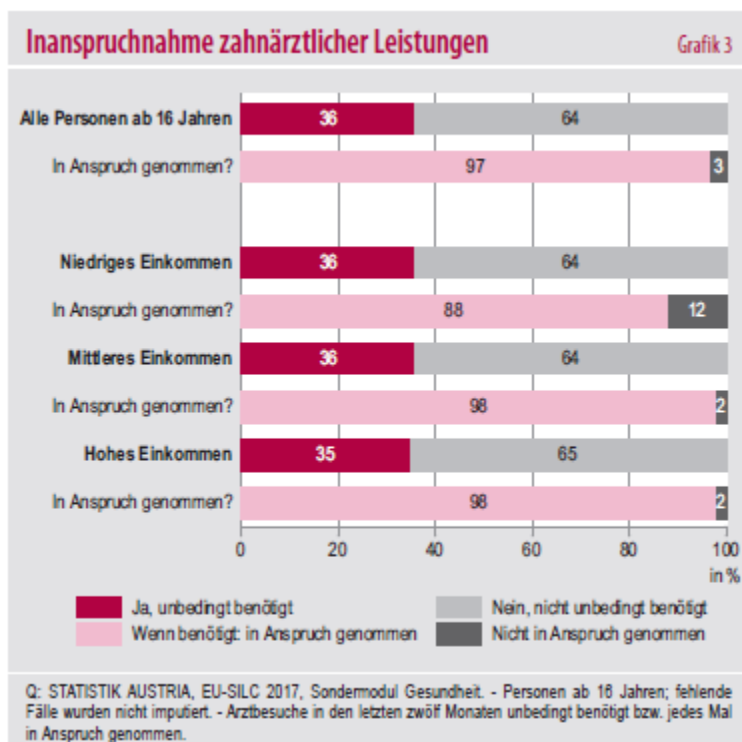


## Losing Face: Barriers to Health Care for People Living in Poverty

Martin Schenk

The lower the income and educational qualifications, the lower the take-up rate of medical benefits. Surveys by Statistik Austria show the differences for urgently needed treatments according to income and education. People in low-income households forego dental or other medical treatment more frequently than those in middle- and high-income households, even though they urgently need them. 12% of adults with low incomes who needed dental treatment did not claim it. Over three-quarters named financial reasons for that (Lamei et al, 2019).

Fig. 1: Claiming benefit for dental treatment



A further barrier is still that health facilities are difficult to access. It can still be shown “that socially disadvantaged persons, in particular from rural areas, have greater problems with accessibility. 41 percent of those living in places with fewer than 5000 inhabitants said that the accessibility of medical care tended to be poor” (Habl, 2009, 180).

In a qualitative study, barriers and gaps in the Austrian health system were recorded from the angle of those living in poverty (Riffer/Schenk, 2015). The problems were shown at several levels. Interviewees mentioned unaffordable excess costs to be paid privately, or inadequately available rehabilitation measures. The lack of access to health benefits was raised, the differences between city and country, unaffordable care, incomprehensibility of diagnoses and findings, difficulties with expert opinions, shaming and anxieties. People under the poverty line face the non-affordability of health benefits. Due to unaffordable excess costs or a lack of cost refund by the statutory health insurance, they can often not finance items like medical aids,

spectacles, shoe inlays or hearing aids. The same applies to dentures and other necessary dental treatment. A broken pair of glasses or a rotten tooth can therefore cause great problems because they can either not be replaced properly or only with an enormous financial outlay. Shaded spectacle lenses to avoid headache, a dental brace for children, or a modern wheelchair, to be mobile outside their flat – all these become unaffordable luxuries. Do I manage to pay the personal contribution for new crowns or do I pay the rent for my little apartment? Sonja Taubinger from Linz often faces questions like these. When in doubt, she decides against her health. For easily understandable reasons: "What use are the most beautiful teeth if I have to go back to sleeping rough?" Sonja Taubinger sells the street newspaper *Kupfermuckn*. She knows only too well the horrors of being homeless and unprotected.

