



State of Health in the EU

Austria

Country Health Profile 2017

The Country Health Profile series

The *State of Health in the EU* profiles provide a concise and policy-relevant overview of health and health systems in the EU Member States, emphasising the particular characteristics and challenges in each country. They are designed to support the efforts of Member States in their evidence-based policy making.

The Country Health Profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by Member States and the Health Systems and Policy Monitor network.

Contents

1 • HIGHLIGHTS	1
2 • HEALTH IN AUSTRIA	2
3 • RISK FACTORS	4
4 • THE HEALTH SYSTEM	6
5 • PERFORMANCE OF THE HEALTH SYSTEM	9
5.1 Effectiveness	9
5.2 Accessibility	11
5.3 Resilience	13
6 • KEY FINDINGS	16

Data and information sources

The data and information in these Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated in June 2017 to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 28 Member States unless otherwise noted.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following StatLinks into your Internet browser:
<http://dx.doi.org/10.1787/888933593361>

Demographic and socioeconomic context in Austria, 2015

		Austria	EU
Demographic factors	Population size (thousands)	8 633	509 394
	Share of population over age 65 (%)	18.5	18.9
	Fertility rate ¹	1.5	1.6
Socioeconomic factors	GDP per capita (EUR PPP ²)	36 900	28 900
	Relative poverty rate ³ (%)	8.3	10.8
	Unemployment rate (%)	5.7	9.4

1. Number of children born per woman aged 15–49.

2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.

3. Percentage of persons living with less than 50% of median equivalised disposable income.

Source: Eurostat Database.

Disclaimer: The opinions expressed and arguments employed herein are solely those of the authors and do not necessarily reflect the official views of the OECD or of its member countries, or of the European Observatory on Health Systems and Policies or any of its Partners. The views expressed herein can in no way be taken to reflect the official opinion of the European Union. This document, as well as any data and map included herein, are without prejudice to the status of or sovereignty over

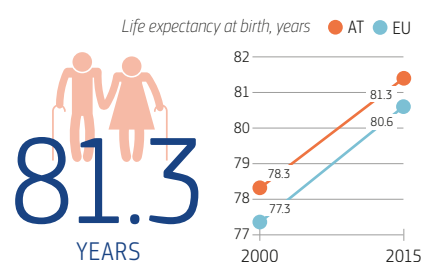
any territory, to the delimitation of international frontiers and boundaries and to the name of any territory, city or area.

Additional disclaimers for WHO are visible at <http://www.who.int/bulletin/disclaimer/en/>

1 Highlights

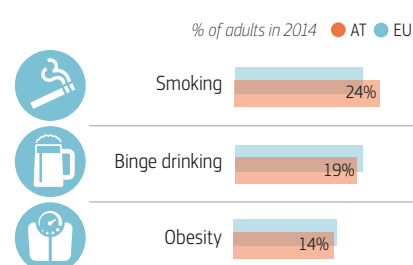
Despite improvements in the health status of Austrians, population ageing and unhealthy lifestyles pose important challenges to the Austrian health system. The health system is fragmented, with responsibilities shared between federal and regional governments and self-governing bodies such as social insurance funds. Improving governance and strengthening primary care have been major aims of recent and current reforms.

Health status



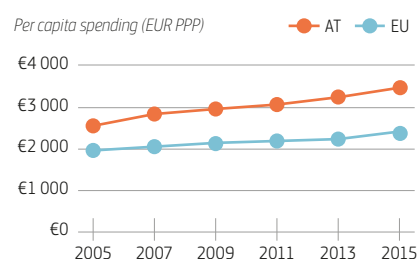
Life expectancy at birth was 81.3 years in 2015, up from 78.3 years in 2000 and above the EU average. While cardiovascular diseases and cancer remain the leading causes of death, both diabetes and dementia increasingly contribute to mortality and now feature among the top 10 causes.

Risk factors



In 2014, nearly one in four adults in Austria were daily smokers, which is above the EU average and unchanged from the level in 1997. Alcohol consumption among adults remains high, although the share of adults reporting heavy alcohol consumption on a regular basis is slightly below the EU average. While obesity rates remain below the EU average, they have been on the rise: 14% of adults in Austria are now obese compared with only 9% in 1999.

Health system

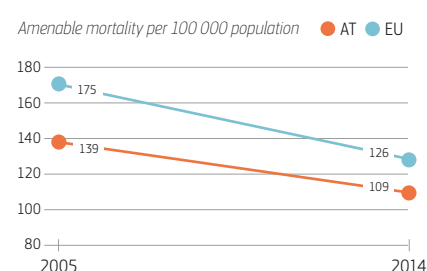


Health spending in Austria is higher than in most other EU countries. In 2015, Austria spent EUR 3 808 per capita on health care, about EUR 1 000 more than the average across the EU (EUR 2 797). This equated to 10.3% of GDP – up from 9.6% in 2005 and somewhat above the EU average of 9.9%. About three-quarters of health spending is publicly funded, but the proportion paid out-of-pocket (18%) is higher than in most other high-income EU countries, such as Denmark, Germany and the Netherlands.

Health system performance

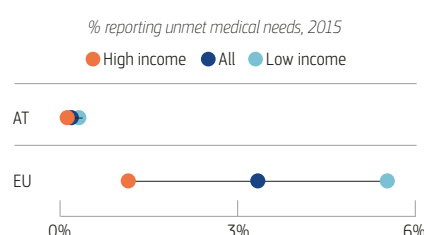
Effectiveness

Amenable mortality rates are lower than in many other EU countries, indicating good performance of the health care system in treating people requiring acute care.



Access

Access to health care in Austria is good, with very few households reporting unmet needs for medical care and little variation between income groups.



Resilience

Rising expenditure pressures pose risks to the fiscal sustainability of the Austrian health system. Potential exists for efficiency gains by reducing overreliance on the hospital sector. Reforms to improve governance were implemented, but the system remains fragmented.



2 Health in Austria

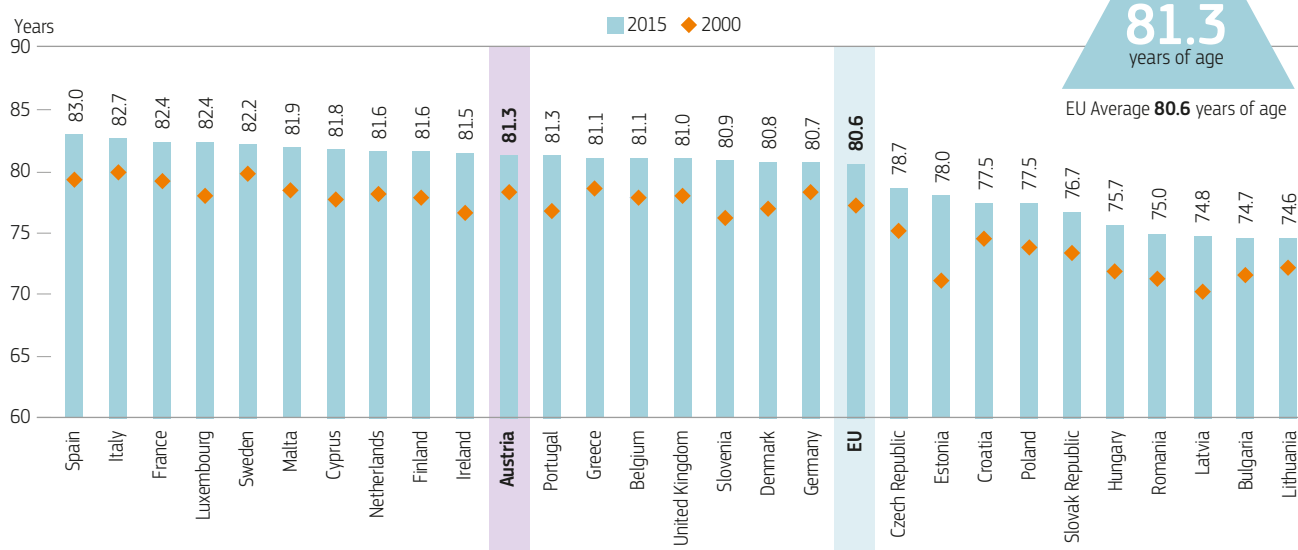
Life expectancy is increasing and remains above the EU average

Life expectancy at birth in Austria increased by three years between 2000 and 2015, to 81.3 years (Figure 1). Austrian life expectancy is above the EU average but is more than a year lower than in Spain, Italy and France. As in other EU countries, a substantial gap persists in life expectancy between women and men: life expectancy at birth for Austrian women (83.7 years) is nearly five years higher than that of Austrian men (78.8 years). However, the gap has closed by more than one year since 2000.

Most of the gains in life expectancy in Austria are realised after the age of 65, with the life expectancy of women at age 65 reaching 21.3 years (up from 19.6 years in 2000) and that of men reaching 18.1 years (up from 16.0 years in 2000). However, not all of these additional years are lived in good health. At age 65, Austrian women and men can expect to live about eight years free of disability, about 1.5 years less than the EU average.¹

1. These are based on the indicator of 'healthy life years', which measures the number of years that people can expect to live free of disability at different ages.

