 8 drew attention to the understudied role of healthcare for notions and practices of belonging. It showed that a personal sense of belonging evolves based on affective relationships of trust with healthcare providers and facilities visited repeatedly. The healthcare system facilitates this inclusion process through its physical spaces, materialities and personnel, creating a counter-dynamic to legal, practical and discursive exclusions. You may remember Maria who proudly navigated the healthcare system "alone" after receiving guidance from a few friends. The refugees involved in my research prioritised empowerment over support, implicitly rejecting the common perceptions of them as vulnerable, helpless and passive. Instead, they embraced independence and self-determination in the healthcare system as a means of asserting their agency.

My findings align with a limited but growing number of empirical studies on the lived experiences of migrants that showed how the use of healthcare can foster a sense of belonging (Mattes & Lang, 2021; Raffaetà, 2019; for details, see Chapter 2). For example, Vietnamese patients in a German outpatient psychotherapeutic clinic developed a positive sense of togetherness through shared visits to public places during therapeutic interventions (von Poser & Willamowski, 2020) and Eastern European sex workers experienced a sense of belonging after obtaining health insurance in Germany (Probst, 2022). Moreover, I showed how spatial aspects (for example, knowing ways of travelling to and back from healthcare institutions) and objects (for example, a

familiar jar of candy and a personal e-card) in the healthcare system contribute to developing a sense of belonging. I made sense of these findings by drawing upon posthumanist thinking (Barad, 2007; Coole & Frost, 2010; see Chapter 8), which has been increasingly incorporated into the research on healthcare institutions. Intensive care units (Caronia & Mortari, 2015) and hospitals (Chabrol & Kehr, 2020) are thereby understood as having agency, tying into the larger scholarship on how places matter with regard to belonging (for example, Antonsich, 2010; Wright, 2015).

A recent scoping review offers an overview of research on the role of place in refugees' mental health in destination countries of the Global North. It suggests understanding place as a "as multifactorial construct that embeds the post-migration context of refugee mental health within a broader asylum landscape" (Ermansons et al., 2023). However, the role of healthcare facilities as places and healthcare objects that create a sense of belonging among refugees – addressed in Chapter 8 – has thus far received little attention. Few studies addressed this relationship, and none explored it in the refugee context. A quantitative survey conducted among migrants in China showed that possessing a social security card increases the sense of belonging (Chu et al., 2022). Moreover, Brenman's (2021) study on an NGO in the UK that offers psychological support for migrants is worth highlighting. Employing ethnographic and visual data to research how patients perceived the NGO's relocation to new premises, she showed how both the material entities and spatial attributes of therapeutic environments co-constitute belonging (Brenman, 2021).

Moreover, my research shows that, while refugees can develop a personal sense of belonging to Austrian society within the healthcare system, it can also be challenged by instances of exclusion. Contrasting meanings of the Austrian e-card illustrate how health policies can simultaneously include and exclude refugees. During my fieldwork from 2018 to 2020, I noticed posters in healthcare facilities reminding patients to present an identification document alongside their e-card when checking in at the reception desk (see Figure 26). These posters were issued by the Federation of Social Insurance Institutions (since 2020, under the social insurance reform, known as the Umbrella Organisation of Austrian Social Security Institutions; see Chapter 3). In Chapter 8, I described how the e-card signifies a material instantiation of belonging. It fosters a personal sense of belonging among its holders, which strengthens with each doctor's visit.

Figure 26. Poster issued by the Federation of Social Insurance Institutions, stating "For each treatment: Please bring e-card and ID card. Thank you!" (my own translation from German)

The e-card's function for creating belonging contrasts with a legal stipulation that was later imposed on e-cards, which served as a vehicle for the discursive construction of refugees as outsiders. In 2020, a legal change mandated that all e-cards must include personal photos. This change was embedded in a discourse characterised by gender-based, anti-Muslim racism and xenophobia that marked male Muslim immigrants, particularly refugees, as abusers of the social system: They were unjustly accused of sharing their e-cards with people without insurance coverage (see Chapter 3). Political scientists classified the introduction of photos to the e-card as a welfare chauvinist[100] policy enacted by the 2017–2019 ÖVP–FPÖ government in the realm of healthcare (Falkenbach & Heiss, 2021). These contrasting meanings illustrate how inclusion via healthcare occur in simultaneity with instances of exclusion.

10.2.2.3 Citizenship

Chapter 9 showed how the healthcare system's secondary function of inclusion emerges in the enactment of citizen–state relationships when refugees access institutionalised medical care.

[100] Welfare chauvinism refers to welfare benefits restrictions for the native population (see Chapter 3).

These insights from my thesis align with key ideas of biopolitics and practice-based approaches to citizenship, which understand citizenship to comprise more than possessing a country's passport. Chapter 9 described how refugees perceive the healthcare system as the "good state", in contrast to their negative experiences with other state institutions, such as asylum courts. The entitlement to medical services and their utilisation contribute to the establishment of citizenship for refugees, effectively including them as social citizens (see also Bambra et al., 2005; Spahl & Österle, 2019). With the notion of "relational citizenship", the medical anthropologist Jeannette Pols (2016) outlined a practice-based approach to understanding citizenship. Its central focus on the dynamic and evolving nature of the relationship between citizens and the state resonates with the double movement outlined across the chapters discussing this thesis' findings: the simultaneous experiences of exclusion in everyday life and inclusion within the healthcare system.

> The term "relational citizenship" moves citizenship away from the relationship between individual and state toward the relationship between citizens and the way they shape social spaces. It describes citizenship as a social activity of living together, rather than as an individual trait or set of rights. …. It allows for an analysis of how the parties renegotiate norms rather than assume that newcomers such as long-term mental health clients, but also people with intellectual disabilities, will adapt to existing norms. (Pols, 2016, p. 188)

Pols' perspective on "citizenship as a social activity of living together" offers a valuable lens through which my findings can be viewed. It highlights the dynamic nature of citizenship, which is shaped through concrete interactions over time. This resonates with my discussion of the dynamic process of cultivating a sense of belonging through interactions within the healthcare system (Chapter 8) and the journey of becoming social citizens by using medical services (Chapter 9). Refugees' sense of belonging, nurtured through their experiences in healthcare settings, and their perception of medical institutions as benevolent and of the healthcare system as the "good state" contribute to a reshaping of the citizenry. As refugees engage with the healthcare system, they gradually become part of the Austrian "we" from which they had been excluded in other areas of their lives. Unlike more substantial systemic changes or large-scale public actions, such as the introduction of new laws or public protests against restrictive asylum policies, inclusion via healthcare draws attention to aspects that are frequently hidden and seldom acknowledged (for example, developing a sense of belonging through knowing healthcare facilities). These aspects are deeply embedded in the mundane experiences of everyday life, revealing the healthcare system's potential for contributing to wider social and political transformation.

Moreover, my discussion of citizen–state relationships (Chapter 9) highlights the ambivalent role of institutionalised healthcare for refugees. Biopolitical theory is helpful for understanding my findings on how the Austrian healthcare system shapes refugees as citizens. The term biopolitics, developed by Michel Foucault in the 1970s, originally referred to the disciplining of individuals and the regulation of the population. The concept and its numerous actualisations by subsequent scholars have substantially discussed how healthcare – broadly comprising institutionalised medical care in the healthcare system, hygiene measures, educational books, public health measures, etc. – governs people and forms national populations (Foucault, 2003 [1976]; Lemke, 2011; see Chapter 2).

Health policies, as a governmental technology in the Foucauldian sense, shape people's behaviour (Lemke, 2011) and "normalise" them to create a healthy population (Lupton, 1995). In this way, health policies also contribute to the categorisation of people outside of the norm as "abnormal" (Davis, 2018). The introduction of the body mass index and anti-obesity policies are illustrative examples of how certain groups of people were categorised as outside the norm (Evans & Colls, 2009) and of how the biopolitical rationale of optimising the population by normalising its members may be problematic. People who conform to the "normal" ideal imagined by healthcare policies also face the risk of devaluation:

> The problem … is that strategies of optimizing human life, whether through political, medical, or other technologies, involve norms and standards for measuring achievement and establish what qualifies as better, desirable, or improved, and what does not. Thus, such strategies constitutively imply scales of differential human value. (Braun, 2021, p. 20)

The findings in Chapter 9 elucidate how the concepts of normalisation and categorisation as "abnormal" gain significance in the context of refugee healthcare. As newcomers, refugees are shaped through the healthcare system and undergo a transformative process. I discussed practices within the Austrian healthcare system that gradually shape refugee patients as "good citizens" and "normalise" them as part of the Austrian citizenry. Thus, I critically examined the expectations placed on refugees by Austrian authorities regarding their adaptation to the healthcare system. Healthcare practices convey specific expectations regarding how "good citizens" should behave (Probst, 2022) in the Austrian context, including attending preventive medical check-ups, relying on the general practitioner as a gatekeeper to specialised medical services, and maintaining a healthy diet.