In particular, the participants raised the issue of non-affordable psychotherapy. Necessary regular individual psychotherapy or outreach therapies have to be financed privately. There are very few places for therapies financed by the health insurance funds, which entail long waiting times. With these therapies, you usually can't choose the therapist. The study mentioned that a relationship of trust with the therapist is extremely important in psychotherapy. What are called the "support funds" of the statutory health insurance were also criticised. These funds are supposed to support people who can't pay for various services themselves due to economic hardship. However, it turns out that money from these funds is not so easy to get. People in precarious financial situations cannot rely on money from the support funds. There is no legal entitlement to it and applicants can only hope for the best and are dependent on the mercy of the health insurance. This uncertainty also leads to them not taking advantage of certain examinations at all, or to uncertainty about the continuation of therapy after the examination.

After the focus groups, joint workshops took place with two delegates from each group, in which people affected by poverty discussed possibilities for improving the identified problem areas based on the category tree. This resulted in wishes and suggestions for better access to the health system for low-income people. They saw accompanying services ("going with them") as providing central support for people affected by poverty when they had to go for expert assessment, to health services, offices and authorities. They also called for easier access to free psychotherapy and the expansion of therapy and counselling facilities such as psychosocial emergency services outside the urban centres. They all considered financial support to be required for treatments with high personal participation (dentures, orthodontic plates, etc.) as well as for necessary medical aids (hearing aids, orthopaedic aids, etc.). Such extras, not included in the prescription fee exemption, are not affordable for people with precarious jobs

They would like to see improvements in the accessibility of health facilities. People with little money have great problems reaching health facilities, especially in rural areas. Even short distances are hard to reach without a car. When poverty and illness come together, mobility is completely limited. More respect in the expert situation was another point raised by people affected by poverty. There should be better training, awareness-raising and monitoring of experts, they said, and existing findings should be taken into account. Forms, diagnoses and therapies should be more comprehensible and readable. This requires a more appropriate and simpler language for forms - and more time for explaining diagnoses and therapies. Finally, the participants in the study suggested holding dialogue forums with doctors, decision-makers and

other health professionals. People living in poverty would then get into conversation with health system actors and make them aware of the concerns and situation of people on low incomes.

### **Lack of insurance**

Although health insurance in Austria is relatively comprehensive, it does not cover people at the margins, in extraordinary life situations and with transitional status. This is a fluctuating number of people who for all kinds of reasons are not (any more) covered by health insurance. What they all have in common is a very low income. Around 27,000 people as at December 2015 did not have health insurance in Austria (Fuchs et al., 2018). Ms K. was doing casual work, Mr G. was in a serious mental crisis; Ms L. had been too embarrassed to apply for minimum benefit, Mr G. was working here unofficially on a building site, Ms M. had returned after a longish stay abroad. Ms K. had work, but she couldn't really live on it. Her precarious income was so low that she had to decide: do I pay the health insurance or the rent or the school books for the children? When she unexpectedly fell seriously ill, the costs of treatment overwhelmed her.

This is typical of precarious jobs such as internships, bogus self-employment or undeclared work. Legally, those affected could sue for their withheld insurance. In practice, however, younger people often do not dare to assert their rights because they want long-term work in the company in question. Or, for example, it may be a small industrial sector, where word of a potential complaint quickly spreads to all the companies that might consider employing them later. Older people often prefer uninsured employment to no employment at all, for fear of consequences from the employer.

And immigrants are afraid of losing their residence permit if they sue their employer for their rights. Mr G. has a fit of depression. In such phases of psychological crisis, his ability to organise himself fails. He misses all appointments. He is in danger of losing his accommodation and is unable to cope with daily life. The psychosocial support centres in municipalities and districts are inadequate. Ms L. does not apply for minimum benefit, like many others. The reasons are shame, harassment at the social welfare office, fear of poverty becoming entrenched, stigmatising reports in widely read media. But if you live as a destitute person without minimum benefit, you also live without health insurance.

Occasionally, people are also not insured when they return a longish period abroad and have to find their feet again in Austria. It often takes quite a while to clarify whether, for example, they are entitled to unemployment benefit or minimum benefit as income support.

