European Commission



State of Health in the EU

Austria

Country Health Profile 2019

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European Observatory on Health Systems and Policies
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The Country Health Profile series

The *State of Health in the EU*'s Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

The 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 the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Information.

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Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated 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. These EU averages do not include Iceland and Norway.

This profile was completed in August 2019, based on data available in July 2019.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following URL into your Internet browser: http://www.oecd.org/health/Country-Health-Profiles-2019-Austria.xls

Demographic and socioeconomic context in Austria, 2017

Demographic factors	Austria	EU
Population size (mid-year estimates)	8 798 000	511 876 000
Share of population over age 65 (%)	18.5	19.4
Fertility rate[1]	1.5	1.6
Socioeconomic factors		
GDP per capita (EUR PPP[2])	38 100	30 000
Relative poverty rate[3] (%)	14.4	16.9
Unemployment rate (%)	5.5	7.6

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 60 % of median equivalised disposable income.
Source: Eurostat Database.

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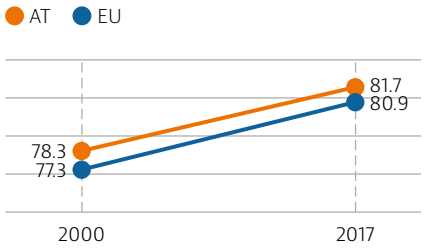
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1 Highlights

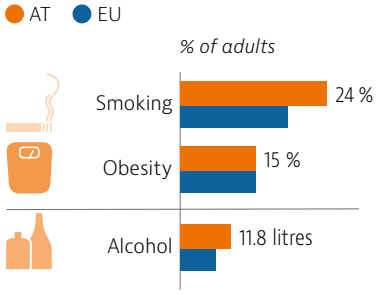
Although health status in Austria is improving, behavioural risk factors and an ageing population continue to challenge the health system. Accessibility and quality of health care are generally good, but hospitals play a disproportionate role in health care. Current reforms aim to improve primary care and correct imbalances in the health workforce. A new governance system brings together the federal and regional levels of government and social health insurance to improve coordination. Nevertheless, the Austrian health system remains structurally fragmented and comparatively costly.



Life expectancy at birth, years

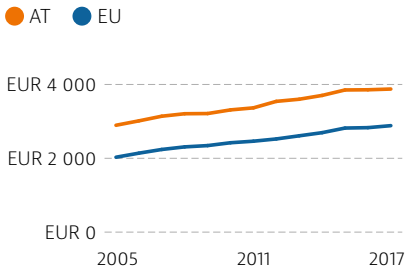
Health status

In 2017 life expectancy at birth was 81.7 years, 3.4 years higher than in 2000 and 0.8 years above the EU average. Heart diseases are the main cause of death, but mortality from diabetes is increasing. About 70 % of Austrians report good health, but this proportion is smaller among the lowest income groups. While Austrians are living longer, more years of life are lived with chronic diseases and disabilities than the EU average.



Risk factors

Behavioural risk factors are a major driver of morbidity and mortality – especially poor diets, smoking and alcohol consumption. Adult smoking rates have not declined over the past two decades, and smoking is now more prevalent than in most EU countries. Despite a reduction since 2000, alcohol consumption remains above the EU average. While Austrian adults are among the most physically active in the EU, adolescents are among the least active.



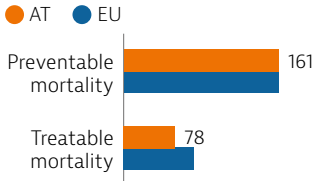
Per capita spending (EUR PPP)

Health system

Austria has a social health insurance system. Health expenditure per capita was almost EUR 3 900 in 2017, about EUR 1 000 above the EU average, representing 10.4 % of GDP (9.8 % EU average). Although expenditure growth is similar to the EU average, Austria continues to spend substantially more on inpatient care than most countries and has a high number of physicians and hospital beds. Imbalances are emerging between generalists and specialists, and between rural and urban areas. Reliance on physicians without social health insurance contracts is increasing.

Effectiveness

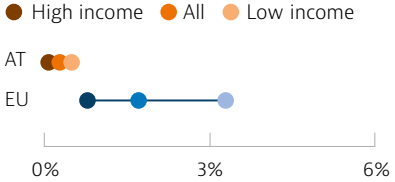
While preventable mortality is close to the EU average, mortality from treatable causes is lower than in most EU countries. The performance of acute care is slightly better than the EU average, but the number of avoidable hospitalisations remains high.