There emerges a tension between the prescribed, "normal" behaviour and alternative healthcare practices that refugees may want to engage in. This tension was also observed in other studies

on refugees in Austria. Schiocchet, in interviews with Arabic-speaking refugees, highlighted a disconnect between the expectations of Austrians regarding the 2015 refugee cohort and the desires of the refugees themselves.

> [While Austrians claim the] need for "social integration", national economic security, and the maintenance of cultural identity, the displaced Arab-speakers have typically expressed their need for social understanding, respect, and a chance to participate and be productive in the host society. (Schiocchet, 2019, p. 233)

My findings raise critical questions regarding the extent to which the expectations imposed on refugees as patients within the healthcare system may lead to their health behaviours being labelled as "abnormal". This categorisation of abnormal behaviour is at risk of being extended to refugees as a collective group, similar to other processes of othering found in refugee healthcare.

Scholarship has shown how healthcare can enact the exclusion of refugees and migrants. Healthcare may contribute to the reconstruction of refugees as racialised subjects, knowingly or inadvertently perpetuating structural biases against non-White persons, as discussed in a recent *Bioethics* special issue (Ganguli-Mitra, et al., 2022). This reconstruction could impact how these patients are perceived and treated within and beyond the healthcare system, possibly perpetuating systemic discrimination based on race or ethnicity. In a Western biomedical view of health, healthcare professionals' racism towards asylum seekers and other non-White migrants may often be unintentional (Kehr, 2018; Willey et al., 2022). Moreover, public health measures, such as tuberculosis care and antimicrobial screening, may portray refugees as potential "disease threats" (Fang et al., 2015; Grove & Zwi, 2006; Kamenshchikova et al., 2018; Kehr, 2016; Olsen et al., 2016; von Unger et al., 2019; see Chapter 2).

This thesis' argument regarding the healthcare system's function of inclusion is diametrically opposed to these forms of exclusion via healthcare. In addition to demanding refugee integration, examining attempts to normalise refugees through healthcare, and focusing on forms of othering in medical institutions, this thesis shows how practices within the healthcare system can serve as a basis for reconsidering more diverse forms of citizenship. They could provide a starting point for reimagining who is part of the "we" in the Austrian national community.

10.2.3 Simultaneous Inclusion and Exclusion through Health Policies

Thus far, this chapter provided an overview of contributions to the literature on how refugees' health needs are shaped by their lived reality in destination countries (Chapters 5 and 6) and the

healthcare system's role in fostering inclusion (Chapters 7–9). Inclusion via healthcare occurs within the context of mundane experiences of exclusion. However, the exclusion of refugees also manifests within the healthcare system, both implicitly and overtly: The discussed solidaristic practices occur against the backdrop of persisting barriers and gaps within institutionalised healthcare for refugees (Chapter 7). The personal e-card provided to asylum seekers fosters a personal sense of belonging among them, but it also became a catalyst for xenophobic discourse (Chapter 8). While refugees perceive the healthcare system as the "good state", the healthcare system also plays a role in shaping them as "good citizens". This requires refugees to surrender a part of their acquired health knowledge and adapt (Chapter 9).

In this section, I discuss these findings in conjuncture and relate them to similar research in the social studies of health and in refugee studies. Influential concepts, which addressed refugee health as embedded in destination countries' socio-political contexts, include un/deservingness, welfare chauvinism, and necropolitics (for a detailed discussion of these concepts, see Chapter 3). Welfare chauvinism (restricting social benefits to "our own") and un/deservingness approaches (distinguishing between migrants who deserve state support and those who do not) are built upon binary distinctions. They categorise populations into groups eligible for generous healthcare services and those with restricted access to healthcare. From a legal perspective, a distinct division exists between documented migrants' entitlement to healthcare and undocumented migrants' lack of access to it (Geeraert, 2018). However, these concepts can only partially address the various aspects of refugee health that this thesis describes.

According to Foucault's original concept of biopolitics, healthcare institutions are crucial mechanisms of governance. These institutions shape citizens in specific ways, thus enabling the management of the population within a nation-state (Foucault, 2003 [1975–1976]). Further conceptualisations of biopolitics showed how refugees are governed by a logic different from that governing citizens, thereby following a binary logic in which citizens are nurtured and refugees' lives are devalued. The prominent concept of necropolitics (how social and political power lets certain parts of the population die, within a racialised post-colonial context; Mbembe, 2003, 2019) is particularly illustrative of such a binary approach in contemporary biopolitics. Empirically grounded biopolitical studies on refugees in Europe have, for example, focused on how this population group has been neglected, addressing Greek hotspots (Topak, 2020), deaths in the Mediterranean Sea (Montenegro et al., 2017; Presti, 2019), and the Calais refugee camp (Davies et al., 2017). These studies show how the nations' own populations' lives are fostered while refugees' lives are devalued.

The findings presented in this thesis challenge the rather simplistic interpretations of state rationales expressed in the concepts of welfare chauvinism, un/deservingness, and necropolitics. These concepts tend to create a binary distinction between the ways in which a native "us" and a foreign "them" are governed. In contrast, I showed how refugees are subject to processes of both inclusion and exclusion and how health policies – as legal texts, practice, and discourse – continuously shift the boundaries of belonging for them.

A more nuanced approach to biopolitics was formulated by the medical anthropologist Didier Fassin. He challenged Foucault's focus on the population as a collective entity formed by citizens by shifting attention to the disparities among various groups of people that are articulated through health governance and manifest in people's bodies. He introduced the term "politics of life" to emphasise how concrete lives within a nation-state are subjected to different forms of governance (Fassin, 2009, 2018; see Chapter 2). This thesis adopted a similar perspective, focusing on the specific lived experiences of a marginalised group and discussing how their health experiences diverge from those of others in Austria.

My findings corroborate similarly nuanced previous research that has presented refugees' experiences in destination countries as a double movement. For example, migration scholars, while not directly addressing health, focused on the intermediate state existing between liminality and belonging for refugees (Hynes, 2011; O'Reilly, 2020). Recognising the diverse domains and levels at which inclusion and exclusion take shape, these concepts are better understood in a relational manner. Rather than existing as two opposing binary states, inclusion and exclusion span a continuum (Ataç & Rosenberger, 2013). In other words,

> refugees experience both regimes of exclusion and inclusion as they confront the challenges of involuntary displacement. Refugees face legal, financial, and cultural barriers that restrict their ability to move about, enroll in school, access health care, or find housing in the countries that host them. Refugees have to confront existing stereotypes and prejudices. Yet, refugees can also find spaces where they can make themselves heard, obtain rights from host states, and receive support from local communities. (Inhorn & Volk, 2021, p. 8)

Recent empirical studies have drawn attention to the multiple forms that biopolitics may take in refugees' lived experiences, presenting nuanced biopolitical dichotomies of life and death and of inclusion and exclusion (Aradau & Tazzioli, 2020; Minca et al., 2021; Wiertz, 2021).[101] My findings

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[101] With regard to multiplicity, I also want to acknowledge the concept of the "body multiple", as articulated by the medical anthropologist Annemarie Mol (2002). This concept highlights how the body comes into being in concrete practices, moving beyond the conventional notion of "true" and objective medical

should be understood in accordance with this “biopolitics multiple” (Aradau & Tazzioli, 2020), as this notion can address how refugees are governed through multiple logics at the same time: through inclusion and exclusion as well as through biopolitics in the original sense and as devalued “other” lives.

10.3 Methodological Reflections

Chapter 4 presented an account of my methodological approach. In this section, I offer reflective conclusions concerning the research process, as well as a discussion on the limitations inherent in my study design. First, I highlight the strengths of the multi-perspective methodology used. Second, I discuss certain dimensions of analysis that may warrant further exploration, including the urban–rural divide and refugees’ legal status, gender, race, and religion. Third, I detail the unexpected challenges I encountered when conducting this study; these challenges encompassed navigating the disciplines of political science and anthropology, methodological nationalism, and the conceptual and empirical nuances associated with the term “health” as used throughout this thesis.

10.3.1 Strengths of a Multi-Perspective Methodology

First, this thesis stands out for its integration of diverse perspectives, encompassing those of refugee patients, care providers, and representatives of political parties. This approach fills a critical research gap in the field of refugee health, which was characterised by a lack of multi-perspective studies (Kocot & Szetela, 2020), and yielded unexpected insights. For example, I found a discrepancy between care provider and refugee perspectives. Care providers perceived their actions as supporting refugees as disadvantaged patients, which I conceptualised as solidarity (Chapter 7). However, the refugee interviews showed that, from their standpoint, achieving emancipation and empowerment through navigating the healthcare system independently held greater importance than receiving support (Chapter 8). Solidaristic care providers were focusing on compensating for the inequities in the healthcare system, while for refugees, gradually belonging in Austria was of paramount importance.