Figure 1. Austria's life expectancy remains above the EU average

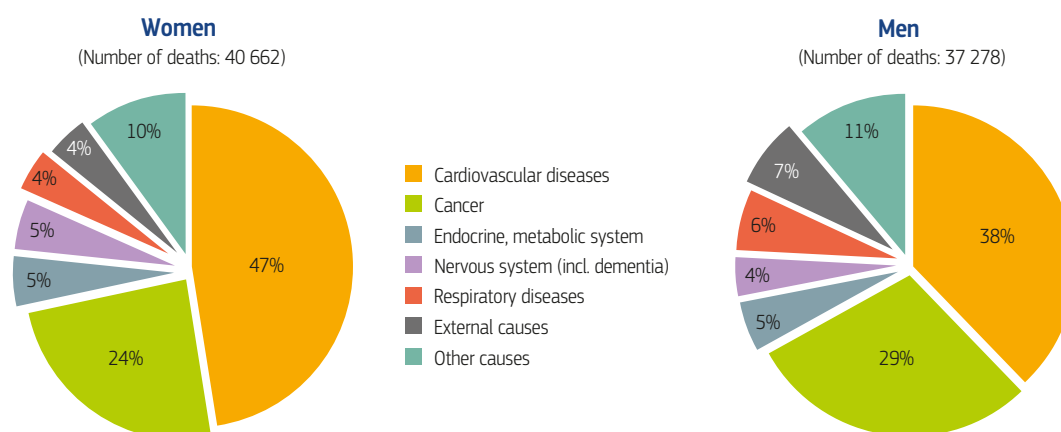


Source: Eurostat Database.

Cardiovascular diseases and cancer together account for more than two-thirds of deaths in Austria

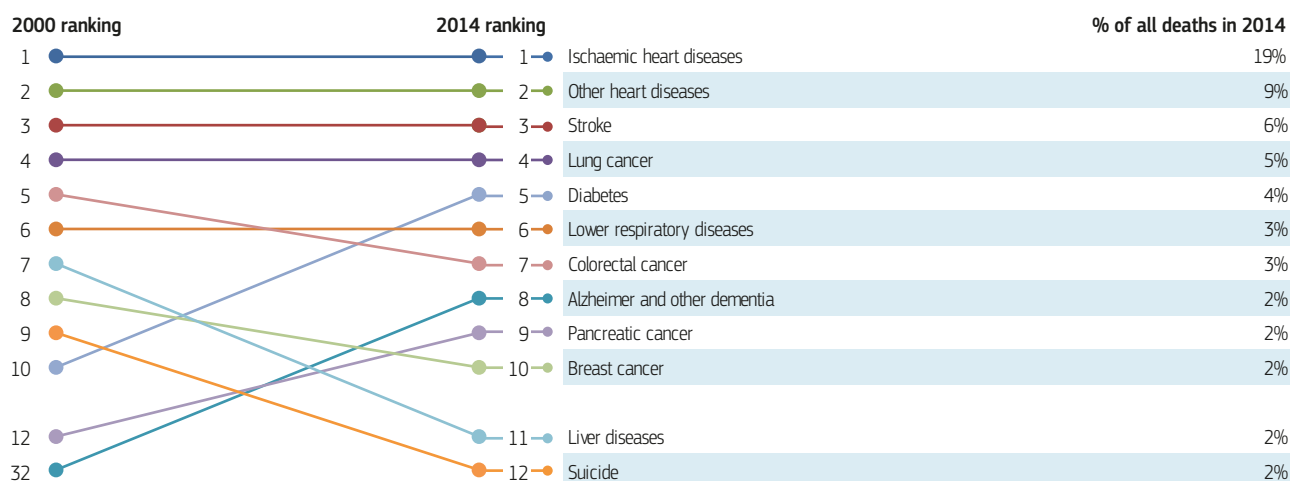
Cardiovascular diseases are the leading cause of death – followed by cancer – for both women and men in Austria (Figure 2). In 2014, 33 500 people died of cardiovascular diseases (accounting for 47% of all deaths among women and 38% of all deaths among men) and 20 615 died of cancer (accounting for 24% of all deaths among women and 29% of all deaths among men).

Looking at more specific causes of death, lung cancer is the fourth leading cause after heart diseases and stroke, accounting for 5% of all deaths in 2014 (Figure 3). While diabetes was only ranked tenth in 2000, the number of people dying from this chronic condition has increased substantially since, making it the fifth most common cause of death in 2014. Similarly, deaths from Alzheimer's and other dementias have become increasingly common, reflecting the ageing of the Austrian population and lack of effective treatments, as well as better diagnosis and more precise coding.

Figure 2. Cardiovascular diseases and cancer account for the majority of deaths in Austria

Note: The data are presented by broad ICD chapter. Dementia was added to the nervous system diseases' chapter to include it with Alzheimer's disease (the main form of dementia).

Source: Eurostat Database (data refer to 2014).

Figure 3. Diabetes is now the fifth leading cause of death behind cardiovascular diseases and lung cancer

Source: Eurostat Database.

Musculoskeletal problems and poor mental health add to the disease burden in Austria

In addition to the high burden of disease caused by heart diseases, stroke and cancer, musculoskeletal problems (including low back and neck pain) and major depressive disorders are increasing causes of disability-adjusted life years (DALYs)² in Austria (IHME, 2016). Self-harm (suicide and attempted suicide) is another important, although decreasing, health problem.

Based on self-reported data from the European Health Interview Survey (EHIS), one in five people in Austria have hypertension, one in thirteen have chronic depression and one in twenty have diabetes. Wide inequalities exist in the prevalence of these chronic conditions by education level: twice as many people with the lowest level of education live with them compared to people with the highest level of education.³

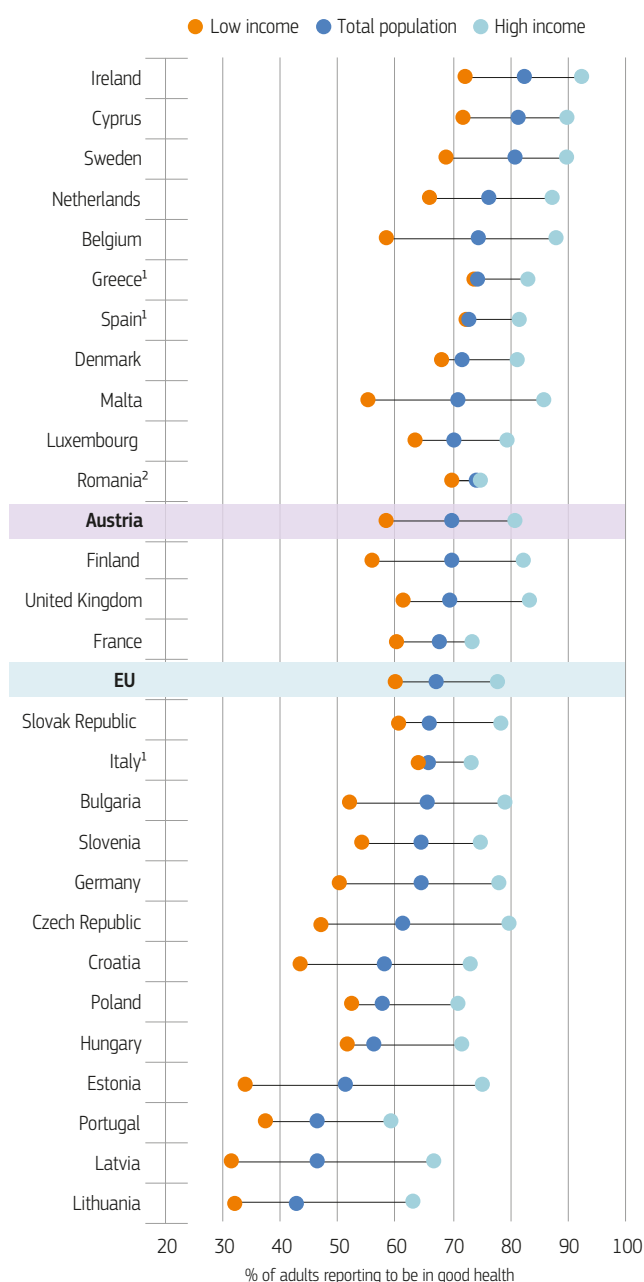
2. DALY is an indicator used to estimate the total number of years lost due to specific diseases and risk factors. One DALY equals one year of healthy life lost (IHME).

3. Inequalities by education may partially be attributed to the higher proportion of older people with lower educational levels; however, this alone does not account for all socioeconomic disparities.

Most Austrians report being in good health but disparities by income level persist

Seven out of ten Austrians (70%) report being in good health, slightly higher than the EU average (67%). As in other EU countries, a gap in self-rated health exists by socioeconomic status. More than 80% of Austrians in the highest income quintile report being in good health, compared with less than 60% of the population in the lowest income quintile (Figure 4).

Figure 4. Most Austrians report being in good health but large disparities exist by income group



1. The shares for the total population and the low-income population are roughly the same.

2. The shares for the total population and the high-income population are roughly the same.

Source: Eurostat Database, based on EU-SILC (data refer to 2015).

3 Risk factors

More than a quarter of the entire disease burden in Austria is related to unhealthy lifestyles

The health status of Austrians and health inequalities are linked to a number of health determinants, including the living and working conditions of people, the physical environment in which people live, and a range of behavioural risk factors. This is reflected in the national public health framework – the Austrian Health Targets (see Section 5.3) – which considers the focus on health determinants as a basic principle. Based on Institute for Health Metrics and Evaluation (IHME) estimations, over 28% of the overall burden of disease in Austria in 2015 (measured in terms of DALYs) could be attributed to behavioural risk factors, including smoking and alcohol use, as well as diet and low physical activity contributing to high body mass index and other health risks (IHME, 2016).

Smoking rates and alcohol consumption remain high among adults but are declining among adolescents

Almost one-quarter (24%) of Austrian adults were regular smokers in 2014, above the EU average of 21% (Figure 5). In contrast to the marked decline in smoking rates seen in many EU countries



since 2000, rates of Austrian adults reporting that they smoke every day are at the same level as in 1997. Smoking habits in men and women followed different paths, though. While the proportion of male daily smokers came down from 30% in 1997 to 27% in 2014, daily smoking in women rose from 19% to 22%. Steep declines in regular smoking were seen for 15-year-old Austrian girls (from 37% in 2001–02 to 14% in 2013–14) and boys (from 26% in 2001–02 to 15% in 2013–14).