People without health insurance go to outpatient clinics that treat them without insisting on an up-to-date e-card. At St Mary's outpatient department in Graz, the most frequent diagnoses are psychiatric (19%), acute infections (12%), as well as blood pressure/heart and chronic pain (11% each). The clinical pictures of the patients of Amber-Med in Vienna are similar: top of the list are high blood pressure, various infections, diseases of the musculoskeletal system and diabetes types 1 and 2. The survey sheets of the study of the European Centre and Diakonie Austria show that, of the possible reasons for going to the outpatient clinic, the ones most frequently mentioned were "a chronic problem" (34%), "an acute problem" (32%) and "pregnancy" (13%). In relative terms, a chronic problem was most frequently cited by persons aged 60 and over (53%), an acute problem by persons with Austrian citizenship (44%) and pregnancy by women under 30 (29%) (Fuchs et al. 2018).

If illness is already a burden for insured patients, the healing process is particularly difficult for Amber-Med patients due to their living conditions. In addition to illness, there is also the burden of uncertainty about residence status, poor housing and living conditions, and a lack of language skills or knowledge about possible rights. The patients of Amber-Med can hardly ever enjoy rest to recuperate, or appropriate nutrition and living conditions. A large proportion of them suffer from extremely high survival stress. "I often see that they carry important documents around hidden in their clothes, and when we make copies and give them a clear plastic folder because the originals are almost falling apart, they are at a loss and don't know where to put it. With the stress of survival, they just can't build a regular life where you keep documents in a file," says a doctor from AmberMed.

The two main socio-medical tasks of outpatient clinics for the uninsured are (1) treating diseases and (2) attempting integrate patients into the existing social and health care systems. This happens through the early detection of infectious diseases, prevention of chronification and after-effects of diseases, education about latent conditions (e.g. diabetes, high blood pressure, etc.), support with hygiene measures and further access to public services and the resources of the health system. Amber-Med offers a general surgery four half-days a week, where people can drop in without a prior appointment. Specialist consultations focus on gynaecology, support for pregnant women and paediatrics. Thanks to cooperation with the midwifery centre, expectant mothers and their relatives have the opportunity to take consult a midwife twice a month. Furthermore, there is specialist care in the fields of neurology, psychiatry, cardiology, diabetes, urology and dermatology.

This is because major problems can arise if action is not taken in time to treat the condition, leading to serious consequences and greater expense. The cost of treating a minor injury, such as a burnt finger, can explode by a factor of 7.3 if not treated. In other words, it can cost more than seven times as much (Trummer, 2014).

Another finding of the study is that taking the right action can achieve a lot. The number of uninsured persons fell greatly with the introduction of basic health care for asylum seekers in 2004, and for unemployed persons in 2006, when the protection period was extended beyond the expiry of an employment contract. Another positive step, in 2010, was granting health insurance coverage to all minimum benefit recipients.

### **Non-take-up in the lower social safety net**

One in three claimants does not collect their minimum benefit. Not doing so in the lowest level of social safety net immediately leads to exclusion from health insurance. The non-take-up risk is consequently linked directly with the health care for the poorest ten percent of the population. Tens of thousands of people in Austria do not receive what they are entitled to and what would help them. The reasons are: social shame, fear of stigmatisation, lack of information, bureaucratic hurdles and the unfriendliness of staff at the authorities. If the claiming of minimum benefit were "full", the risk of poverty in Austria would fall by almost 1%, i.e. there would be 60,000 fewer people suffering from poverty (Fuchs et al 2019). The claimant percentage rises through: legal certainty, procedural quality, anonymity, friendly staff, information and destigmatisation of accepting benefit. The introduction of minimum benefit led

to a clear decline in non-take-up; in 2009, 114,000 households (51%) did not claim social welfare, in spite of their entitlement. When minimum benefit was introduced, this number fell to 73,000 (30%) (Fuchs et al, 2019) by 2015.

What we are also seeing is that the social risks are exported into the cities. We see this particularly clearly if we consider the distribution of minimum benefit claimants. The take-up of means-tested social benefits in big cities in the whole of Europe is considerably higher. The reason is that a large number of low-income people move for shame from the country to the more anonymous city, because the share of home-owners among the low-income people is far lower in cities than in the country, because information and counselling centres are much thicker on the ground in cities than in the country and because some such centres are particularly unhelpful and unfriendly in dealing with clients. It is therefore not surprising that the take-up is higher in cities.