Age-standardised mortality rate per 100 000 population, 2016

Accessibility

The health benefit package is slightly more comprehensive than in the EU as a whole. Population coverage is near-universal and accessibility of care is generally good. Austria has one of the lowest rates of self-reported unmet medical needs in the EU.



% reporting unmet medical needs, 2017

Resilience



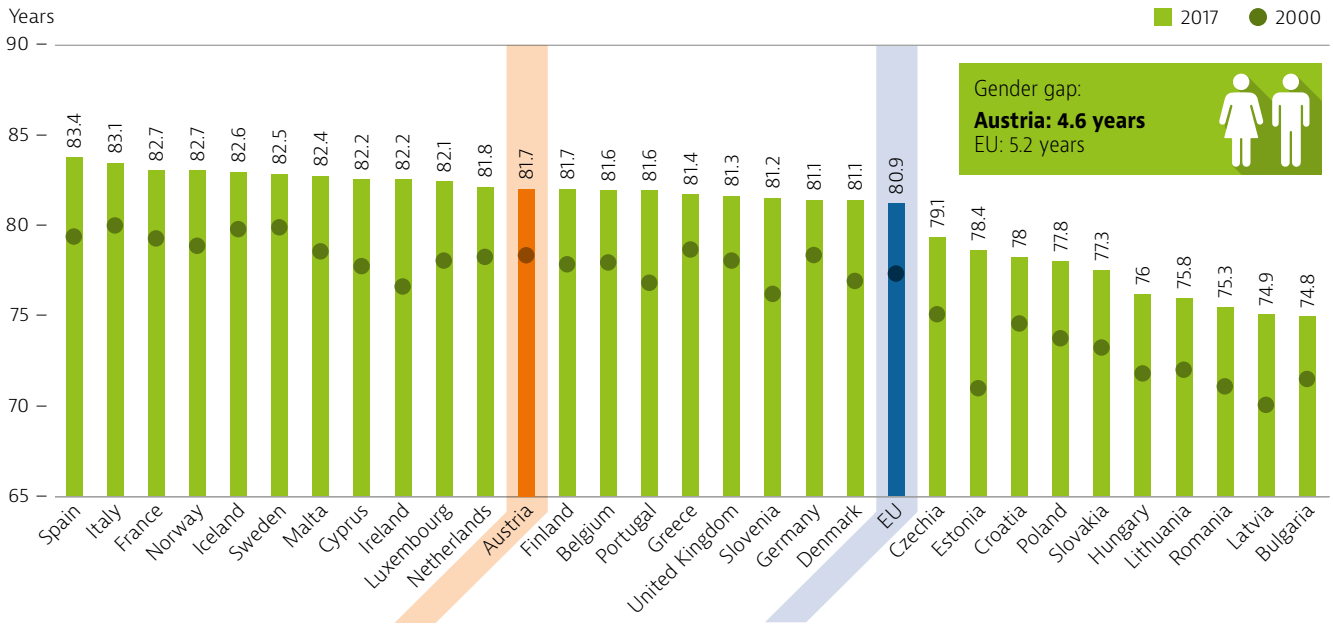
Public spending on health care is projected to increase from 7 % of GDP in 2016 to 8.3 % by 2070, while public spending on long-term care is projected to double, from 1.9 % to 3.8 % of GDP. Overall expenditure caps are in place, but fragmentation and the absence of structural reforms may impair the health system's ability to adapt to new challenges.

2 Health in Austria

Life expectancy has increased and is above the EU average

In 2017, life expectancy at birth in Austria was 81.7 years, almost one year more than the EU average but nearly two years less than in Spain and Italy (Figure 1). Since 2000, it has increased by 3.4 years (just below the 3.6 years increase across the EU). Life expectancy has increased somewhat more rapidly for men than for women: this trend is similar in other EU countries. Nevertheless, the gender gap in life expectancy was 4.6 years in 2017 (79.4 years for men, 84.0 years for women), slightly below the EU average of 5.2 years.