Little progress was made in reducing alcohol consumption in Austria, with adults consuming 12.3 litres per capita in 2014, the third highest rate in the EU and more than 2.0 litres above the EU average. On the other hand, while overall alcohol consumption is high, binge drinking⁴ rates in Austria (19%) are slightly below the EU average (20%). Among adolescents in 2013–14, 20% of 15-year-old girls and 27% of 15-year-old boys reported having been drunk at least twice in their life – shares similar to the EU average.

Rising obesity rates among adults and adolescents present a major challenge

Low physical activity and poor diet can lead to high body mass index, high blood pressure, high cholesterol and other risk factors for cardiovascular diseases, diabetes and some cancers. Based on

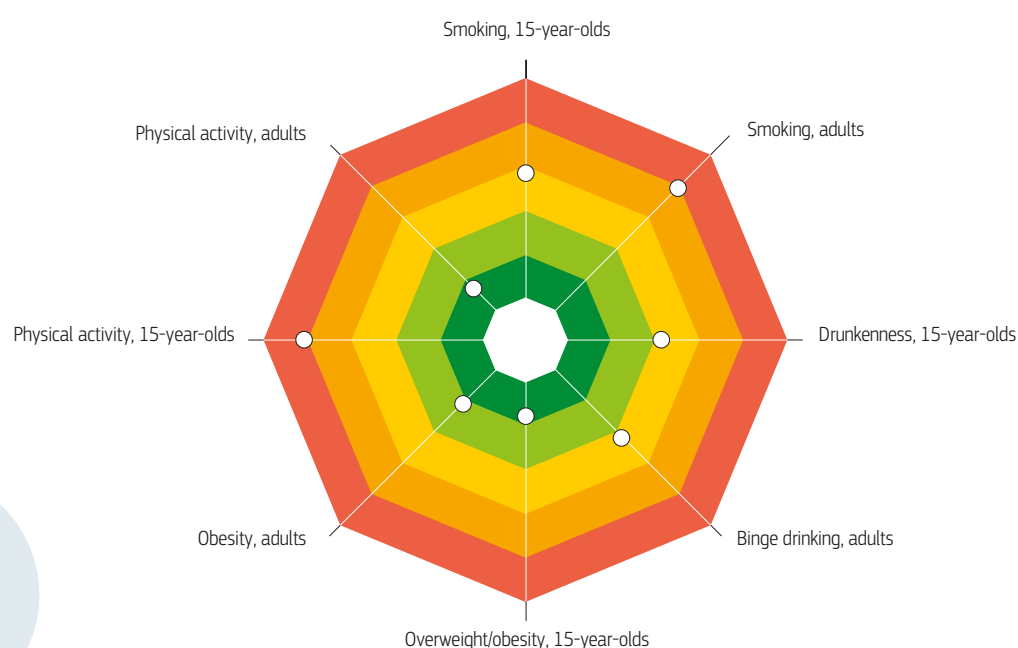
self-reported data (which may underestimate the true prevalence of obesity), about one in seven (14%) Austrian adults report being obese. While this share is still lower than in most other EU countries, it has increased substantially since 1999, when only 9% of Austrian adults were obese.

Similarly, prevalence of overweight and obesity for adolescents remains among the lowest across the EU, but increased considerably between 2001–02 and 2013–14 (from 11% to 15%). Austrian adults are among the most physically active in the EU, but physical inactivity among 15-year-olds is relatively high. In part to respond to these trends, the Austrian government implemented national action plans related to nutrition and promotion of physical activity (see Section 5.1).

Many behavioural risk factors are more common among disadvantaged populations

As in other EU countries, many behavioural risk factors are more common among poorly educated or lower income groups. In Austria, smoking rates are 83% higher in the lowest-educated population than in the highest-educated population. Even more striking, obesity rates are more than twice as high in the population with the lowest level of education.

Figure 5. Austria shows mixed results on behavioural health risk factors compared to other EU countries



Note: The closer the dot is to the centre the better the country performs compared to other EU countries. No country is in the white 'target area' as there is room for progress in all countries in all areas.

Sources: OECD calculations based on Eurostat Database (EHIS in or around 2014), OECD Health Statistics and HBSC survey in 2013–14. (Chart design: Laboratorio MeS).

4. Binge drinking behaviour is defined as consuming six or more alcoholic drinks on a single occasion, at least once a month over the past year.

4 The health system

Austria's complex health system has been reformed to improve governance

The Austrian health system is complex: governance is shared between the federal and the regional level ('Länder'); many responsibilities have been delegated to self-governing bodies (social insurance and providers); and health care financing is mixed, with the federal level, the regional level (Länder and municipalities) and social insurance funds all contributing to the budget.

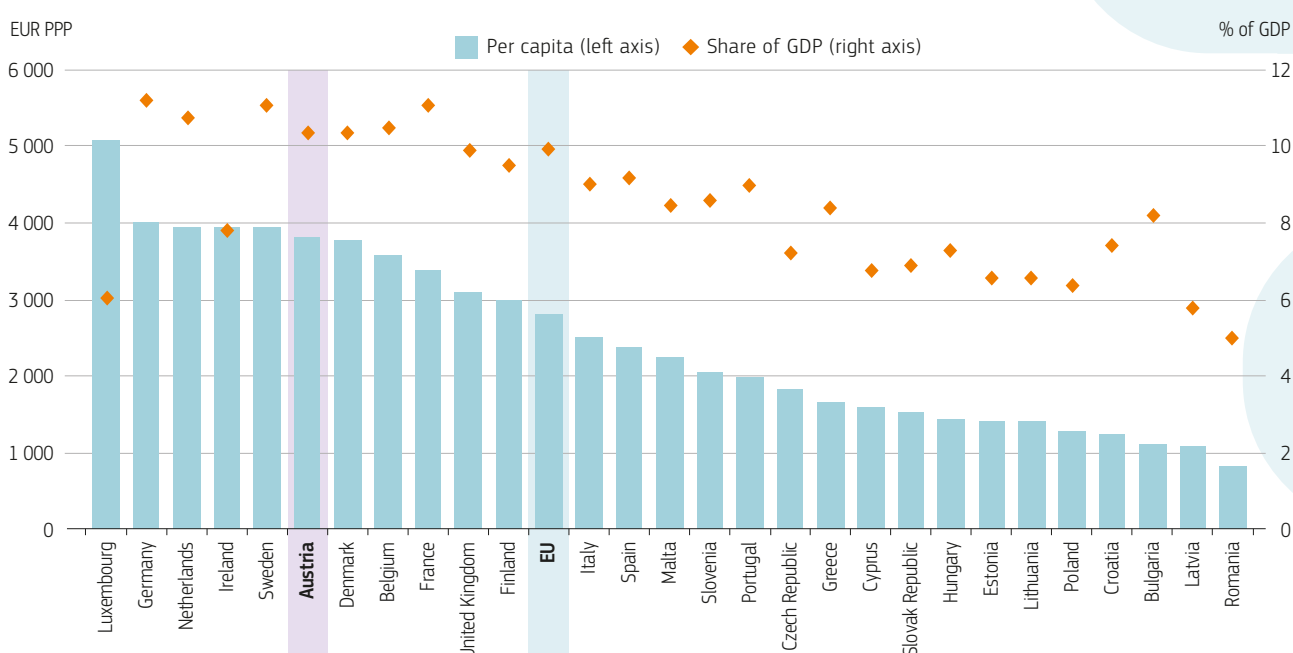
The federal government is responsible for regulating social insurance and most areas of health care provision – except hospital care, where the basics are defined at the federal level but the Länder are responsible for the specifics of legislation and implementation. Eighteen social health insurance funds, including one for each of the nine regions, come together under the Main Association of Austrian Social Security Institutions (including also the pension and accident insurance funds). Social insurance funds collectively negotiate with regional Medical Chambers and other health professions regarding health care provision in the areas of ambulatory (or outpatient) and rehabilitative care and pharmaceuticals.

Decentralised planning and delegation of responsibilities allow decision making to be adjusted to local needs – but often also lead to fragmentation and inadequate coordination. Efforts were made over a number of years to achieve more joint planning, governance and financing by bringing together the federal and regional levels and coordinating these with social insurance funds. The 2013 health reform was an important step in this direction, introducing a federal and nine regional commissions on health system governance involving all relevant actors (see Section 5.3).