In literature about the welfare state, everything that is not a cash payment is mostly subsumed under “benefits in kind”. I would, however, propose making a distinction between “things” and services. That would help us to differentiate with respect to minimum benefit. Social services are care assistance, general assistance, child care, educational programmes, family counselling. Benefits in kind, by contrast, cover in the true sense “things” such as food, housing, underwear, hygiene articles, school materials etc. The offer and support through social services generally raises the room to manoeuvre and opportunities for participation of those concerned. In the case of services in kind, the effects are, generally speaking, the other way around. In certain cases, the direct transfer of the rent could be useful, e.g. if the person has an addiction or a psychological crisis, as a justifiable exception, as also used to be stipulated with minimum benefit. However, if “benefits in kind” are generally ordered for all, special systems will arise for people living in poverty and means-tested, to be followed by stigmatisation, less self-reliance and reliance on charity.

“Georg Simmel, at the start of the 20<sup>th</sup> century, made decisive progress in the way people talk and think about people in poverty, with his decision not to see a poor person as someone to be treated with contempt or pity,” (Cremer-Schäfer, 2014, p. 836). Simmel related the question of neediness to the organisational structure of the welfare system. Definitions of poverty mostly express less what a person needs than what society is willing to concede that person.

In search of the appropriateness of assistance, a whole array of control instruments were set up in many places; to transform financial benefits into an “in-kind” or voucher system these monitoring provisions have to be further tightened up. To do so, the whole of the daily life of those concerned has to be constantly ‘moralised’. What is allowed? One or two tooth-brushes? What do we concede? Shampoo or soap? What is appropriate? A pair of jeans for the daughter? Is a present for the son’s birthday party still allowed? In Germany these debates have already taken place – with all the negative effects. The then German health minister Horst Seehofer attempted to adduce the “frequency of changing underwear” as the prime criterion. Seehofer wanted to settle the number of underpants social assistance recipients are allowed to own, in order to gain approval for a subsidy to buy more underwear – in order to see whether they were really classifiable as “needing underwear”.

Amartya Sen (1998) said that every distribution system that presupposes a certain definition of who is “poor” tends to influence the self-respect of the dependent person and the way they are perceived by others. When the extent of neediness is dominant, it turns citizens with social rights into petitioning subjects. Stigmatising benefit recipients as passive recipients of charity with no rights is, however, a procedure with an in-built downward suction effect – an institutionalised spiral of poverty. Should we still wait until families are destitute in order to be allowed to finally help them? Social research calls this mechanism “consolidating poverty”. The more shaming and pressure, the fewer their resources. Anyone who is rendered helpless finds it more difficult to help others. Someone from whom everything is taken cannot give any more. Shaming weakens the powers of resistance and makes you more vulnerable. Nothing comes from nothing. Nothing can be squeezed out of them anymore. “It is also the whole threat to our livelihood, never knowing what the government is going to decide, not being able to resist any more; because I don’t get well I am completely dependent on it,” says Christine with respect to the current social assistance cutbacks. “Only I feel it more close to the bone” (the Poverty Conference, 2019).

How important a good minimum benefit would be for health was shown in the data of Statistik Austria (2020) on living conditions of women, men and children in the lowest social safety net. There are very high rates of health restrictions, chronic disease and disability. Strong negative effects are becoming visible with respect to housing. Living on the edge every day has massive negative impacts on health, opportunities and participation of children. And many families are poor even if someone is in work. All the data derives from just before the reductions and cuts in the new “social assistance”. Many of the impacts have now become central issues, such as cramped living conditions in a home office, home-schooling or strains on children. A large group are not very well and are vulnerable. 23% of minimum benefit recipients refer to a poor state of health, 22% are strongly impaired by a disability, 55% are chronically ill (Statistik Austria, 2020).

People with minimum benefit are much more burdened by their living costs than the rest of the population. At the same time, 11 percent can’t keep their apartment warm. That occurs five times more often than in households without minimum benefit. It is hardly surprising that minimum benefit recipients also live in much smaller and lower-grade dwellings. While the average living space in Austria is about 90 square metres, minimum benefit recipients have around 60 square metres, which is considerably less. Households with children without minimum benefit on average live in 110 square metres, those with minimum benefit, by contrast, in 68 square metres. Their apartments are not only smaller but also of poorer quality, as the survey shows. 21 percent reported that they were damp, mouldy or not well insulated. Bleak living conditions are a particular hindrance to educational opportunities and children’s health: 20% of children have to live in damp apartments; 56% of them are overcrowded; in 25% there is noise disturbance.