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knowledge. Mol’s central argument, regarding how “*ontologies* are brought into being, sustained, or allowed to wither away in common, day-to-day, sociomaterial practices” (Mol, 2002, 6), inspired me to consider my empirical findings on healthcare in terms of multiple meanings.

Initially, this discrepancy puzzled me and raised doubts about the analytical value of my analysis. However, upon reflection, I began to view my study as a nuanced approach to refugee health. I reinterpreted the collected data in the context of the multiple meanings associated with healthcare, an idea that I subsequently elaborated as the central theme underpinning the entire thesis. The creative engagement with conflicting perspectives, contradictions, and gaps within the various types of data collected was facilitated by the method of analysis employed – a combination of SitA (Clarke, 2003; Clarke et al., 2015, 2018) and CGT (Charmaz, 2006).

Moreover, accompanying refugees over a two-year period offered several advantages. It facilitated recruitment, as gatekeepers were more willing to introduce me to potential participants and it allowed me to establish a trusted relationship with the participants over time. Additionally, I could postpone conversations on difficult topics for the moment knowing that I could revisit those topics in later meetings. This was particularly important regarding my ethically challenging research, ensuring the protection of participants, who were not pressured to talk about incidents that directly burdened them at the moment, such as during acute uncertainty following a doctor's visit. This extended timeframe also allowed me to observe how the refugees learned to navigate the healthcare system and stabilise their health independently. I was provided with a more detailed and comprehensive understanding of the refugees' experiences compared to a single interview. For instance, Maria's first interview focused on her concerns about finding employment, but in a later interview, she had secured a job and shared how it had positively impacted her life.

10.3.2 Empirical Limitations

Second, my methodology has empirical limitations. When selecting seven key refugee research participants, I aimed to represent a broad spectrum of persons whose main characteristics mirrored the composition of the 2015 refugee cohort. Previous studies involving refugees illustrate the importance of different demographic characteristics, including legal status[102], gender, race, family status, home country (Gifford, 2021), and religion. Past experiences can also increase health vulnerability, as exemplified by the risk of re-traumatisation during medical examinations in destination countries among victims of torture (Schippert et al., 2021). Owing to

[102] I excluded undocumented refugees from this study because of their distinct situation, which other studies focused on (Ataç et al., 2020; Rosenberger et al., 2018; Stiller & Humer, 2020).

the limited size of the participant group in this study, it was only possible to draw preliminary conclusions regarding the impact of certain personal and legal characteristics. For instance, despite the generally equivalent entitlement to healthcare services for asylum seekers and recognised refugees, the findings presented in Chapter 5 suggest that the uncertain legal status of asylum seekers has a detrimental impact on their health.

Moreover, this thesis only marginally addressed the gender-specific aspects of refugee health. Female refugees face unique health needs and experiences, including gender-based violence and anti-Muslim racism linked to wearing a hijab (see, for example, Freedman, 2016; Hawkins et al., 2021; Mengesha et al., 2018; Shishehgar et al., 2017). This was illustrated by Maissa's wish for a gynaecologist's appointment post-childbirth to discuss contraceptive options. The consequences of such contraceptive health challenges remain unexplored in this thesis.

Similarly, men encounter distinct challenges affecting their well-being. For example, a study on Syrian refugees in Sweden found that men's mental health, especially those related to social pressures and economic stressors, was more adversely affected than women's (Alexander et al., 2021). Furthermore, male refugees may struggle to meet internalised expectations of providing a new home for their family members who often arrive later. Around 2015, with the increasingly securitised European border regime, the perilous journey to high-income European countries by land and sea was often undertaken by men (see Figure 27). This contributed to exclusionary discourses in Austria that portrayed these men as potentially dangerous, and politicians employed these narratives to justify stringent asylum policies, invoking "images of othered masculinities" (Scheibelhofer, 2017).

In my research, the key refugee research participants consisted of three male asylum seekers and four female recognised refugees. While women statistically had a higher likelihood of receiving positive asylum decisions (see Figure 28), I strove to collect information on female asylum seekers and male recognised refugees as well. When sampling participants, I had initial meetings with two women in asylum accommodations who later declined to participate in the study. My understanding of the health experiences of male recognised refugees was gained through the narratives of Maissa, Rima, and Sabah, who discussed their husbands' health experiences. Additionally, insights into the needs of refugee groups that did not directly participate in this study were obtained through interviews with care providers.

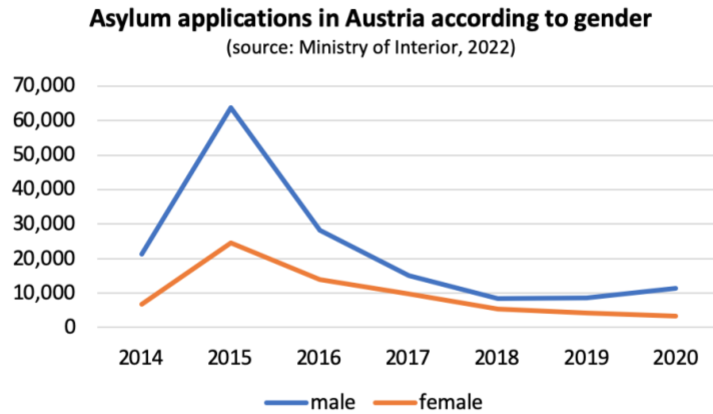

Figure 27. Asylum application according to gender, 2014–2020

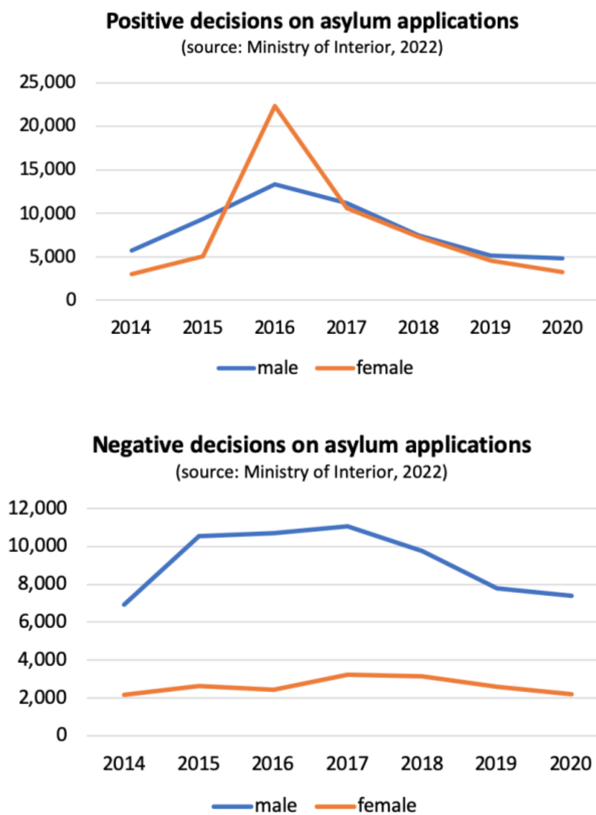

Figure 28. Positive and negative decisions on asylum application in Austria according to gender, 2014–2020

Furthermore, this thesis did not extensively explore the dimensions of race and religion. An editorial from a recent special issue dedicated to the topic of racism in healthcare aptly pointed out "that racism has been side-lined not only in healthcare, but also in our theorizing about health and well-being and bioethics' place in these discussions" (Ganguli-Mitra et al., 2022, p. 233). While I remained attentive to instances of overt and unintended racism within institutional

healthcare settings during my fieldwork and while analysing my findings (Ganguli-Mitra et al., 2022; Kehr, 2018; Weheliye, 2014; Willey et al., 2022), I did not interpret my data through the specific lens of race.

European countries' responses to refugees fleeing the war in Ukraine since 2022 have highlighted the relevance of race within asylum debates and public perceptions. Discursively, there has been an emphasis on the cultural proximity of these new refugees, who are perceived as White Christians, engendering more inclusive legal measures being enacted to accommodate their needs. In March 2022, the European Commission activated the Temporary Protection Directive, affording Ukrainians the right to protection without necessitating standard asylum procedures. Refugees who arrived in Austria in 2015 were predominantly non-White people from Muslim-majority countries. Notably, I realised that I had, to a large extent, conflated these demographic characteristics with the overarching category of "refugee" in the European context.