Austrian health spending is high, with inpatient care accounting for a relatively large share

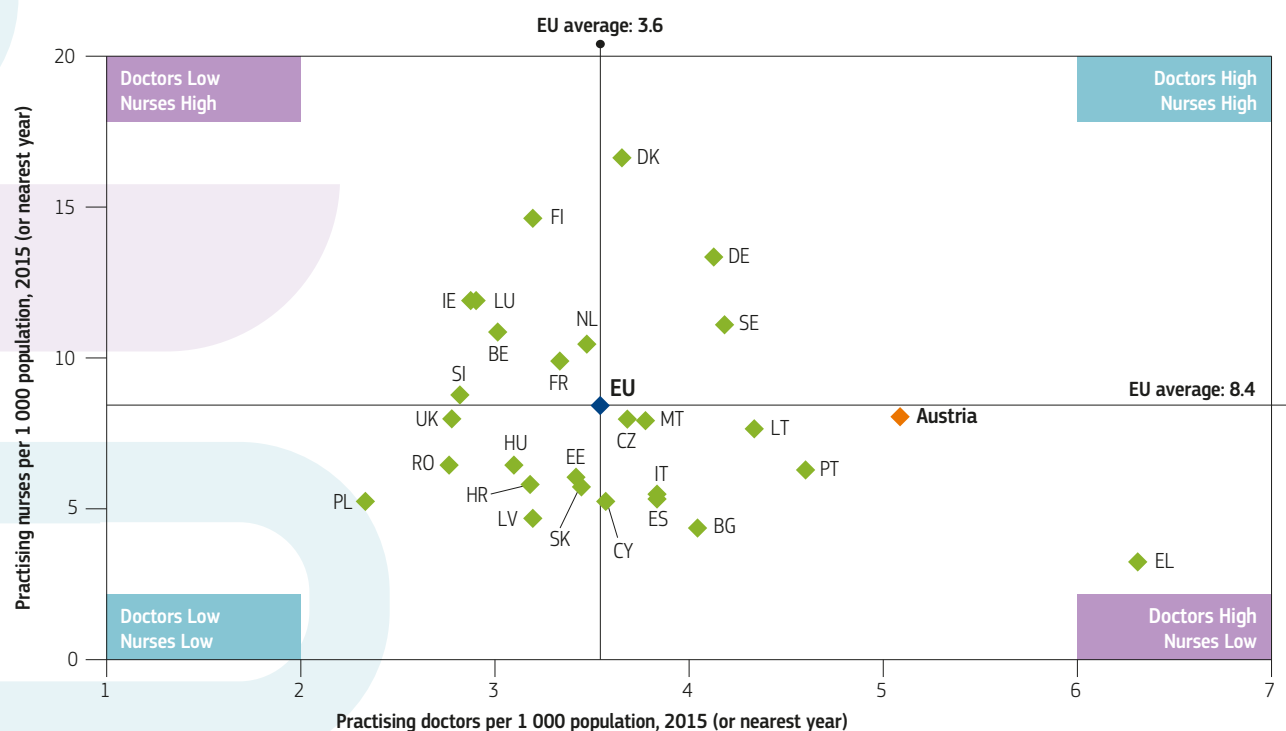
The Austrian health system is relatively expensive (Figure 6). Around EUR 3 800 was spent on health per capita in 2015 (adjusted for differences in purchasing power), about EUR 1 000 more than the EU average. However, in relative terms, health expenditure in Austria (10.3% of GDP) has grown more slowly than in many other EU Member States since 2005 and is only slightly above the EU average (9.9% of GDP). Nonetheless, Austria's health care expenditure is projected to grow substantially over the next decades (see Section 5.3).

Figure 6. Austria has an expensive health system and outspends the EU average by €1 000 per capita



Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2015).

Figure 7. Austria has a relatively high number of physicians



Note: In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30% in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.

Source: Eurostat Database.

Social insurance funds are the main source of financing, contributing 44.8% of current health expenditure in 2015. Coverage is universal and automatically determined by place of occupation. Contributions for health are generally fixed at 7.65% of gross income (shared between employees and employers). There is no competition between funds. All cover broadly the same benefits although some differences exist.

Insurance funds pay for ambulatory care provided by contracted physicians, using a mix of contact capitation and fee-for-service. Patients can also see non-contracted physicians but are reimbursed only for 80% of what insurance would usually pay for contracted care. Payments for non-contracted care account for a large share of out-of-pocket spending.

The share of direct government spending – mostly related to contributions of the Länder for the financing of inpatient care – increased slowly over time. Austria spends more than one-third of its health expenditure on inpatient care – a share that is higher only in Greece and Poland. In 2005, a Regional Health Fund was established in each region, pooling resources from federal

authorities, Länder, and social insurance funds. Since then, the Regional Health Funds pay for inpatient care provided by public and nonprofit hospitals on the basis of an Austrian version of Diagnosis Related Groups.

A large hospital sector and the second highest number of physicians in the EU

Austria has a very large hospital sector. Despite official plans to reduce the number of hospital beds, the bed-per-population ratio in Austria remains the second highest in the EU after Germany. Bed numbers have reduced by only 5% since 2000, while countries like Finland or Denmark made reductions of around 40% over the same period. The density of major medical equipment (CT, MRI, PET scanners) is also above average in Austria but mostly concentrated in hospitals.

Austria has the second highest physician-to-population ratio in the EU after Greece (Figure 7). It has also trained a lot of medical students, which explains the rising number of physicians – from 3.9 to 5.1 practising physicians per 1 000 population between

2000 and 2015. However, due to a quota on first-year students introduced in 2006, Austria witnessed a substantial decline in medical graduates in recent years. Further, as most physicians work in hospitals and/or as specialists, only 15% work as General Practitioners (GPs) in private practice.

Free choice of provider and no gatekeeping contribute to high hospital activity

Patients in Austria benefit from free choice of provider and unrestricted access to all levels of care (GPs, specialists and hospitals). They can choose to access not only contracted but also non-contracted physicians, the latter of which steadily increased in recent years. Yet this may contribute to social and regional inequalities (see Section 5.2).

A major aim of current health reforms is to strengthen the comparatively weak primary care system (Kringos et al., 2013). In addition, efforts are made to improve coordination through the introduction of disease management programmes – but unlike in Germany, this has so far been limited to patients with diabetes. Prevention continues to be relatively underfunded, accounting for only 2.2% of health expenditure in 2015 – only two-thirds of what EU countries spend on prevention on average (3.1%).

Austria is characterised by a very high level of activity in inpatient care. It has the second highest number of discharges in the EU after Bulgaria (Figure 8), though numbers have steadily declined since 2008. More than one out of four Austrians are discharged from a hospital every year (256 discharges per 1 000 population). In fact, Austria has the highest number of knee replacements in the EU and the second highest number of hip replacements.

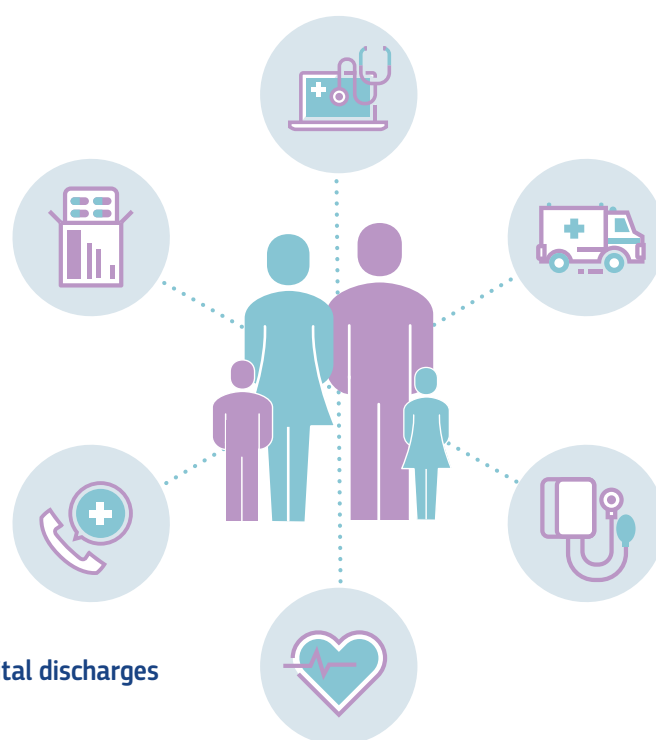
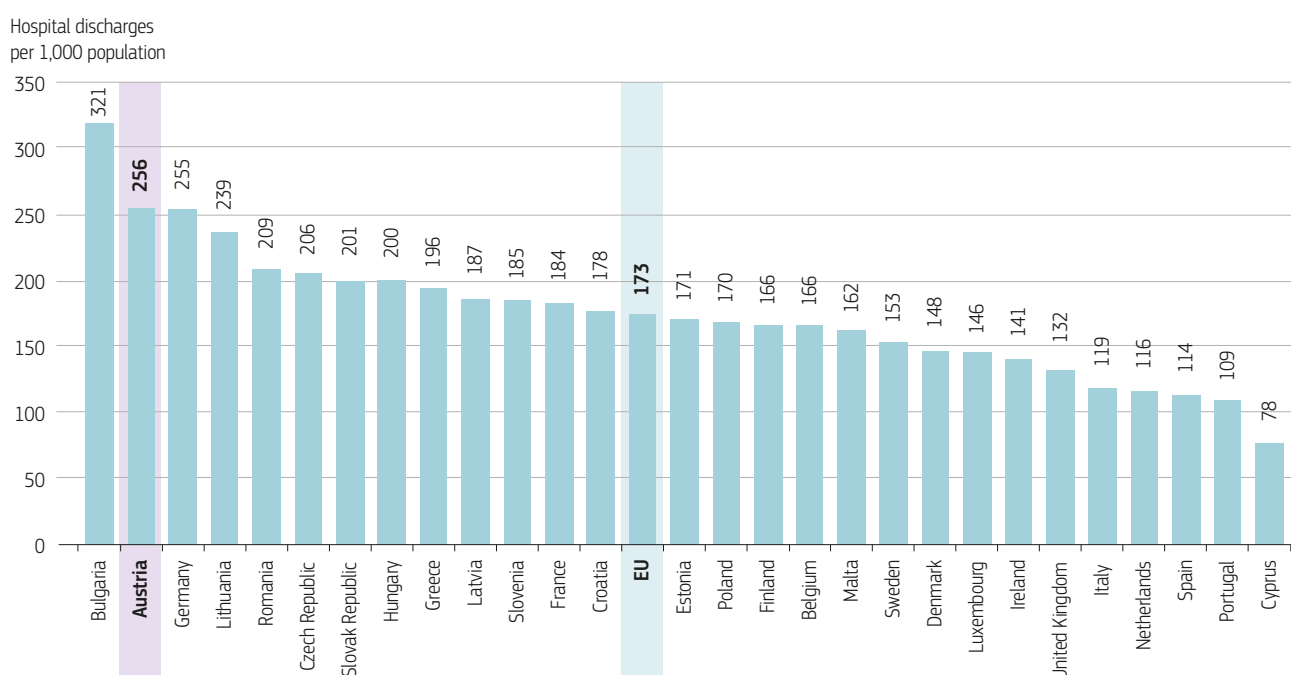


Figure 8. Austria has the second highest number of hospital discharges in the EU



Source: OECD Health Statistics, Eurostat Database (data refer to 2015 or nearest year).