Figure 1. Life expectancy has risen steadily and remains above the average in the EU

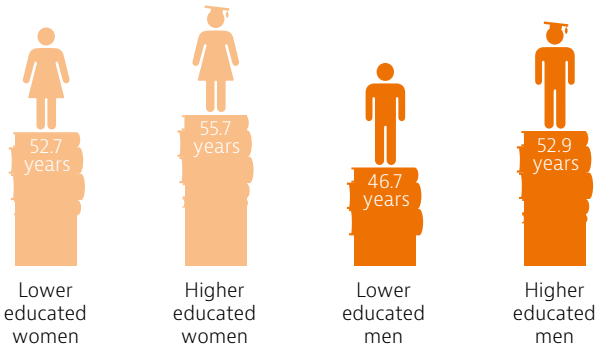


Source: Eurostat Database.

Social inequalities in life expectancy are larger among men than women

Inequalities in life expectancy exist not only by gender but also by socioeconomic status. Men with the highest level of education can expect to live about six years longer than those with the lowest level, while the gap is only three years among Austrian women. These gaps are lower than the EU averages of 7.6 and 4.1 years respectively (Figure 2). The education gap in longevity is partly explained by higher mortality rates and higher exposure to various risk factors among people with low levels of education. These include, for instance, higher smoking rates and worse nutritional habits (see Section 3). The gap in life expectancy is also related to differences in income and living standards.

Figure 2. The education gap in life expectancy is 6.2 years for men and 3 years for women



Education gap in life expectancy at age 30:

Austria: 3 years
EU21: 4.1 years

Austria: 6.2 years
EU21: 7.6 years

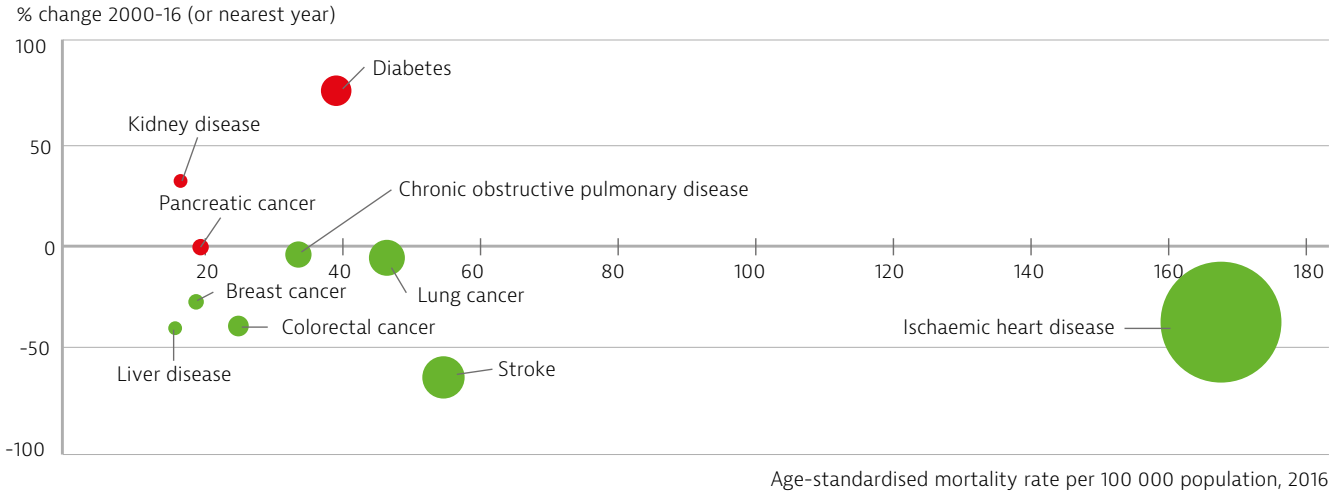
Note: High education is defined as people who have completed tertiary education (ISCED 5-8), whereas low education is defined as people who have not completed their secondary education (ISCED 0-2).
Source: Murtin et al., OECD Statistics Working Paper N°78 (2017).

Heart diseases remain the main cause of death but mortality from diabetes is increasing

The increase in life expectancy in Austria since 2000 has been driven mainly by reductions in mortality rates from circulatory diseases, notably ischaemic heart disease and stroke (Figure 3). Despite these reductions, circulatory diseases remained the leading cause of death in 2016, accounting for nearly 34 000 deaths (42 % of all deaths).