The aforementioned comment by Ganguli-Mitra et al. (2022) on the sidelining of race may be reflected in my choice to not analyse my data through the lens of race. However, I believe that there was also a methodological dimension influencing my analytical approach. Within the context of this study, there existed an informal net of care through which refugees navigated their health needs. I described how refugees were recommended good doctors by fellow refugees from the same country (Chapter 6), how social workers in accommodation facilities provided lists of healthcare practitioners known for their refugee-friendly approach, and how there were informal support networks among dedicated healthcare professionals (Chapter 7). Different research designs may be better suited to explore the adverse effects of racial factors within the Austrian healthcare system.

10.3.3 Navigating Two Disciplines, Methodological Nationalism, and the Term "Health"

Third, conducting research at the intersection of political science and medical anthropology posed unexpected challenges. My interactions with political scientists and anthropologists at conferences and other scholarly gatherings allowed me to form methodological concerns, and at times, I felt that I did not fully adhere to the requirements of either discipline. On the one hand, this thesis does not address key concerns of political science. For example, I did not comprehensively document all legal changes pertaining to refugees' health, nor did I consider an international perspective and supranational factors, such as those within the EU. Studies, for example, identified the lack of coordination among EU member states as a hindrance to

addressing the health needs of refugees (Mipatrini et al., 2017; Pavli & Maltezou, 2017). On the other hand, my methodology does not align with the standards of in-depth anthropological research, which typically involves the researcher fully immersing themselves in the field.

I became further aware of the challenges associated with navigating the intersection of disciplines when linking back to theory and the broader academic literature. In response, I sought to progress by drawing from studies in political science and medical anthropology, with a particular focus on scholarship resisting clear disciplinary categorisations, such as refugee studies and the social studies of health. I humbly request the understanding of rigorously disciplinary readers and hope that my approach, possibly because of its multi-disciplinary nature, can offer a valuable contribution to the social studies of refugee health.

Furthermore, readers may critique this thesis as an example of methodological nationalism, which posits that the nation-state naturally represents the societal and political structure of the modern world. While I share concerns about the pitfalls of methodological nationalism (Wimmer & Glick Schiller, 2002), I am cautious about assuming that the significance of nation-states has been diminishing in recent years. To the contrary, their relevance seems to have grown, evident in events such as Brexit, the escalating intra-European disputes regarding refugee admissions since 2015, and the substantial electoral gains of protectionist right-wing parties across Europe. These developments collectively underscore a resurgence in the prominence of the nation-state.

In connection with these worrying developments, I would like to point out how this thesis contributes to a more comprehensive understanding of the Austrian healthcare system's personal, social, and political implications by drawing attention to a marginalised group's experiences. My focal point has been accentuating the healthcare system's capacity to foster the societal inclusion of refugees. My aim is to stimulate readers to reconsider the essence of public healthcare systems, not merely as vehicles for providing medical services but as national infrastructures with the potential to nurture more inclusive and equitable societies. In the following section, I discuss the ways in which policymakers can cultivate the inclusive function of the healthcare system without perpetuating patterns of exclusion.

10.4 Policy Implications

When I initially embarked on researching the experiences of refugees with regard to Austrian health policies, I encountered scepticism from fellow political science scholars regarding the significance of researching healthcare for documented migrants. In Austria, the availability of

social benefits for refugees and immigrants faced a trend of tightening restrictions during the latter part of the 2010s (see Chapter 3). In contrast, entitlements to healthcare remained unchanged. Some political scientists I spoke to during the research design phase felt that my research topic did not have significant relevance – specifically, they deemed it as lacking "policy relevance" – due to the existing comprehensive legal entitlement to healthcare services refugees possess from the moment they submit an asylum application.

My colleagues' reservations were mirrored in the way policymakers and political institutions approached the issue of refugee health, as they largely neglected it. My research shows that, within the realm of Austrian health policy, refugees are a marginal topic, garnering limited attention from health policymakers and representatives of political parties. A telling example of this is how no one from the Ministry of Health was willing or available to talk to me about refugee health, despite my repeated requests. Furthermore, the initial, ambitious project of establishing a national coordination platform for improving psychosocial support for refugees, which began in 2016, was quickly scaled down to function solely as a networking platform for relevant NGOs. This transformation was indirectly instigated by the political shift to the right during the tenure of the ÖVP–FPÖ government from 2017 to 2019, in anticipatory obedience by the platform members. Notably, during my interview with the Green Party's health spokesperson, he characterised the topic of refugee health as a "hot potato" that "no one wants to deal with" (see Chapter 1). In contrast to the limited research and prevailing political indifference regarding this topic, this thesis provides valuable insights into public policies related to refugee health in Austria. Thus, it enhances the empirical understanding of the subject matter and demonstrates potential for improved policymaking.

I employed a distinct approach to studying policies, namely an interpretive and critical practice-based approach (see Chapter 1). Drawing upon "interpretive policy analysis" (Bevir & Waring, 2018; Fischer et al., 2015; Münch, 2016; Yanow, 1996, 2007) allowed me to focus on the meaning of practices and discourses in researching policies. This approach diverges from standard approaches in political science that typically focus on the legal formulation of health service entitlements and the identification of implementation gaps. For scrutinising Austrian healthcare policies, and asylum policies when relevant, I included the practices and lived experiences of patients and care providers in my analysis (Wagenaar, 2011). Valuing the advantages and strengths of ethnography with regard to political science, this thesis follows in the steps of Dubois' "critical policy ethnography" (Dubois, 2009, 2015) and Schatz's "political ethnography" (Schatz, 2009). Both view ethnography as a versatile method for comprehensively researching policies,

unearthing unintended consequences, and highlighting largely overlooked areas in traditional political science research. Ethnography can thereby be understood as political in itself, inherently carrying policy relevance (Katz, 2004). My approach also derives inspiration from anthropological studies of policy (Shore & Wright, 2011) and the broader field of medical anthropology. I understand my approach as critical because of its divergence from mere "techno-empirical policy analysis" (Fischer et al., 2015, p. 9) and its aim in combating inequities (Clarke et al., 2018) – mirrored in my findings on the Austrian healthcare system's function of inclusion, which contributes to imagining alternative, more equal power structures.

In the following section, I outline the policy implications of my research insights regarding the multiple meanings of healthcare. First, relevant factors for refugee health that current health policies disregard are highlighted. Second, the policy implications of the potential forms of inclusion that emerge from healthcare are discussed. Third, this thesis' findings regarding Austria are contextualised from an international perspective.

10.4.1 Health Policymaking to Counter Health Problems Based on Exclusions

This thesis shows how the medical services provided within the Austrian healthcare system cater to refugees' health needs inadequately and incomprehensively. The specific life conditions faced by refugees and exclusionary asylum policies – including legal regulations from asylum procedures, housing guidelines, integration measures mandated by law, political discourses, structural exclusions – engender health challenges that remain unattended within Austria's generally inclusive health policy framework (Chapter 5). These findings align with the existing international research on how refugees' health needs need to be understood in the context of their lived realities in destination countries, as described at the beginning of this chapter.

Considering refugee healthcare in the context of their everyday experiences in an often hostile host country has important implications for policymaking in the realm of public health and beyond. It underscores the necessity for policymakers to address not only legal entitlements to healthcare and the practical barriers to access but also deeply rooted divisions between "us" and "them" perpetuated by policymaking, prevailing discourses, and the everyday lives of refugees. A shift towards a more inclusive society becomes paramount in safeguarding the health of the entire population, necessitating a more holistic and empathetic approach in healthcare.

Furthermore, I show the importance of self-care practices that exist outside of the scope of health policy legislation and institutionalised healthcare. While they are not healthcare services

provided in the healthcare system, they can be seen as health services that promote and maintain refugees' overall health and well-being (Chapter 6). Ideally, political measures should support these self-care practices among refugees. Consideration of self-care practices could, for example, be integrated into preventive healthcare strategies, addressing a general deficiency within the Austrian healthcare system (see Chapter 3).

My research also shows how, within the healthcare system's institutions, some care providers engage in solidaristic practices that compensate for persisting barriers in practice (Chapter 7). Health policymakers should consider providing financial compensation to cover the additional costs incurred by these acts of solidarity in the treatment of refugees. For example, health insurance covering extended consultations focused on patients' biographical history could be a viable step. As discussed in more detail in the concluding remarks of Chapter 7, the ideal scenario entails the establishment of institutionalised support mechanisms aimed at alleviating the emotional, financial, and temporal burdens placed on solidaristic care providers. This proposition aligns with recent research on solidarity within publicly funded healthcare systems (Kieslich et al., 2023; Pot, 2022; West-Oram, 2021). These studies highlight the importance of formalising and institutionalising solidaristic practices to ensure their long-term viability. This is further emphasised by my findings regarding the constrained resources within the Austrian healthcare system (Chapter 7), which create challenges for healthcare practitioners striving to act in solidarity.