5 Performance of the health system

5.1 EFFECTIVENESS

Overall amenable mortality rates are lower than on average across the EU

Amenable mortality⁵ refers to deaths that could have been avoided through timely and effective care and gives an indication of the effectiveness of the health care system. In 2014, Austria recorded amenable mortality rates that were lower than those of many other EU countries for both women and men, but still considerably above the best-performing countries, including France, Spain and Italy (Figure 9). Ischaemic heart diseases accounted for 39% of the

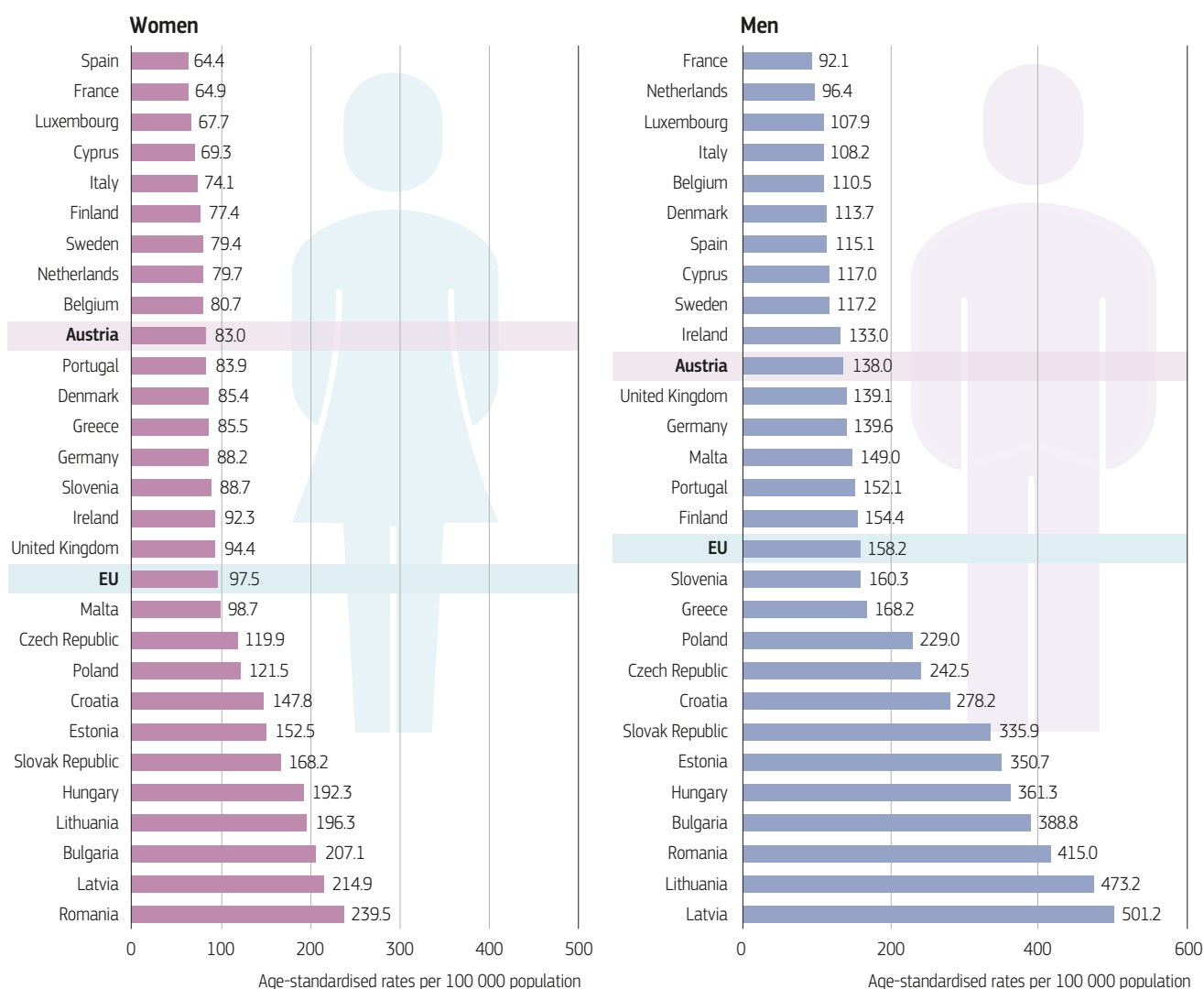
5. Amenable mortality is defined as premature deaths that could have been avoided through timely and effective health care.

8 300 deaths that were deemed to be amenable to treatment. Other important causes of amenable deaths were stroke (11.5% of the total), colorectal cancer (11.5%) and breast cancer (9.5%).

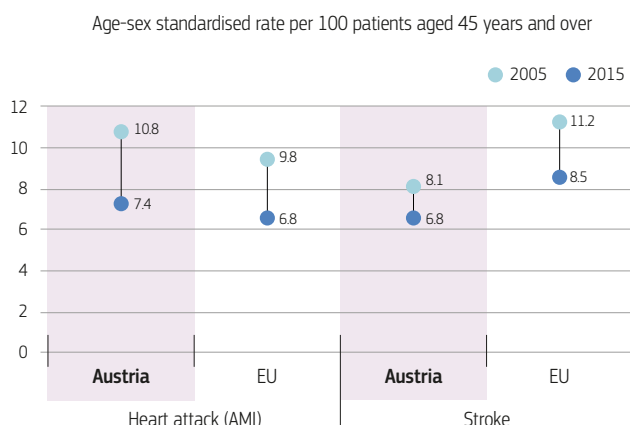
The quality of acute care has improved

Austria is generally doing well in providing acute care for people admitted to a hospital following a stroke, with a higher percentage of patients surviving this life-threatening condition than in most other EU countries. On the other hand, the performance appears less good in providing acute care for people admitted for a heart attack (AMI), with case-fatality rates slightly higher than the EU average – although substantial improvements were achieved over the past decade (Figure 10).

Figure 9. Austria has below-average rates of amenable mortality but lags behind the best performers



Source: Eurostat Database (data refer to 2014).

Figure 10. In-hospital case-fatality rates following heart attack and stroke decreased in Austria

Note: The EU average is based on 18 countries with data available in 2005 and 2015 or the nearest year.

Source: OECD Health Statistics.

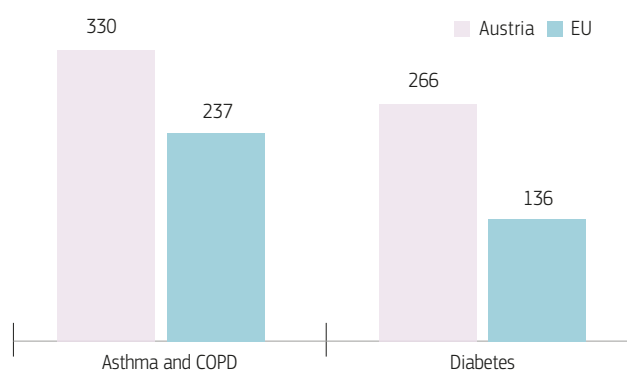
Despite above-average screening rates for both breast and cervical cancer, survival rates for women diagnosed with such cancers are only around the EU average, suggesting that the effectiveness of treatment could be improved (OECD/EU, 2016). On the other hand, Austria has one of the highest survival rates of people following diagnosis for colorectal cancer.

High number of avoidable hospitalisations suggests room for improvement in primary care

High hospital admission rates for chronic diseases including asthma and chronic obstructive pulmonary disease (COPD) as well as diabetes suggest that the effectiveness of primary care services could be improved (Figure 11). Such chronic conditions can normally be managed effectively in primary care settings without requiring hospital admission. Improving the continuity of care for the growing number of people living with one or more chronic diseases becomes increasingly important to achieve good health outcomes and control costs.

Strengthening primary care remains a priority and is one of the major objectives of the 2017 health reform package. The reform aims to enhance primary care capacity through the establishment of new multidisciplinary primary care units, either in the form of primary care centres at a single location or as a network of health professionals across several locations.

The reform envisages the creation of at least 75 such primary care units by 2021 and earmarked EUR 200 million for this purpose. The multidisciplinary units should comprise at least a core team of GPs and qualified nurses but can also include paediatricians and other health and social professionals such as physiotherapists or social workers. The reform further aims to increase access to

Figure 11. Austria has very high rates of avoidable hospital admissions for chronic conditions

Note: Data refer to age-sex standardised rates per 100 000 population.

Source: OECD Health Statistics (data refer to 2015).

primary care by ensuring longer opening hours, particularly during evenings and weekends, in an attempt to reduce the burden on hospital outpatient departments (BMGF, 2017).

Early disease detection is well established but gaps in vaccination coverage remain

Austria generally performs well in ensuring high population coverage for cancer screening. Screening rates for breast cancer are well above the EU average. Almost three-quarters of women aged 50–69 report that they have undergone a mammography examination within the past three years.⁶ Austria also fares well with regard to cervical cancer screening. Nearly nine out of ten women aged 20–69 were screened within the past three years – one of the highest rates among EU countries. In addition, free vaccination against the human papillomavirus to prevent cervical cancer was added to the publicly financed school immunisation programme in 2014.