Cancers are the second most frequent cause of death, although cancer-related mortality has also decreased since 2000. Lung cancer is the most frequent cause of cancer death, but mortality from this condition has decreased slightly. The mortality rate from diabetes, on the other hand, has strongly increased since 2000. This may reflect the rising prevalence of overweight and obesity (see Section 3) and a relative weakness of primary health care in Austria.

Figure 3. Ischaemic heart disease is the leading cause of death, but diabetes mortality is rising



Note: The size of the bubbles is proportional to the mortality rates in 2016.
Source: Eurostat Database.

Self-reported health status is close the EU average, while adolescents report better health

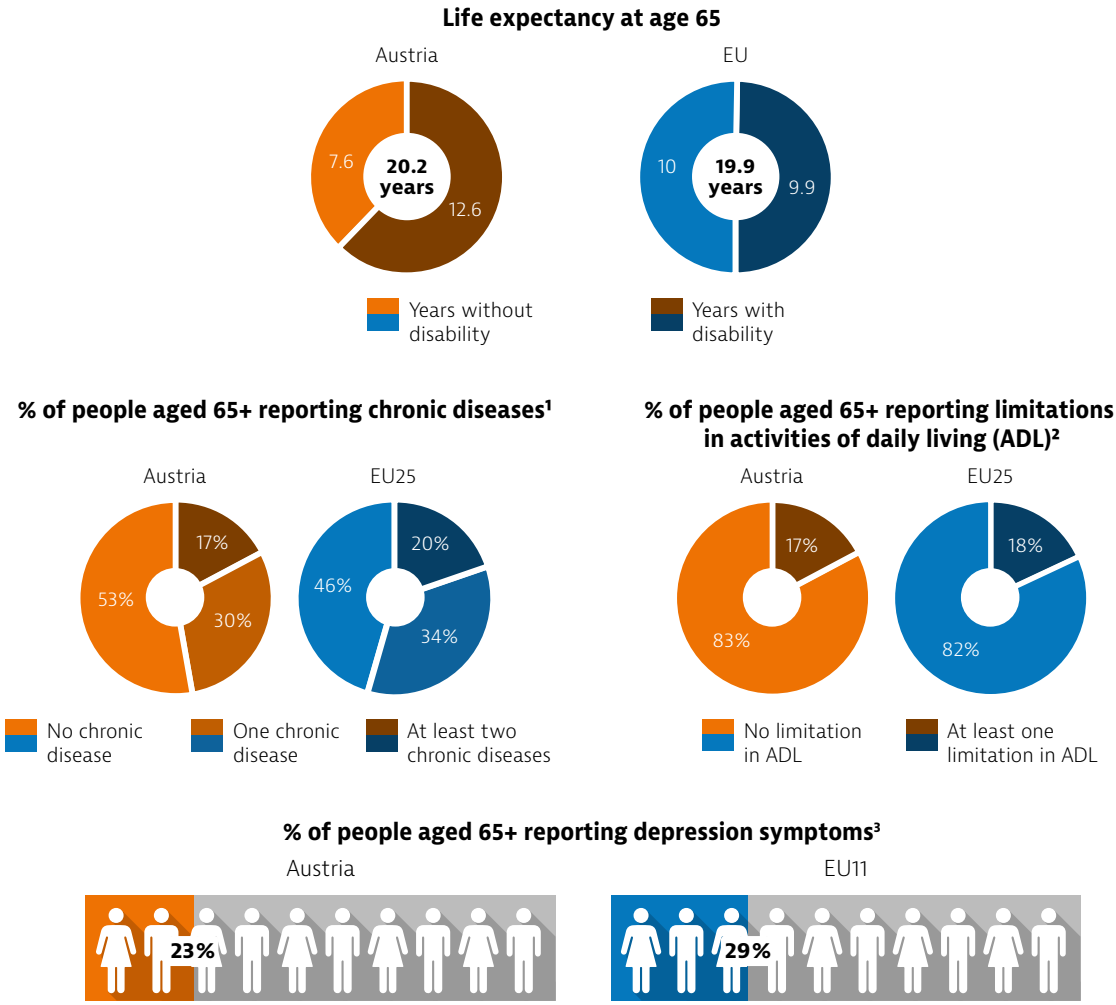
About 70 % of the Austrian population report being in good health, a share similar to the EU as a whole. Austria fares relatively well in terms of self-reported adolescent health. The proportion of adolescents who report high life satisfaction is above the EU average, while the proportion who report multiple health complaints more than once a week is significantly below the average (Inchley et al., 2016). Adolescents in more affluent families report higher life satisfaction in all countries, but this gap across income levels is small in Austria relative to other European countries. Interestingly, reporting of multiple health complaints more than once a week is more prevalent among affluent families in Austria, while the opposite is true in most other countries.