10.4.2 Harvesting the Healthcare System's Function of Inclusion

A representative survey among refugees who arrived in Austria around 2015 found a high level of trust in the country's healthcare system (Kohlenberger et al., 2019). None of the 73 participating women reported distrust in healthcare providers as a reason for refraining from seeking medical services, and only 7% of the 447 participating men indicated any degree of mistrust. This trust could serve as a pivotal point for initiating policy actions. Although I did not place trust at the forefront of this thesis, I show how certain experiences and practices in the healthcare system foster inclusion and emplacement for refugees, and these insights help elucidate why refugees express such a high degree of trust in the healthcare system.

The healthcare system's function of inclusion presents opportunities for shaping a diverse and equitable society in Austria, one in which refugees are part of the "we". Future healthcare policymaking, ideally in collaboration with policymakers from the asylum and integration sectors,

should consider these inclusive aspects of the healthcare system. Recognising the healthcare system's inclusive function holds transformative potential for the role of healthcare systems within present-day welfare states.

To foster the healthcare system's inclusive function, my research suggests several avenues for policymakers to consider. These include increasing awareness among healthcare practitioners, restructuring the initial medical examinations conducted in reception centres, and institutionalising solidarity-based practices by care providers in the general structures of the system. First, healthcare practitioners often lack an awareness of their role in establishing a sense of belonging for newly arrived refugees. I gained this insight through conversations with members of an expert group on migration and health in Austria, which included researchers and representatives of NGOs. I shared some preliminary findings from this study with them in June 2021. Raising awareness among healthcare practitioners with regard to healthcare's non-medical, inclusive dimensions acquires particular importance when considering that health facilities play a pivotal role in shaping refugees' relationships with the Austrian state (see Chapter 9). Often, these facilities are refugees' first point of contact with state institutions, following their interactions with asylum authorities and other institutions designated for refugees.

Second**,** it is important to consider the initial medical examinations conducted in reception centres (El-Khatib et al., 2019; Mayrhuber et al., 2016; see Chapter 3) in relation to the inclusive function of the healthcare system. These examinations must mandatorily occur within 24–72 hours after an asylum application is submitted. Currently, the Ministry of the Interior's institutional jurisdiction poses an obstacle to achieving integrated healthcare. Little information is available on the examinations, and the transfer of information to the institutions of the healthcare system is rare. My findings on the experiences of refugees and doctors in the healthcare system and on the repeated examinations in asylum accommodations organised by social workers (see Chapter 7) suggest that these examinations tend to be shallow. They fail to comprehensively identify mental and physical health issues (Kux, 2017) and do not establish a solid foundation for inclusion in Austria. Initial medical examinations could be expanded to better address the medical needs of refugees while also fostering a more positive relationship between them and the Austrian state. To achieve this, in addition to the allocation of additional resources, the Ministry of the Interior must openly discuss the content and procedure of the initial medical examinations.

Third, for policymakers aiming to enhance the healthcare system's inclusive role for refugees, there is a need to institutionalise practices rooted in solidarity within the general structures of

the system. These solidaristic practices create an informal, parallel system for caring for refugees within the publicly funded Austrian healthcare system. This parallel system can be observed in the provision of lists of refugee-friendly doctors in asylum accommodations, the emergence of informal networks among Arabic-speaking medical professionals, and the preferential care provided by native-language-speaking doctors. These practices effectively bridge gaps in refugee care. An argument for formalising these support structures within separate institutions can be made. Consider, for example, the self-organised group of healthcare workers aiming to establish a volunteer-run monthly information centre with professionals from different medical fields offering healthcare services to Arabic-speaking refugees in their native language (Chapter 7). However, my findings cast a critical perspective on such institutionalisations that run parallel to the facilities and services of the publicly funded healthcare system, as there is a risk that they may undermine the function of inclusion that this thesis highlights.

Finally, by recognising Austria's healthcare system as a vehicle for fostering inclusion, it is possible to explore how its potential can be leveraged to combat inequity and promote social cohesion beyond the refugee population. This thesis' insights highlight how the healthcare system serves as an arena for democratic struggles over freedom, equality, and solidarity (Rajal et al., 2020). My analysis shows how democracy is both negotiated and experienced through everyday healthcare practices. This includes care providers' efforts to combat injustices and inequity (Chapter 7), the nurturing of a sense of belonging among marginalised groups (Chapter 8), and the shaping of citizen–state relationships (Chapter 9). These dimensions of healthcare may contribute to the inclusion of other migrant groups without a history of forced migration, such as Austrian citizens with Turkish parents or descendants of refugees from the Yugoslavian War.

10.4.3 The Inclusive Function of Austria's Healthcare System from an International Perspective

In Austria, healthcare provisions for refugees are characterised by their relatively early access to comprehensive medical services offered within the Austrian publicly funded healthcare system's general facilities from the moment of filing an asylum application (Bachner et al., 2018; Knapp, 2019; see Chapter 3).[103] In the context of the comprehensive healthcare services offered within

[103] To the best of my knowledge, there are no policy documents and guidelines within the Austrian healthcare system that are specifically tailored to address the unique requirements of refugees. Future research endeavours could consider a broader scope by examining the situation of migrants in general. For example, a content analysis of health policy documents in Ireland, Spain and Portugal found inclusive

the publicly funded Austrian healthcare system's general facilities, NGOs operating outside of institutionalised care structures play a marginal role in the realm of healthcare, with the exception of mental healthcare and some instances of bridging solidarity through which refugees are connected to the healthcare system's institutions (see Chapter 7). In a broader European context, research on refugee healthcare consistently underscores the necessity of integrated healthcare approaches, as opposed to short-term emergency responses, to adequately meet refugees' health needs (Aljadeeah et al., 2022; Puchner et al., 2018). Furthermore, refugees in Austria are provided with an e-card upon commencing asylum procedures. This ensures comprehensive documentation of their medical treatment, extending beyond the transition to recognised refugee status, and facilitates refugees' inclusion by helping them belong in Austria (see Chapter 8).

Often, other countries' healthcare provisions for refugees are less comprehensive than those in Austria. For example, within the US, various studies categorised healthcare for refugees as exclusionary, featuring regular co-payments (Inhorn & Volk, 2021). Within the broader context of the EU, the entitlement to healthcare services for refugees varies widely across member states (World Health Organization, 2018). Providing healthcare to refugees is particularly challenging for countries at the external borders of the EU, where large numbers of refugees are hosted under difficult conditions. In Greece, until the spring of 2016, healthcare services were primarily administered by NGOs until the formalisation of refugee camps and the subsequent state takeover of healthcare responsibilities. Nevertheless, refugees in Greece struggle with substantial financial burdens due to the structure of the Greek healthcare system, which is characterised by a combination of public and private services. Additionally, the geographical remoteness of several camps poses challenges in accessing medical facilities. This especially affects the residents of refugee camps on Greek islands, who often rely on volunteers to access healthcare services (Gunst et al., 2019; Kousoulis et al., 2016).

Some countries instituted a parallel healthcare system for asylum seekers. For example, in Finland, asylum seekers have limited access to medical services, primarily provided within the reception centres. They are integrated into the broader healthcare system only in specific situations, typically when specialized medical care is required (Tuomisto et al., 2019). In Turkey, while legally extending access to medical services within the publicly funded healthcare system

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approaches towards migrant health. These approaches aim to enhance services by providing specialised training for healthcare professionals and utilising cultural mediators (Ledoux et al., 2018).

to the country's substantial population of Syrian refugees, a parallel healthcare system was concurrently established. Parallel migrant health centres specifically intended for Syrians have been opened across the country (Spahl & Österle, 2019; Yıldırım et al., 2019).

Healthcare systems without comprehensive entitlements to medical services for refugees, as well as those with parallel systems, rarely enact the inclusive function of healthcare that I found in the Austrian context. Austria, which is characterised by its comprehensive and early entitlement to medical services for refugees, demonstrates how healthcare systems can effectively facilitate the emplacement, belonging, and inclusion of refugees within the larger population. Recently, Germany has tentatively begun to transform healthcare for refugees from the prevailing parallel system to a more integrated system. The provision of medical services for asylum seekers in the German context is organised within a parallel legal and administrative framework, exhibiting varying implementations across its 16 *Länder*. It was shown that insurance through the German Asylum Act leads to a dependence on bureaucrats who often value medical concerns based on refugees' demonstrated will to work on their health. Thus, the parallel system engenders greater difficulty in accessing medical services (Menke & Rumpel, 2022). This approach faced criticism from ethical, medical, and financial perspectives, with some researchers advocating for "the (re-)integration of asylum-seekers in statutory social and health insurance" (Gottlieb & Schülle, 2021, p. 120). Progress in this direction was made by three of the German *Länder*, which initiated the issuance of e-cards for asylum seekers. These cards are virtually indistinguishable from the public statutory health insurance cards, except for a discreet additional code signifying the person's status as an asylum seeker. This change was found to alleviate some of the challenges associated with the parallel healthcare system (Gottlieb et al., 2021).