Despite established childhood vaccination programmes, some gaps remain with regard to vaccination coverage, leaving unvaccinated populations vulnerable to infectious diseases. In 2014, Austria abolished the age limit for the free measles vaccination and launched a public awareness campaign with the aim to increase uptake. However, in 2015, Austria reported 300 cases of measles, corresponding to a rate of 35.3 cases per million inhabitants – second only to Croatia among EU countries (ECDC, 2016). After a drop in reported cases, the national reporting system documented 79 measles cases in the first half of 2017 – more than in all of 2016.

6. This share does not yet take into account the organised breast cancer screening programme that was launched in 2014 to replace the former 'opportunistic' screening system, under which women needed a referral from their doctor to get access to mammography screening.

Austria has relatively low influenza vaccination coverage for older people. While Austria recommends influenza vaccination and typically subsidises its uptake, it is generally not provided free of charge. In 2014, only about 20% of people aged 65 and over were vaccinated against influenza compared to more than 70% in the Netherlands and the United Kingdom – both countries that provide influenza vaccination free of charge for the elderly.

Several measures aim to address behavioural risk factors linked to preventable deaths

Preventable mortality provides an important pointer for the effectiveness of intersectoral public health policies. This refers to deaths that could have been avoided through public health interventions focusing on wider determinants of public health, such as behaviour and lifestyle factors. The overall preventable mortality rate for Austria is around that of the EU average and behavioural risks linked to preventable deaths – in particular, the relatively high consumption of tobacco as well as alcohol, and the rise in obesity – are important public health issues (see Section 3). A number of measures aiming to address some of these issues were introduced recently.

Smoking is the main risk factor for lung cancer. Even though mortality from lung cancer is lower in Austria than in many other EU countries, it remains the leading cause of death after cardiovascular diseases (see Section 2). While the development of a comprehensive policy on the protection of nonsmokers started relatively late compared to other countries, Austria introduced a number of measures in recent years, including smoking bans in public places (see Box 1). In addition, Austria published its first Addiction Prevention Strategy – covering illegal and legal drugs including tobacco and alcohol – in 2016, providing the basis for the direction of addiction policy in the coming years.

Austria is still one of the EU countries with the lowest rates of overweight and obesity among both children and adults, although rates increased substantially over the past 15 years (see Section 3). This development potentially contributes to increased mortality from cardiovascular diseases and other health issues in the longer term.

In response to these trends, Austria developed the National Action Plan on Nutrition, first adopted in 2011 and updated in 2012 and 2013, which aims to reduce over-, under- and malnutrition and to reverse the trend of rising overweight and obesity rates by 2020. The Action Plan establishes targets as well as strategies, and documents ongoing and planned measures of Austrian nutritional policy. This was complemented in 2013 by the National Action Plan on Physical Activity, which sets targets for specific population

BOX 1. RECENT POLICY CHANGES FOR THE PROTECTION OF NON-SMOKERS IN AUSTRIA

The Tobacco Act of 1995 was amended in 2004 to include a general ban on smoking 'indoors in public places' and a far-reaching ban on advertising tobacco products. The 2008 amendment of the Tobacco Act extended the protection of non-smokers to include restaurants and bars but still allowed smoking in separate rooms or when the surface area of an establishment was under a certain threshold.

More recently, the Tobacco Act was amended in 2015 to introduce a comprehensive smoking ban in restaurants and bars that will come into effect on 1 May 2018. In May 2016, the EU Tobacco Products Directive (2014/40/EU) became effective – it bans flavoured cigarettes, makes larger health warnings on packages mandatory, and introduces safety, quality and packaging regulations pertaining to e-cigarettes.

groups and gives recommendations on possible measures to increase physical activity.

5.2 ACCESSIBILITY

Austria has the lowest proportion of people reporting unmet medical needs across EU countries

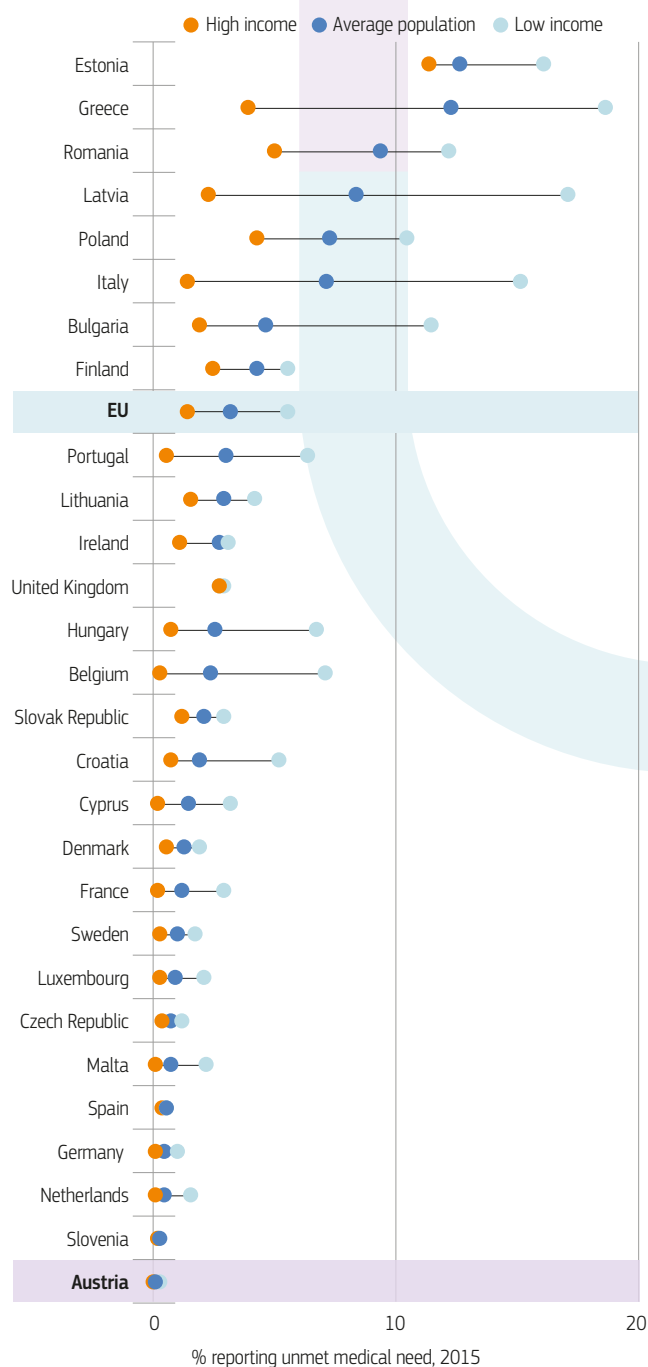
The Austrian health system performs generally well in ensuring access to health care services. The share of the population reporting unmet needs for a medical examination or treatment due to financial reasons, waiting times or long travel distances to access services is the lowest in the EU, with very little variation across income quintiles (Figure 12).

The health system provides near universal coverage, with 99.9% of the Austrian population covered by social health insurance in 2015, including coverage of dependents on the basis of the contributor's payment ('co-insurance') and the possibility of self-insurance with a statutory health insurer for anyone with permanent residence in Austria and not already covered by compulsory health insurance.

Nevertheless, some residents remain uninsured. The main causes for non-insurance are a lack of insurance despite employment (e.g. people in 'mini-jobs' whose income does not exceed a certain threshold and who do not purchase self-insurance), unemployment without entitlement to unemployment benefits, loss of co-insurance (e.g. after divorce or exceeding a certain age limit) or lack of a legal residence title (e.g. irregular migrants) (LBI-HTA, 2012).

In 2010, the 'needs-based minimum benefit' replaced the formerly existing social assistance system and brought the beneficiaries of this social welfare programme into the social health insurance system, giving them access to all statutory benefits. Asylum seekers are covered under statutory health insurance, with contributions being paid either from federal funds or the responsible Land.

Figure 12. Austrian residents report the lowest levels of unmet needs for medical care in the EU



Note: The data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.

Source: Eurostat Database, based on EU-SILC (data refer to 2015).

Austria's benefit package is comprehensive, with differences in cost-sharing across social insurance funds

Austria's benefit package is broad and covers most common medical care needs. The guiding principle behind the system is that the provision of treatment must be sufficient and appropriate but should not exceed what is necessary. Except for pharmaceuticals, there are no explicit positive lists specifying which services or products have to be covered by insurance. Negative lists do not exist either. Since July 2015, social health insurance also covers dental braces for children and adolescents under the age of 18 in cases of severely misaligned teeth.

Differences exist between social insurance funds in terms of benefits covered but mainly with regard to regulations on cost-sharing. In particular, the specialist insurance funds covering civil servants, self-employed, farmers, and miners and railway workers have made provisions for cost-sharing across all types of medical care and as such differ from the insurance funds set up under the General Social Security Act (ASVG), which tend to have fewer cost-sharing requirements – nearly 80% of the population is covered under the ASVG.