Many additional years are lived with some chronic diseases and disabilities

In contrast to overall life expectancy, healthy life years at birth are substantially below the EU average. In 2017, Austrians could expect to live 57 years free of disability at birth versus 64 years in the EU as a whole: women could expect to live 68 % of their lives free of disability (77 % in the EU) and men 72 % (81 % in the EU). Regional variation is also substantial, with shorter healthy life expectancy among people living in eastern than western parts of Austria (B-ZK, 2018a).

In 2017, Austrian people aged 65 could expect to live another 20 years, approximately the same as the EU average (Figure 4), but nearly two-thirds of these years are lived with chronic diseases and disabilities. This does not mean that people cannot live a normal life and carry on their usual activities: only one in six report some limitations in basic activities of daily living (such as bathing, dressing or getting out of bed) that may require long-term care. Also, the prevalence of chronic diseases is below EU average and older Austrians are less likely to report symptoms of depression (23 % versus 29 % on average in other countries reporting this indicator).

Figure 4. Healthy life expectancy at age 65 is below the EU average



Note: 1. Chronic diseases include heart attack, stroke, diabetes, Parkinson's disease, Alzheimer's disease and rheumatoid arthritis or osteoarthritis. 2. Basic activities of daily living include dressing, walking across a room, bathing or showering, eating, getting in or out of bed and using the toilet. 3. People are considered to have depression symptoms if they report more than three depression symptoms (out of 12 possible variables).
Source: Eurostat Database for life expectancy and healthy life years (data refer to 2017); SHARE survey for other indicators (data refer to 2017).

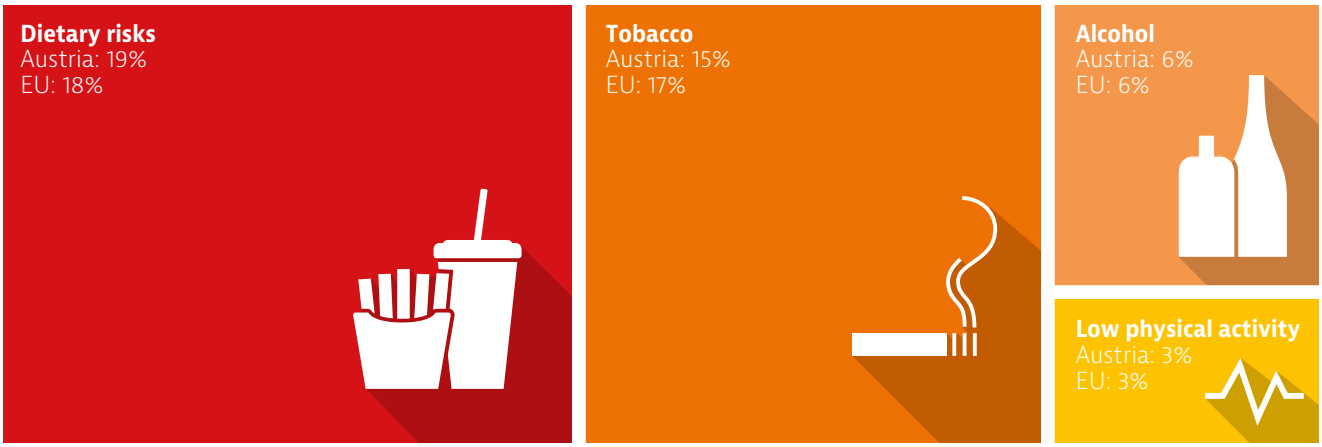
3 Risk factors

Behavioural risk factors are a major driver of mortality

Around 40 % of all deaths in Austria in 2017 can be attributed to behavioural risk factors, including dietary risks, tobacco smoking, alcohol consumption and low physical activity (Figure 5). This proportion is close to the 39 % EU average.