Finally, in some countries, there has been a noteworthy development: Healthcare systems are being utilised to enforce exclusionary asylum policies and are becoming permeated by exclusionary logics – tendencies that run counter to the described instances of integrative care in the Austrian healthcare system that enact inclusion for refugees. Recent studies described how hostile and restrictive policies towards forced migrants have significant repercussions on both their overall health and their ability to access medical care. For example, an interview-based study conducted among healthcare professionals in the UK showed how healthcare policing and restrictive policies hinder asylum seekers' and refugees' access to healthcare services (Asif & Kienzler, 2022). In Canada, hostile portrayals in the public sphere create barriers to healthcare access for asylum seekers. Owing to a lack of awareness regarding the legal framework, many

healthcare professionals often fail to adequately provide the services to which asylum seekers are legally entitled (Chase et al., 2017).

These developments not only hinder the healthcare system's potential to serve as an infrastructure for social inclusion but may also exacerbate existing gaps in healthcare access for refugees. Notably, in my empirical research in Austria, I did not encounter any of these developments. However, future research could further scrutinise these aspects within the Austrian context, especially taking into account recent changes that have enhanced the healthcare system's role of asylum control. These changes include age determination using wrist X-rays and the requirement for hospitals to inform asylum authorities about the discharge times of rejected asylum seekers who recovered from medical treatment, a legal change introduced as part of an update to the Aliens Police Act in 2018 (Dursun & Sauer, 2021; Knapp, 2019).

10.5 Summary

This chapter discussed the findings of my doctoral work in conjunction, relating them to the larger social science literature on refugee health and outlining their implications for policymaking. I showed how studying refugee health raises more questions than those of legal access and of barriers to and facilitators of medical care. Mundane experiences of legal, practical, and discursive exclusion in daily life detrimentally affect refugees' health and well-being. Yet, the entitlement to healthcare services and the utilisation of medical services counteract these forms of exclusion. Refugee health is a personal, social, and political matter through which refugees are included in and excluded from participation in Austrian society. My findings on the Austrian healthcare system's function of inclusion complement existing approaches that integrate refugee health and health policies within the socio-political context of destination countries. They add nuance to the binary concepts of "un/deservingness", "othering", "welfare chauvinism", and "necropolitics" by providing empirical insights into what it means to be governed by different state rationales simultaneously.

Refugees residing in Austria are subject to legal, practical, and discursive exclusions in several aspects of their everyday lives. However, a notable contrast emerges regarding their access to medical services within the healthcare system. This double movement – the coexistence of exclusion in everyday experiences and inclusion facilitated by institutionalised healthcare – can be best understood as simultaneous processes that unfold concurrently. While the mundane experiences of exclusion in daily life detrimentally affect refugees' health and well-being, the

entitlement to healthcare services and the utilisation of medical services counteract these forms of exclusion, ultimately engendering societal inclusion. However, a few of my findings show persisting instances of exclusion within the generally inclusive healthcare system as well.

Nearly a decade ago, when I began researching refugees, Austria embraced a welcome culture (Trauner & Turton, 2017; see Chapter 1), as did many other European countries. In 2015, those seeking asylum were met with compassionate support. However, in hindsight, this initial warmth shifted into more restrictive approaches towards asylum seekers, marking a broader rightward political shift that preluded ever-more exclusionary migration policies. Constructing Europe as a "fortress", the escalating deaths in the Mediterranean appear to have become an accepted normalcy. I see my work as a deliberate counter to this cruel reality. Given the salient and life-or-death nature of healthcare, I believe it can significantly contribute to challenging this reality more effectively than other realms. In Chapter 1, I highlighted Austrian health policies as inclusive, noting that even politicians at the extreme right advocate for adequate and equal medical services for refugees living in the country. This, I believe, is a crucial starting point in formulating strategies against prevailing exclusionary policies. Moreover, as I argue with the healthcare system's function of inclusion, its impact could extend well beyond medical care, fostering better lives for refugees in destination countries. My hope is that the differentiated examination of refugee health in my doctoral work can steer conversations and thoughts towards more compassionate and humane ways of talking and thinking about the topic of asylum.

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Chapter 11: Conclusion

10.6 Introduction

In recent years, scholars and international organisations have emphasised the importance of considering refugees in health policymaking. This emphasis is intended to ensure their health needs are met and to contribute to the overall improvement of population health (Abubakar et al., 2018; Bozorgmehr & Jahn, 2019; Wickramage & Annunziata, 2018; World Health Organization, 2018; see Chapter 1). My doctoral work substantiates this advocacy. To gain deeper insights into the health of and healthcare for refugees during Austria's refugee policy crisis (Rosenberger & Müller, 2020) following the significant upsurge of asylum applications in 2015 and the subsequent shift towards right-wing policies (see Chapter 3), I posed the following questions: How do the health needs of refugees emerge as they navigate the health system and the asylum system? Moreover, how are these met (or not met)?

To answer these questions, I collected empirical data on refugees' living situations and their experiences in the healthcare system. As part of ethnographic fieldwork in Vienna between 2018 and 2020, I accompanied seven men and women to medical appointments, conducted interviews with them at several points in time, visited their homes, created mental maps of their perceptions of the city, and spent time with them on other occasions. They originated from Syria, Afghanistan, Somalia, and Benin and had applied for asylum in Austria around 2015. Additionally, I conducted qualitative interviews with (health)care providers, representatives of political parties, and other professionals from 2019 to 2020, in addition to researching relevant legal frameworks.

The collected data were analysed using grounded theory approaches, specifically a combination of SitA (Clarke, 2003; Clarke et al., 2015, 2018) and CGT (Charmaz, 2006). The combination of these complementary methods allowed me to include different types of data in my analysis, including interview transcripts from different groups of people, observational notes, visual data, and guidelines. I integrated my in-depth empirical research with conceptual work and adopted a critical perspective in interpreting the implications of my data in relation to existing power structures and prevailing modes of asylum and health governance.

Analysing a case study of refugee health largely inductively, I showed how refugees' health needs are often produced and met outside of the healthcare system. The everyday lives of both asylum seekers and recognised refugees create health problems that are difficult to meet with

institutionalised care (Chapter 5), and refugees themselves fulfil their health needs through self-care practices outside of institutionalised care (Chapter 6). Moreover, I examined how the solidaristic practices of care providers within the healthcare system are crucial for closing persisting gaps in healthcare for refugees (Chapter 7).

In addition to the direct answers to my research questions, my doctoral work yields insights into how healthcare practices within and outside the facilities of the Austrian healthcare system create, enact, and contest the inclusion and exclusion of refugees, answering to my additional research question: How are persons who are not part of the "we" in terms of a narrow understanding of citizenship being thought and acted into being? My interpretive and critical practice-based approach to studying policies (Fischer et al., 2015; Shore & Wright, 2011; Wagenaar, 2011; Yanow, 1996; see Chapter 1) enabled me to address personal, social, and political dimensions of refugee health, which are often disregarded in other research designs. Given the existing comprehensive legal entitlement to healthcare services possessed by refugees in Austria, previous research has primarily focused on undocumented migrants, who have extremely restricted access to medical services, or on situations marked by urgent humanitarian needs, such as those in refugee camps.

In contrast, I highlight how institutionalised forms of healthcare extend forms of societal inclusion to refugees. In the literature on healthcare systems and solidarity, migration has been discussed as a challenge to forms of civic solidarity institutionalised in public healthcare systems (Banting & Kymlicka, 2017; Lahusen & Grasso, 2018). My doctoral work inverts this relationship. This thesis' title – *From medical care to citizenship: Mapping the healthcare systems' function of inclusion for refugees in Vienna, Austria* – references an underexplored aspect of public healthcare systems. The term "inclusion via healthcare" encapsulates the idea that healthcare for refugees not only serves its primary function of providing medical care; it also plays a crucial role in including a marginalised group, facing multifaceted exclusions, in society.

The following section provides a detailed summary of the findings and the discussion chapter, before discussing future avenues for researching healthcare systems' inclusive function. I conclude this chapter with a brief remark on how public healthcare systems, for refugees and others, can help foster equality and social cohesion.

10.7 Summary of Findings

The first part of my findings focuses on how refugees' health needs are formed and met beyond the confines of the healthcare system's institutions. It highlights how the lived reality of refugees causes health problems (Chapter 5) and how refugees themselves maintain their health through self-care practices (Chapter 6). Collectively, these two chapters illustrate the importance of adopting a broad understanding of health that considers personal feelings of illness and the larger living situation. This broader perspective is essential for understanding refugees' health needs and what constitutes adequate healthcare within the context of forced migration.

the enduring stress faced by even recognized refugees, and the vital significance of acquiring Austrian citizenship, specifically having the passport, for their sense of security and well-being.