Children and young people who grow up in low-income households have disadvantages that are visible in several areas. The risk of social exclusion is clear from the few opportunities to invite friends home, hold parties and take part in non-cost-free school activities. Children on minimum benefit can take part 15 times less in sport and leisure-time activities, attend 10 times fewer parties, invite their friends round 6 times less often and take part in school activities 11 times less than others can (Statistik Austria, 2020).

And yet over half of families with children (57%) are gainfully employed. That points to the "working poor" and precarious work. The "working poor" is the elephant in the room in the debate about minimum benefit.

These figures say a lot. Firstly, they refute the propaganda of the last few years that trampled underfoot the real life situation of those concerned. Secondly, they focus on the difficult situation for the poorest ten percent of the population, now in the Covid-19 crisis. And thirdly, they spotlight the direction the necessary improvement measures need to take.

### **Social shame, status und health**

Social shame was already present at the barriers to health care and with the non-take-up risks. Shaming is a threat that hangs easily in the air but heavily on body and soul. Social shame is not merely a harmless personal feeling. Shaming is a social weapon of the more powerful in a given situation. Other people stare at me. Others determine the way I have to see myself. That is a massive encroachment on a person's integrity. Those affected fear losing face and know that their reputation is threatened. They would like to disappear from the face of the earth. Shame is the great companion of poverty and directly linked with the issue of others' gaze. In his classic *The Wealth of Nations* Adam Smith noted back in 1776: being poor is "being unable to appear in public without shame". It is about the freedom of being able to decide yourself on your own visibility and invisibility. Shaming is a question of vision and reputation. In Ancient Greek, "person" means "face". For the philosopher Philip Pettit (2017), "just freedom" therefore means meeting others at eye level. He proposes the test to "change the angle of vision" – being able to look others in the eye without any reason for fear or submissiveness.

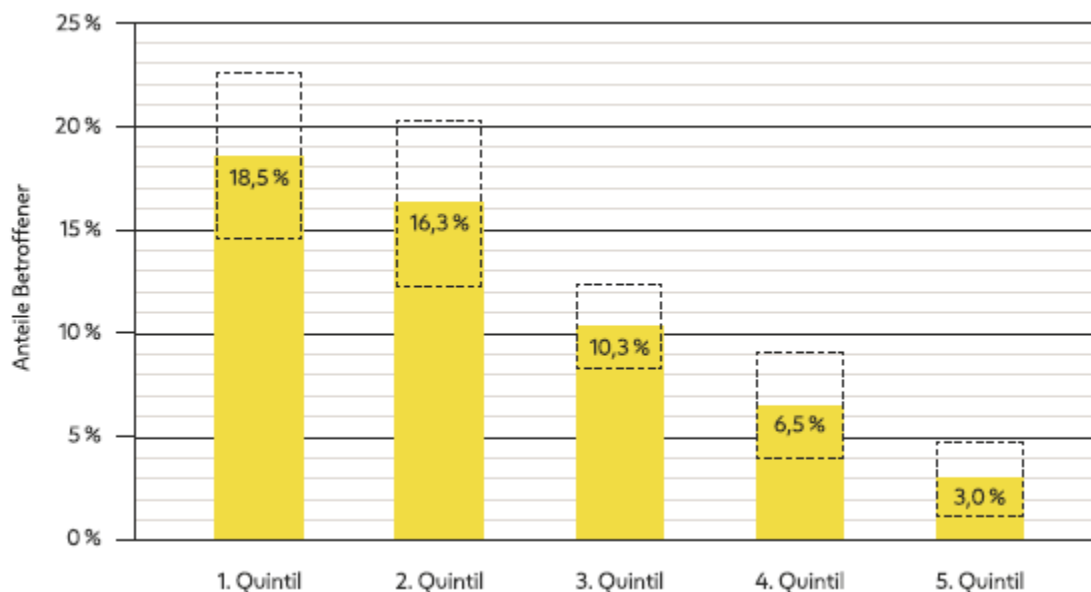
### **Humiliation gets under your skin**