Around 19 % (15 000) of all deaths in 2017 were attributed to dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption). Smoking (including direct and second-hand smoking) was estimated to account for another 15 % (12 000) of all deaths. About 6 % (4 500) of all deaths were attributed to alcohol consumption and 3 % (2 500) to low physical activity.

Figure 5. About 40 % of all deaths can be attributed to modifiable lifestyle risk factors



Note: The overall number of deaths (31 000) related to these risk factors is lower than the sum of each one taken individually (35 000) because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable consumption and high sugar-sweetened beverages consumption.
Source: IHME (2018), Global Health Data Exchange (estimates refer to 2017).

Smoking is now more prevalent in Austria than in most EU countries

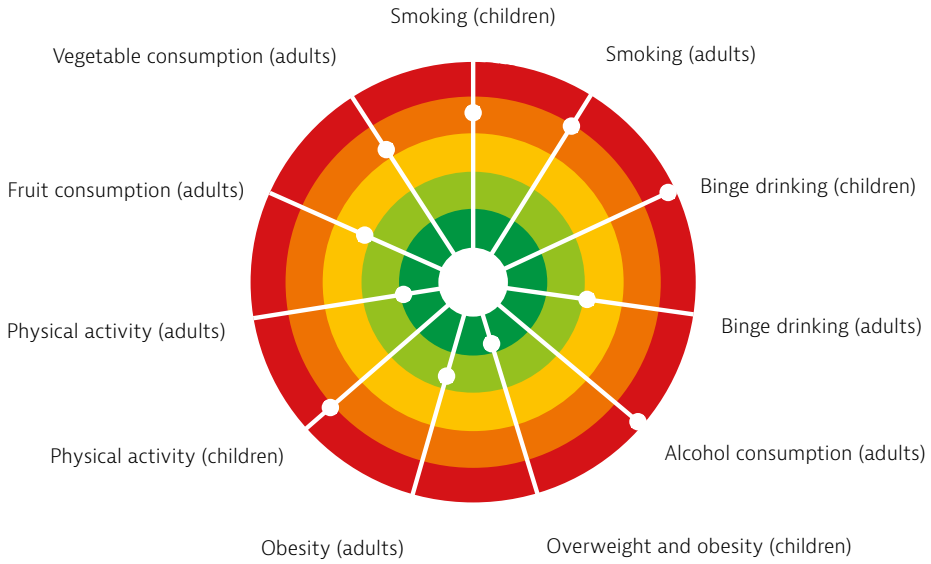
While smoking-related mortality is below the EU average, smoking rates among Austrian adults have not declined over the past two decades and smoking is now more prevalent than in most other EU countries. The persistent high prevalence results from increased smoking rates among women, offsetting the reduction among men. On the other hand, smoking rates among 15-year-olds have declined, although they remain higher than in most other EU countries. Austrian policies to discourage smoking are detailed in Section 5.

Overweight, obesity and unhealthy diets represent important public health issues

Overweight and obesity rates have increased; unhealthy diets and low physical activity among adolescents may partly explain these trends. The rate of obesity among adults increased from 12 % in 2006 to 15 % in 2017, and around four out of ten adults report that they do not eat at least one vegetable or fruit every day. On the other hand, Austrian adults are among the most physically active in the EU.

The rate of overweight and obesity among 15-year-olds has also risen to reach 15 % in 2013-14, but it remains substantially below most other EU countries (Figure 6). The proportion of 11- and 13-year-olds who report daily fruit consumption is higher than the average across the EU, and the difference between affluent and less affluent families is smaller than in most countries (Inchley et al., 2016). Adolescent girls report particularly low physical activity: only 5 % of 15-year-old girls reported doing at least moderate physical activity each day in 2013-14, compared with 18 % of boys. Adolescents in affluent families are less physically active than those in less affluent families, while the opposite is true in many other countries (Inchley et al., 2016).

Figure 6. Alcohol and tobacco, unhealthy diets and lack of physical activity are major risk factors



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.
Source: OECD calculations based on ESPAD survey 2015 and HBSC survey 2013-14 for children indicators; and EU-SILC 2017, EHIS 2014 and OECD Health Statistics 2019 for adults indicators.