Financial protection is comprehensive despite relatively high out-of-pocket payments

Although the level of out-of-pocket payments in Austria (18% of health expenditure) is only slightly above the EU average (15%), it is relatively high compared to most other high-income EU countries, such as Denmark (14%), Germany (13%) and the Netherlands (12%). This does not appear to translate into elevated unmet medical need (Figure 12) or widespread financial hardship. Financial protection appears good relative to other EU countries, as indicated by the very low share of households with catastrophic out-of-pocket payments (around 2%).⁷

Austria ensures access to health care and protection from excessive expenditure through numerous exemptions from cost-sharing requirements. For example, vulnerable groups such as patients with notifiable infectious diseases (e.g. hepatitis, HIV/AIDS), asylum seekers, beneficiaries of certain social benefits (e.g. pensioners receiving 'compensatory allowances') and people with income below a certain threshold are exempt from prescription fees. Exemption from prescription fees also gives automatic entitlement to a range of other exemptions, such as co-payments for hospital stays or the annual service fee for the social insurance chip card that grants access to health services ('e-card').

7. Catastrophic expenditure is defined as household out-of-pocket spending exceeding 40% of total household spending net of subsistence needs (i.e. food, housing and utilities).

The introduction of a cap on prescription fees for all insured individuals in 2008 has limited the sometimes considerable financial burden caused by such fees. Individuals for whom expenditure on prescription fees reaches more than 2% of their annual net income are exempt from paying the fee for the rest of the calendar year. More recently, the 2017 health reform package abolished co-payments for hospital stays by children.

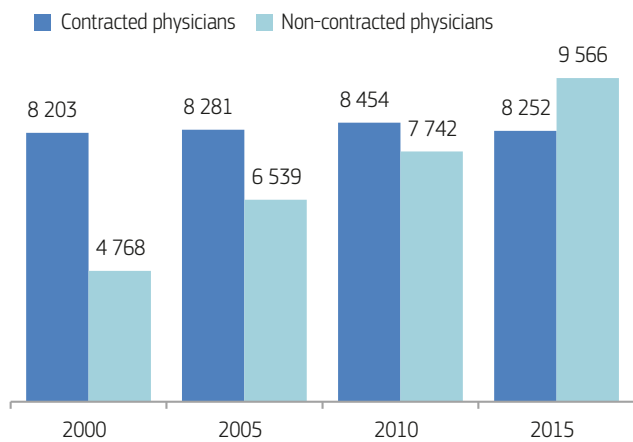
A stagnating supply of contracted physicians may contribute to social and regional inequalities

The number of ambulatory care physicians who are in a contractual relationship with one or more social insurance funds is stagnating (Figure 13). The increase in the number of ambulatory care physicians since 2000 was driven mostly by non-contracted physicians. Overall, non-contracted physicians spend much less of their time providing ambulatory care compared with their contracted colleagues, as most work only in private practice in addition to salaried work in other settings, such as hospitals. Yet recent years witnessed an increase in the activity of non-contracted physicians providing ambulatory care along with their steadily rising numbers.

This development may contribute to social inequalities. As the fees of non-contracted GPs and specialists are largely unregulated and only partly covered by social health insurance (see Section 4), access to ambulatory care is increasingly based on ability to pay rather than medical need. This may also contribute to disparities between Länder as well as between urban and rural areas. Non-contracted physicians are free to choose their location, whereas the geographic distribution of contracted physicians is defined by location-based staffing plans negotiated between regional health insurance funds and regional Medical Chambers.

Currently the density of contracted GPs appears to be well balanced across Austria, but more pronounced disparities exist for contracted specialists. For example, a 2.5-fold difference exists between the two Länder with the highest and lowest density of contracted neurologists and psychiatrists. Similarly, the density of contracted radiologists shows a threefold difference across the Länder.

Figure 13. The number of ambulatory care physicians with a social insurance contract is stagnating



Source: Austria Press Agency, Austrian Medical Chamber.

5.3 RESILIENCE⁸

An ageing health workforce creates further challenges for ambulatory care provision

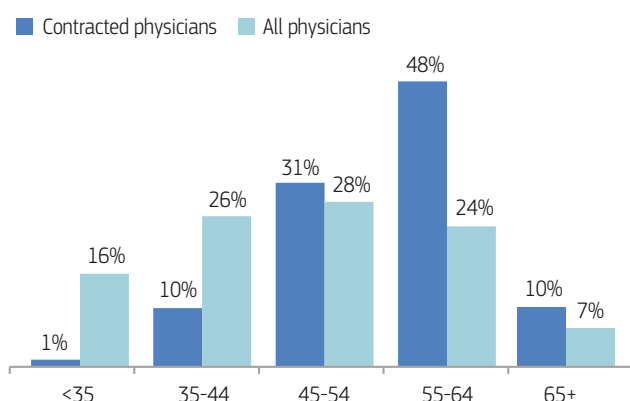
Concerns about social and regional inequalities resulting from the stagnating supply of contracted ambulatory care physicians are likely to be exacerbated by the age structure of these doctors. Nearly six out of ten contracted physicians are at least 55 years old and will retire in the next 10 to 15 years (Figure 14). To maintain accessibility and effectiveness of the health system, particularly in the context of an ageing population with increasingly complex health needs, it is important to ensure a sufficient number of health professionals with the right skill mix. Recent efforts to enhance primary care capacity through the development of multidisciplinary primary care units that complement the activities by traditional ambulatory care physicians working in solo practices can play a positive role in addressing these challenges.

Rising expenditure pressures pose risks to fiscal sustainability

Population ageing will create pressures around the fiscal sustainability of the Austrian health system in the medium and long term. Public spending on health and long-term care is expected to increase considerably over the coming decades while, at the same time, ageing will reduce the share of the population of working-age needed to finance this public spending. The 2015 Ageing Report (European Commission and European Policy Committee, 2015) projects public spending on health care and long-term care to both

8. Resilience refers to health systems' capacity to adapt effectively to changing environments, sudden shocks or crises.

Figure 14. Six out of ten contracted physicians in Austria are aged 55 and over



Note: Data for contracted physicians refer to physicians who had a contract with a regional health insurance fund as of 31 December 2014.

Source: HVSV 2017, OECD Health Statistics (data refer to 2014).

increase by 1.3 percentage points of GDP between 2013 and 2060 – well above the average projected increases for the EU for health (0.9 percentage points) and long-term care (1.1 percentage points).

To tackle this issue, the 2013 health reform introduced a global budget cap for public spending on health. The reform set a limit on nominal public health spending growth of 4.5% in 2012 and was gradually reduced to 3.6% in 2016, aiming to bring it in line with projected annual average GDP growth. While these financial targets were met, they have been criticised for their lack of ambition (Rechnungshof, 2013).

The 2017 health reform package extends the efforts to contain spending to 2017–21, introducing more stringent financial targets with caps on public health spending growth gradually reducing from 3.6% in 2017 to 3.2% in 2021. Although these stricter targets may help to contain public spending, ensuring fiscal sustainability of Austria's health system remains an important challenge. The European Commission projections point to above-average public spending growth despite assuming lower growth rates for health expenditure over the same period (European Commission, 2017).

Scope exists for efficiency gains, particularly by reducing overutilisation of hospital care

Increasing the efficiency of the Austrian health system is particularly pertinent in view of fiscal sustainability concerns. Although the Austrian health system performs better than the EU average in terms of life expectancy and amenable mortality, many countries achieve similar or better outcomes for a lower per capita cost. The high number of avoidable hospitalisations (see Section 5.1) and imbalances in the resource allocation between

the hospital and primary care sector (see Section 4), in particular, point towards room for efficiency gains.

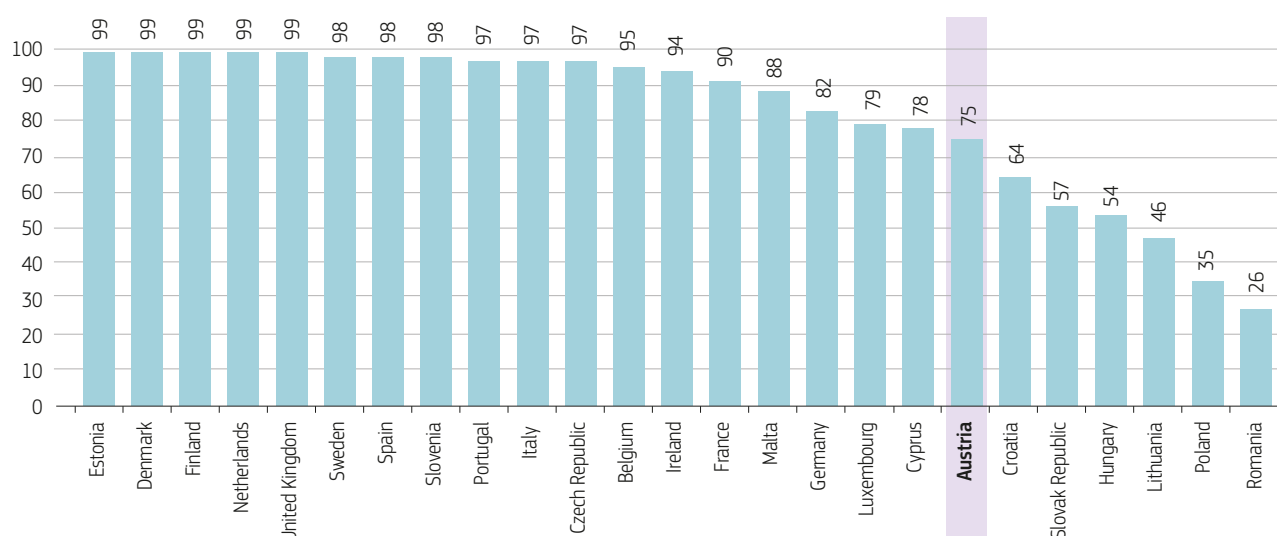
Managing chronic conditions better within primary care settings could help to prevent further deterioration of patients' health and hence reduce unnecessary hospital admissions. Strengthening primary care can also help to reduce self-referrals for minor ailments and conditions to hospital outpatient departments, where the costs of treatment are much higher. Continued support for the development of disease management for chronic conditions such as the 'TherapieAktiv' programme for patients with diabetes and ongoing efforts to enhance primary care capacity (see Section 5.1) are important steps towards achieving better value for money.