Chapter 5 addresses the role of refugees' everyday experiences with regard to their health. It describes how asylum seekers develop new health problems while awaiting the court's decision on their asylum applications, the challenges they face in maintaining good health in asylum accommodations, the devastating consequences of a rejected asylum application, the ongoing stress experienced by even recognised refugees, and the crucial role of formally obtaining Austrian citizenship, in the sense of possessing the passport, for their sense of security and well-being. To describe the entangled relationship between health and daily experiences of social and political exclusion, I introduce the term "everyday health risks". It highlights how refugees perceive health and illness through the lens of their everyday experiences. They interpret and contextualise these experiences within broader socio-political developments. Everyday health risks are characterised by the intertwining of experienced, discursive, and political exclusions, all of which materialise as dire health consequences for refugees.

Thereby, Chapter 5 contributes to a better understanding of post-migration stressors in high-income European destination countries (see Chapter 2), addressing the relatively understudied connection between the living situation in host countries and health needs (Agyemang, 2019; Nowak et al., 2022). The Austrian context is characterised by anti-immigrant nationalist policies, a xenophobic discourse that particularly targets refugees, and anti-Muslim racism (see Chapter 3). These factors render the case study relevant for similar socio-political contexts within and outside Europe. The findings presented in Chapter 5 align with recent critical qualitative research that has shown how refugees' narratives of health and illness are intertwined with their living situations and the political contexts of their host countries (Isaacs et al., 2022; Mayblin et al., 2020; Newbold & McKeary, 2018; Parkinson & Behrouzan, 2015; Tomkow, 2020).

Chapter 6 emphasises how refugees themselves counter everyday health risks outside of healthcare institutions in the standard sense. It describes how they engage in a variety of self-care practices that are beneficial to their health and well-being, illustrated with examples of revisiting public places associated with well-being, using mobile phones, engaging in religious practices, pursuing paid work, and experiencing mutual support among refugees.

The second part of my findings focuses on the publicly funded healthcare system in Austria, drawing attention to health practices within medical facilities. Chapters 7–9 show how refugees' comprehensive entitlement to medical services is put into practice and discuss multiple meanings of institutionalised healthcare that extend beyond medical care. Chapter 7 discusses how the lived solidarity of healthcare practitioners and other care providers reduces existing barriers to healthcare for refugees, based on a practice-based approach to solidarity (Prainsack & Buyx, 2012, 2017). It contributes to the literature on gaps in and facilitators of healthcare for refugees (Kohlenberger et al., 2019; Leitner et al., 2019; Mayrhuber et al., 2016; see Chapter 2). Care providers' solidaristic practices in Austria compensate for the lack of cultural and biographical sensitivity among healthcare practitioners towards refugees, unresolved language barriers, insurance gaps during legal status changes, instances of discrimination from certain medical professionals, inadequate care coordination, and a general scarcity of resources and time in the healthcare system. I show how the daily work of solidaristic care providers dismantles these barriers, in addition to highlighting structural changes that could mitigate these.

Chapter 7 categorises four forms of lived solidarity: Concretising solidarity shapes institutional solidarity in the healthcare system through care providers' everyday actions, such as taking the time to listen to patients. Compensating solidarity fills the gaps within the healthcare system. Creating solidarity establishes new rules and structures in the healthcare system.[104] Finally, bridging solidarity describes practices by care providers within and outside the healthcare system that connect refugees with institutionalised healthcare.

Furthermore, Chapter 7 highlights the diverse motivations that drive care providers to enact solidarity with refugees. These motivations are rooted in commonalities such as shared language, cultural backgrounds, and parenthood experiences. These commonalities allow care providers to perceive refugee patients as persons, seeing beyond their legal status and ethnic backgrounds.

[104] In a previous joint publication, my doctoral thesis supervisor Barbara Prainsack and I had already formulated the notions of "concretising solidarity", "compensating solidarity", and "creating solidarity" (Spahl & Prainsack, 2021).

Motivations are also rooted in differences, extending to supporting refugees as unique persons who may be overlooked within standardised healthcare practices. Some healthcare practitioners may possess a sense of responsibility within a healthcare system that has flaws and limitations. Finally, my findings underscore the significance of recognising how material conditions can either facilitate or impede solidaristic practices.

Focusing on the perspective of refugees, Chapter 8 discusses how their experiences within the Austrian healthcare system provide them with a sense of belonging. I show how refugees emphasise their ability to manage their health independently and feel empowered through emotional connections and familiarity with healthcare facilities. Places, such as waiting rooms and objects (for example, the jar of candy that Maria helped herself to when waiting for the doctor to enter the treatment room), matter to refugees. Moreover, Chapter 8 highlights the personal significance of the e-card. In addition to facilitating access to medical services, it functions as a material instantiation of belonging for the holder. Finally, refugees assert their sense of belonging by valuing the healthcare system's solidaristic basis. I describe how Abdi valued medical check-ups for community well-being, even after his asylum claim had been rejected and he was facing deportation, and how the other refugees involved in this research demonstrated their commitment to communal and solidaristic welfare by expressing their intention to donate blood, despite language and origin barriers. The findings of the chapter invoke belonging as a personal dimension, a perspective that has been advanced in recent research concerning healthcare in the context of refugees and immigrants more broadly (Brenman, 2021; Mattes & Lang, 2021; Raffaetà, 2019; von Poser & Willamowski, 2020). This underscores how the navigation of healthcare systems and the use of medical services can provide refugees with an opportunity to actively create a sense of belonging in their host country.

Chapter 9 shows how practices in the healthcare system and healthcare guidelines create, contest, and negotiate specific notions of the state and the citizen. It draws upon an understanding of "citizen" and "state" that diverges from the prevailing understanding in political science, which typically concerns legal categorisations. In contrast to the notion of formal citizenship, social citizenship hinges on social rights and identity criteria, such as a shared language and common values. This implies that citizenship can be acquired along multiple dimensions that do not necessarily depend on a sequential, chronological order. In essence, one's entitlement to social rights, even in the absence of legal citizenship status, may still indicate citizenship. It may make them social citizens (Baldi & Goodman, 2015; Joppke, 2007; Morris, 2002; Sainsbury, 2012; see Chapter 9). Health constitutes a vital right of social citizenship (Bambra et

al., 2005). Through their inclusion in the publicly funded and solidarity-based healthcare system in legal and practical terms, refugees become social citizens.

Chapter 9 also explores how refugees' interactions with the Austrian healthcare system shape their relationships with the state. I show how the refugees involved in this research regarded the healthcare system as the "good state", in contrast to negative experiences with other institutions, such as asylum courts. This elevates healthcare institutions to a distinct and crucial position in the landscape of institutions that shape refugees' relationships with the Austrian state. They valued the provision of high-quality care, which surpassed what they had experienced in their home countries, and presented medical services as positive experiences in Austria. An example is Maissa, who generally felt insecure leaving her flat but felt safe within the institutions of the healthcare system and lauded healthcare practitioners for their amiability and assistance.

Moreover, Chapter 9 addresses the way the healthcare system shapes refugees into a specific kind of citizen. This process does not adhere to an exclusionary rationale that others refugees as non-citizens; rather, it normalises them as citizens in a biopolitical sense (Braun, 2021; Lupton, 1995; see Chapter 2). I illustrated this by showing how refugees get "the state" under their skin: It integrates itself into refugees' lives through healthcare practices such as routine blood tests. Normalisation also underpins policy documents and policymakers' perspectives; the integration paradigm permeates healthcare for refugees with institutionalised and explicit expectations regarding how refugees should navigate their health and their broader role as newcomers in Austria. Based on the healthcare information offered in courses for orientation and on Austrian values, as well as assertions from healthcare professionals and policymakers, refugees are expected to address their health needs as designed by the Austrian healthcare system.

Finally, Chapter 10 discusses the theoretical import of my findings within the broader field of social studies on refugee health. It places Chapters 5 and 6 in the context of the existing literature exploring how refugees' health needs are shaped by their everyday experiences in destination countries. Moreover, it reflected the theoretical implications of my findings on the inclusive function of the Austrian healthcare system: I highlight how the solidaristic practices by care providers, next to their primary aim of closing healthcare that persist for refugees in practice, also function as drivers for the societal inclusion of this marginalised group. Through this secondary function, the solidaristic practices by care providers contribute to broader struggles against exclusionary structures, which deprive refugees of social participation. Moreover, my findings speak to the concept of "belonging" by illustrating how engaging with the healthcare system can create a sense of belonging for refugees in Austria. They also relate to the concept of

"citizenship", as they demonstrate that utilising medical services carries significance in shaping refugees as Austrian citizens and thereby in forming citizen–state relationships. Moreover, Chapter 10 engages in a reflective discussion of the strengths and limitations of my doctoral work, in addition to discussing its implications for health policymaking while drawing upon the broader academic literature and a comparative perspective.