Economic disadvantage leads to an increased emotional stress. Disparagement hurts soul and body. Humiliation gets under your skin; the strongest impacts are higher stress and higher rates of mental illness. The strongest connections are with high blood pressure and cardiac diseases (see Schenk, 2018). Shaming cuts to the heart. The more often, the longer and the stronger the contempt, the more harmful it is for society. The threat to your own reputation is a strong negative source of stress. If the loss of social status threatens or has already started, or is long since over, it can – if it becomes public – lead to a threatening situation. "The sheer fear of loss of esteem is enough to arouse a special kind of concern" (Salentin, 2002, 76). Salentin's "poverty, shame and stress management" presupposed that social status directly influenced the burden of events and reactions in stressful situations. Assessments and resources influence the reactions, but are themselves dependent on social status. The results showed that economic disadvantage leads to increased emotional stress; and that shame plays a central role when working through economic problems. The fear for a person's own reputation, together with concern about financial interests, taken together indicated the closest statistical connections. Emotional stress mounts up with almost all worries, most strongly however, with a lack of money and reputation. The socio-psychological follow-up effects of shortage exert the same massive emotional effects as shortage itself.

Health researcher Johannes Siegrist (1996, 94) put it this way: “Social crises always unfold their emotion-intensifying impact on the individuals hit by them via the processes of blocking opportunities for action (and hence the opportunity of experiencing agency), the withdrawing of appropriate rewards (hence the opportunity of experiencing self-assessment), the withdrawal of social positions and the exclusion of significant societal groups (and hence the possibility of experiencing personal involvement).” Having no room to manoeuvre, receiving less recognition and being excluded from things that others take for granted, is the expression of a social crisis in which ultimately the agency and self-regulation of the concerned persons suffer. The more unequal societies are, the more deficient are these psychosocial resources. There is less inclusion, i.e. a more frequent feeling of being excluded. There is less participation, so more often the feeling of not being able to intervene. There is less reciprocity, so more often the feeling of not being able to rely on mutual assistance. The strains are not only unequally distributed, so also are the resources to overcome them.

Continual bad stress disturbs the cortisol and adrenalin levels. On the one hand, there is the quick axis via the nerve pathways to the adrenal medulla, which is linked to the hormone adrenalin. And then there is the slower pathway via the hypothalamus in the brain to the adrenal cortex, which releases cortisol. A disturbed cortisol balance weakens the immune system, and increases cardiovascular disease and depression. Feelings of powerlessness, shame or helplessness have immediate physical consequences. The lowest fifth of income recipients has, at 18.5%, the highest share of depression sufferers. In the highest fifth the share of those affected is, at 3%, the lowest (fig. 2).

Figure 2: Depression, prevalence in the last 12 months with Viennese women from the age of 15, household income (City of Vienna, 2020, Austrian Health Interview Survey, 2014)





Seventeen thousand office workers were examined to find out differences in the mortality rate from heart disease. The lower and middle echelons had a one-to-four times higher mortality rate with heart disease than the higher echelons. In a blood test we see that the lower placed had far higher levels of the stress hormone cortisone than the top managers. These groundbreaking findings by health researcher Michael Marmot (2015) have taught us that it's not only the amount of your income that matters, but where it places you in the social hierarchy. The focus is on the correlation between social inequality and status. In other words, how fear for our own social position affects the way we struggle for influence and deal with powerlessness, how dominance and submission are brought about. The wider the social divide becomes, the more likely we are to push others down in order to raise ourselves up. Narcissism and overblown self-esteem increase in societies that become more unequal (Wilkinson und Pickett, 2019).

I am standing by a raging river. I hear the cry for help of a drowning man. I jump into the water, put my arm around him, pull him to the bank and give him nasal-mouth resuscitation. And then, just as he starts breathing again on his own, I hear another cry for help. So I go back into the river, hold him, pull him out, give him artificial respiration - and another cry for help. And so it goes on with no end in sight! I'm so busy pulling people out of the water and giving them artificial respiration that I don't have time to find out who the hell is throwing all these people into the water! This story by physician Irving Zola led to the call "Move upstream!" Move upstream to where the diseases originate! Look upstream to the source, and the root causes.

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