There also appears to be room in Austria to shift certain interventions to less costly settings to reduce overutilisation of expensive inpatient treatment. For example, the share of cataract surgeries carried out as ambulatory cases has grown rapidly in Austria since 2000 but remains lower than in most other EU countries (Figure 15). In addition, virtually no tonsillectomies are carried out as ambulatory cases in Austria, whereas countries such as Finland (86%) and Sweden (73%) performed most of these surgeries as ambulatory cases in 2015.

Despite efforts to strengthen governance, fragmentation of the health system remains a challenge

The Austrian Health Targets ('Gesundheitsziele Österreich') represent the guiding framework for Austrian public health policy in general and for the ongoing health reform process in particular. The framework was adopted in 2012 after a broad participatory process including all relevant stakeholders as well as an online consultation that invited everyone with an interest to express their views. The 10 health targets will be in force until 2032 and have the overarching aim of increasing healthy life expectancy by two years on average over this period. The targets are implemented through intersectoral working groups that define sub-targets and concrete actions and are accompanied by a monitoring process (BMGF, 2016).

A central aim of the 2013 health reform was to improve coordination and cooperation between stakeholders in a fragmented health system. The reform put in place a target-based governance system through a contractual agreement between the federal government, regional governments and social insurance funds ('Zielsteuerungsverträge'). For each of three key areas – structure of provision, processes of care, and focus on outcomes – the contract sets out strategic goals and defines operative targets (including the abovementioned financial targets), together with measures for achieving them.

Figure 15. Ambulatory cases account for a lower share of cataract surgeries than in most other EU countries

Source: Eurostat Database, OECD Health Statistics (data refer to 2015 or nearest year).

At the same time institutional capacity for governance was raised by establishing a federal and nine regional commissions, which are the main bodies tasked with implementing the target-based governance system. These commissions consist of representatives from federal and regional governments as well as the social insurance funds and, as such, make the different levels of government and social insurance jointly responsible and accountable for achieving the agreed targets. With the 2017 health reform package, this new form of governance was extended to 2021.

Yet despite these efforts, the high level of fragmentation in the organisational and financial structure of the Austrian health system remains a distinctive feature. The persistent divide in managing and financing responsibilities, in particular, points to room for further strengthening governance and the ability to steer the system to be able to respond to future challenges. On the provider side, the ongoing rollout of the Austrian Electronic Health Record (ELGA) aims to reduce organisational barriers and improve coordination between hospitals, ambulatory care providers, pharmacies and nursing care facilities (see Box 2).

BOX 2. THE AUSTRIAN ELECTRONIC HEALTH RECORD (ELGA)

In 2012, the Austrian Parliament passed legislation to introduce the Austrian Electronic Health Record (ELGA). Subsequently, ELGA was included as an operative target in the 2013 health reform. The ELGA web portal gives patients and health providers – including hospitals, ambulatory care providers, pharmacies and nursing care facilities – access to medical information covering prescribed medicines and medicines dispensed by pharmacies ('e-Medikation') as well as discharge letters from hospitals, and laboratory and imaging results ('e-Befunde'). Patients can opt out of ELGA entirely or restrict access to selected information, and are able to see who has consulted their individual record.

ELGA is being rolled out step-by-step, starting with e-Befunde in the hospital and nursing care sector: in December 2015, most public hospitals and nursing care facilities in Vienna and Styria were connected to ELGA; other public hospitals and nursing care facilities were added throughout 2016 and 2017; in a next step, ELGA (including e-Medikation) will be extended to include ambulatory care physicians and pharmacies; this will be followed by outpatient clinics, private hospitals and finally dentists.

Source: <https://www.gesundheit.gv.at>



6 Key findings

- Austrians live longer but spend fewer of these extra years in good health compared to many of their EU peers. Relatively low amenable mortality rates indicate that health care is more effective than in most EU countries, although Austria still lags behind the best-performing countries.
- High numbers of avoidable hospitalisations for chronic conditions suggest room for improvement in primary care. Strengthening primary care is a major objective of the 2017 health reform package, which aims to enhance primary care capacity through the establishment of new multidisciplinary primary care units.
- Behavioural risk factors are a major public health issue in Austria. Alcohol consumption and smoking rates have not declined and are among the highest across the EU. Obesity rates, although still lower than in many other EU countries, are on the rise for both adults and adolescents. Encouragingly, smoking rates among adolescents declined in recent years and Austria is finally catching up with other EU countries in terms of policies for the protection of nonsmokers, for example by introducing a comprehensive smoking ban in restaurants and bars. National Action Plans on Nutrition and Physical Activity were put in place to counter the rise in obesity.
- The Austrian health system is complex, with shared responsibilities between different levels of government and self-governing bodies. Decentralised planning and delegation of responsibilities contribute to fragmentation, inadequate coordination, and a divide between managing and financing responsibilities. Recent reform efforts, in particular the 2013 health reform, strengthened governance by promoting joint planning, decision making and financing. Nonetheless, a high level of fragmentation in the organisational and financial structure remains.
- Austria performs well in ensuring access to health care. It reports the lowest levels of unmet needs for medical care across the EU and, despite relatively high out-of-pocket payments, provides comprehensive financial protection for vulnerable groups through numerous exemptions from cost-sharing requirements. A large share of the out-of-pocket expenditure stems from payments for non-contracted care. Non-contracted physicians play an increasingly important role in the provision of ambulatory care. Rising imbalances between contracted and non-contracted physicians may contribute to social and regional inequalities, which are likely to be exacerbated by the ageing of contracted doctors. Nearly six out of ten contracted physicians are at least 55 years old and will retire in the next 10 to 15 years.
- The Austrian health system is relatively costly and has a strong focus on hospital inpatient care as indicated by high hospitalisation rates. Room for efficiency gains appears possible, for example by shifting activities and resources out of the large and costly hospital sector and improving the skill mix within the health workforce. Current reforms to strengthen primary care are an important step in this direction. Increasing the efficiency of the Austrian health system is particularly important given concerns about public spending on health care, which is expected to face growing pressures over the coming decades.



Key sources

Hofmarcher, M. and W. Quentin (2013), "Austria: Health System Review", *Health Systems in Transition*, Vol. 15(7).

OECD/EU (2016), *Health at a Glance: Europe 2016 – State of Health in the EU Cycle*, OECD Publishing, Paris, <http://dx.doi.org/10.1787/9789264265592-en>.

References

BMGF (2017), *Zielsteuerung-Gesundheit ab 2017*, Bundesministerium für Gesundheit und Frauen, Vienna.

BMGF (2016), *Rahmen-Gesundheitsziele: Richtungsweisende Vorschläge für ein gesünderes Österreich – Langfassung*, Bundesministerium für Gesundheit und Frauen, Vienna.

ECDC (2016), *Surveillance Report: Measles and Rubella Monitoring, January 2016*, European Centre for Disease Prevention and Control, Stockholm.

European Commission (2017), *2017 European Semester: Country Report – Austria*, Brussels.

European Commission (DG ECFIN) and Economic Policy Committee (AWG) (2015), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)", *European Economy* 3, Brussels, May.

HVSV (2017), *Vertragsärztinnen und –ärzte in Österreich: Bestandsaufnahme und Analyse*, Hauptverband der österreichischen Sozialversicherungsträger, Vienna.

IHME (2016), "Global Health Data Exchange", Institute for Health Metrics and Evaluation, available at <http://ghdx.healthdata.org/gbd-results-tool> (accessed 31 March 2017).

Kringos, D. et al. (2013), "The Strength of Primary Care in Europe: An International Comparative Study", *British Journal of General Practice*, Vol. 63(616), pp. e742-e750.

LBI-HTA (2012), *Gesundheitszustand von wohnungslosen Menschen und deren Zugang(sbarrieren) zum Gesundheitssystem*, Ludwig Boltzmann Institut – Health Technology Assessment, Vienna.

Rechnungshof (2013), *Entwurf eines Gesundheitsreformgesetzes 2013: Stellungnahme*, Parlament Republik Österreich, Vienna.

Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Malta	MT	Slovenia	SI
Belgium	BE	Estonia	EE	Ireland	IE	Netherlands	NL	Spain	ES
Bulgaria	BG	Finland	FI	Italy	IT	Poland	PL	Sweden	SE
Croatia	HR	France	FR	Latvia	LV	Portugal	PT	United Kingdom	UK
Cyprus	CY	Germany	DE	Lithuania	LT	Romania	RO		
Czech Republic	CZ	Greece	EL	Luxembourg	LU	Slovak Republic	SK		

State of Health in the EU

Country Health Profile 2017

The Country Health Profiles are an important step in the European Commission's two-year *State of Health in the EU* cycle and are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies. This series was co-ordinated by the Commission and produced with the financial assistance of the European Union.

The concise, policy relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU Member State. The aim is to create a means for mutual learning and voluntary exchange that supports the efforts of Member States in their evidence-based policy making.

Each Country Health Profile provides a short synthesis of:

- health status
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

This is the first series of biennial country profiles, published in November 2017. The Commission is complementing the key findings of these country profiles with a Companion Report.

For more information see: ec.europa.eu/health/state

Please cite this publication as:

OECD/European Observatory on Health Systems and Policies (2017), *Austria: Country Health Profile 2017, State of Health in the EU*, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.
<http://dx.doi.org/10.1787/9789264283268-en>

ISBN 9789264283268 (PDF)

Series: State of Health in the EU
ISSN 25227041 (online)