10.8 Future Avenues for Researching Inclusion via Healthcare

Further research is needed to better understand nuances within Austria and beyond. In Chapter 10, I already discussed several methodological challenges that were associated with my study. In this section, I want to further reflect upon possible future research designs for better understanding my findings on the Austrian healthcare system's function of inclusion, in relation and comparison to other contexts.

Comparative research designs may scrutinise the influence of healthcare systems' structures. The Austrian healthcare system is characterised by the limited gatekeeping role of general practitioners, a fact that is generally considered a weakness (see Chapter 3). However, for refugee health and inclusion, this feature might be beneficial. Within Austria's system, persons with SHI have considerable freedom in selecting healthcare providers. They can freely choose their general practitioner and, when referred, select from various specialists contracted with SHI without incurring extra costs except for non-contracted or private doctors. This flexibility extends to non-urgent hospital treatments, such as for surgeries like hernia repair, allowing persons to choose hospitals and often even specific attending physicians. Further inquiries into how the structures of the healthcare system impact inclusion could involve exploring the role of SHI funds for inclusion, examining refugee patients' attachment to their specific SHI fund versus their broader emotional connections with the public healthcare system (akin to a unified institution like the NHS), analysing disparities in inclusion between healthcare systems with and without e-cards, and understanding the significance of personalising these cards with a picture.

Moreover, comparisons with settings where refugees access healthcare via parallel systems (see Chapter 10, for a preliminary international comparison) as well as studying inclusion via healthcare for other refugee cohorts could yield valuable insights. It is notable that the refugees I spoke to generally regarded Austria's healthcare system as superior to those in their home countries. However, in other studies, migrants were found to return to their home countries for medical care due to their perception of the healthcare system being better there (see, for

example, Raffaetà, 2019, in Chapter 2). I heard similar sentiments from Ukrainian refugees arriving in Vienna since 2022. These differences likely stem from various factors, including access to services in one's native language, the quality of healthcare in the home country, and legal and safety considerations for travel.

Furthermore, the urban setting of my research in Vienna, with its abundance of medical practices, significantly shaped my findings. In this context, refugees enjoy the possibility to select between a relatively broad array of healthcare providers This is evident through language-based preferences (for example, Syrians seeking Arabic-speaking healthcare professionals) and recommendations obtained via online platforms such as Facebook or refugee-friendly doctor lists provided by asylum accommodation staff. Vienna stands apart from many other Austrian *Länder* due to its left-leaning government, characterised by coalitions between the social-democratic SPÖ and the Green Party during the time of my fieldwork. With a substantial foreign population constituting 29.9% of its 1.9 million residents in 2018 (see Chapter 3), refugees in Vienna might experience reduced discrimination and have a higher likelihood of accessing healthcare options provided in their native languages with cultural sensitivity. In contrast, rural areas often offer limited choices, potentially undermining the healthcare system's inclusive function, particularly if local physicians are unreceptive to refugees.

Overall, conducting research on healthcare systems' function of inclusion poses methodological challenges. Apart from the inherent complexities and potentially "dangerous" nature of comparisons within and between these systems (Freeman, 2008), exploring this aspect is not straightforward. Directly asking about it in interviews and surveys is not a promising way to research the topic, hindering the use of most quantitative measures. One approach could involve examining how persons navigate and learn about a new healthcare system upon arrival. Another challenge I want to emphasise is the importance of not unquestionably accepting healthcare systems' inclusive functions as fostering social justice and equality. Studies on the UK's NHS showed underlying nationalist and racist biases within this public healthcare structure (Cowan, 2021; Fitzgerald et al., 2020). It is crucial to critically examine the potential downsides of healthcare' inclusive aspects. This entails considering who is included and excluded, and the implications of this inclusion in terms of the pressure persons might encounter to conform and alter themselves when adapting to the system's implicit and formal rules (see Chapter 9).

10.9 Implications for Future Health Policymaking in the Refugee Context and Beyond

My doctoral work's insights hold significant relevance for policymaking, not only within Austria but also in broader international contexts. The case discussed here represents a high-income European country with a well-established welfare state system and a generous public healthcare system. As in several other countries, following the increase in asylum applications in 2015, there was a notable shift in Austria towards right-leaning ideologies in public discourse and politics, marked by xenophobia, anti-Muslim racism, securitisation, and increasingly restrictive migration and asylum policies. In Chapter 1, I identified a tension between Austria's inclusive health policies and its exclusionary asylum policies. My research findings illustrate how these exclusionary asylum policies impede the main goals of health policies, which aim to improve health for all residents in Austria. Instead, asylum policies create health risks for refugees. Furthermore, I highlighted how inclusive health policies counteract exclusion in other areas. This research's insights regarding the interplay between health and asylum policies have important implications for shaping policies in similar settings that aim to address this intricate relationship.

This thesis may inspire a rethinking of the meaning of health policies in the context of refugees and other marginalised groups. Following Bacchi (2009), it

> challenges the commonplace view that policy is the government's best attempt to deal with "problems". In this conventional understanding of public policy, governments are seen to be reacting to fixed and identifiable "problems" that are exogenous (outside) the policy process. (p. 1)

The understanding of health policymaking adopted in my doctoral work differs from prevailing understandings in public policymaking, in which policymakers react to clearly identifiable "problems" (Bacchi, 2009). In the conventional landscape of policy issues concerning refugee health, the focus has often been on ensuring adequate medical care for this population.[105] This has involved addressing core concerns, such as legal entitlements, the capacity of the healthcare system, and practical obstacles to care, such as language barriers and cultural disparities. However, this thesis' focus on the different dimensions of refugee health (see Table 2 in Chapter

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[105] In her book *International political theory and the refugee problem*, Saunders (2017) formulated a differentiated and critical analysis of policy problems and refugees that was influenced by the ideas of Foucault and Arendt. She scrutinised "the refugee problem" as often being constructed not in terms of the problems refugees face but in terms of the problems refugees pose for host countries. This portrayal of refugees as a problem has gained significant traction in recent years, as political discourses as well as election programmes and results within and outside Europe have demonstrated in recent years.

10) engenders other questions, including: How do everyday experiences of exclusion shape refugees' health needs? How can healthcare systems actively contribute to the inclusion of marginalised populations? In what ways can healthcare professionals and healthcare institutions cultivate a sense of personal belonging among their patients and foster trust in state institutions? What forms of exclusion persist even within a healthcare system that is fundamentally designed to be inclusive?

These questions prompt a rethinking of the role of healthcare systems as public infrastructures beyond the mere provision of medical care. On a global scale, the design and implementation of good healthcare systems have emerged as pivotal undertakings for policymakers. Often, the increased involvement of private health insurance and private medical providers has been advocated as an efficient approach to governance. This thesis' findings concerning the Austrian healthcare system's role in facilitating the inclusion of refugees present a compelling argument against the privatisation of healthcare services and the stratification of medical services based on income, residency status, or other distinguishing factors. These findings highlight the societal and political advantages inherent in a public healthcare system founded on the principle of solidarity, which includes refugees as equal beneficiaries. This is in accordance with an emerging academic debate on the multifaceted roles of healthcare institutions beyond the provision of medical care (see, for example, Chabrol & Kehr, 2020; Cowan, 2021; Mattes & Lang, 2021).

Finally, I want to highlight recent research regarding the UK National Health Service (NHS), a public health system founded on the principles of universal access and healthcare as a public service. In her recent book titled *How Britain loves the NHS*, Stewart (2023) addressed the various meanings of the widespread affection expressed by UK residents towards the NHS. This book encourages its readers to reconsider the significance of this public infrastructure beyond its role in providing medical care. Furthermore, it underscores the potential inherent in the positive sentiments generated by the NHS. Stewart (2023) argues

> that the particular relationship that has been fashioned between population and healthcare system can be taken seriously as an asset for collective reimaginings of a sustainable welfare state for everyone, in which the broader societal support for population health are understood as the investments they are. (pp. 14–15)

This thesis addressed the Austrian healthcare system as a public infrastructure where patients develop relationships with healthcare practitioners and support personnel; furthermore, it addressed healthcare institutions in terms of concrete places and material objects, such as the e-card. I showed how these interactions generate positive emotions and cultivate a sense of

belonging and emplacement among refugee patients. Healthcare institutions contribute to refugee inclusion within Austrian society. I aspire for my research to contribute to the ongoing debate regarding how to shape healthcare systems to ensure that they deliver high-quality care to all beneficiaries, irrespective of their social, cultural, and national backgrounds. Ideally, healthcare systems can also function as public infrastructures that foster equality and social cohesion, both through their primary function of providing equitable medical care and their broader function of including marginalised groups in society.

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