Alcohol consumption remains an important risk factor

Overall alcohol consumption per capita has decreased since 2000, but it remains far above the EU average. Data from the RARHA project comparing alcohol consumption across EU countries revealed above-average rates of heavy episodic drinking (binge drinking)[1] in Austria for both men and women (Moskalewicz, Room & Thom, 2016). As in all EU countries, binge drinking is more common among men (one in four in 2014) than among women (about one in eight).

Alcohol consumption among adolescents is also more prevalent than in other countries. The proportion of adolescents who engage in regular binge drinking is higher in Austria than in most other EU countries, and there is hardly any difference between girls and boys. More than half of 15- and 16-year-olds reported binge drinking in the past month in 2015, compared with an EU average of about 40 %. Although early alcohol use decreased substantially between 2002 and 2014, it remained above average in 2014. As in most countries, early alcohol use is more prevalent among adolescents in affluent families (Inchley et al., 2018).

Social inequalities in risk factors contribute to inequalities in health

Many behavioural risk factors in Austria are more common among people with lower education or income levels. In 2014, more than a quarter of adults (27 %) who had not completed secondary education smoked daily, compared to only 15 % among those with tertiary education. In the same vein, almost 20 % of people without secondary education were obese in 2017, compared to only 10 % among those with higher education. The higher exposure of socially disadvantaged groups to risk factors contributes to health inequalities. Interestingly, however, this pattern does not hold true when it comes to drinking: both regular and binge drinking are more prevalent among people with higher education and incomes (B-ZK, 2018b).

1: Binge drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults, and five or more alcoholic drinks for adolescents.

4 The health system

Austria's health system is complex. The federal government is responsible for the legislative framework, including regulation of social health insurance (SHI). SHI funds have operational responsibility for ambulatory and rehabilitative care (outside hospitals) and outpatient medicines, and they negotiate contracts with providers. The states (Länder) regulate hospital care in their jurisdictions within the framework defined by federal legislation and are mainly responsible for the organisation and financing of inpatient and outpatient care in hospitals. Financing is mixed and fragmented because SHI funds, the federal government, the Länder and municipalities all contribute to the health budget.

Continued reform efforts have improved health system governance

Fragmentation of organisation and financing has been addressed to some extent since 2012 through the introduction of the new 'target-based governance' system within a framework of broader reforms. All important actors – the federal government, SHI funds and the Länder – are now part of the Target-Based Governance Commission (B-ZK), the supreme decision-making body that defines targets for the health system and negotiates formal agreements between stakeholders (Box 1). These national-level agreements are legally binding and provide the basis for target-based governance agreements at the Länder level.

In addition, a structural reform to merge the 21 existing SHI funds into five is ongoing. Most notably, nine regional funds are merged into one, which will cover nearly 80 % of the Austrian population from January 2020. The main objective of the new structure is to align insurance coverage and reduce administrative costs. However, the Austrian Court of Auditors and experts have voiced doubts as to whether the merger will lead to the reduction in administrative costs announced by the government. Critics have also pointed out that coverage will not be aligned across all insurance funds because separate funds will remain, for example, for civil servants and self-employed people.

Health spending is high, but expenditure growth has been below the EU average

Spending on health is high in Austria (Figure 7). Current health expenditure per capita was almost EUR 3 900 in 2017 (adjusted for differences in purchasing power), about EUR 1 000 higher than the EU average. Expenditure growth has recently been similar to the EU average in absolute terms and as a share of GDP.

After adjusting for inflation, current health expenditure increased on average by 1.4 % per year between 2009 and 2017 (1.5 % in the EU). Meanwhile, the share of GDP spent on health increased from 10.2 % in 2009 to 10.4 % in 2017 (compared to an increase from 9.7 % to 9.8 % in the EU). A global budget cap for public spending on health was introduced as part of the target-based governance reforms (see Box 1), and growth has been below the target since its introduction. The share of out-of-pocket (OOP) payments (19.2 % of health expenditure in 2017) is higher than the EU average (15.8 %) – mostly related to medicines, long-term care and dental care – but has remained stable since 2010 (see Section 5.2).

SHI funds finance the largest share of health expenditure (44 % in 2017), but direct government spending – mostly contributions by the Länder for inpatient care – also constitutes a large share (30 %). There is no competition between SHI funds as

Box 1. Major reforms are being implemented as part of target-based governance agreements

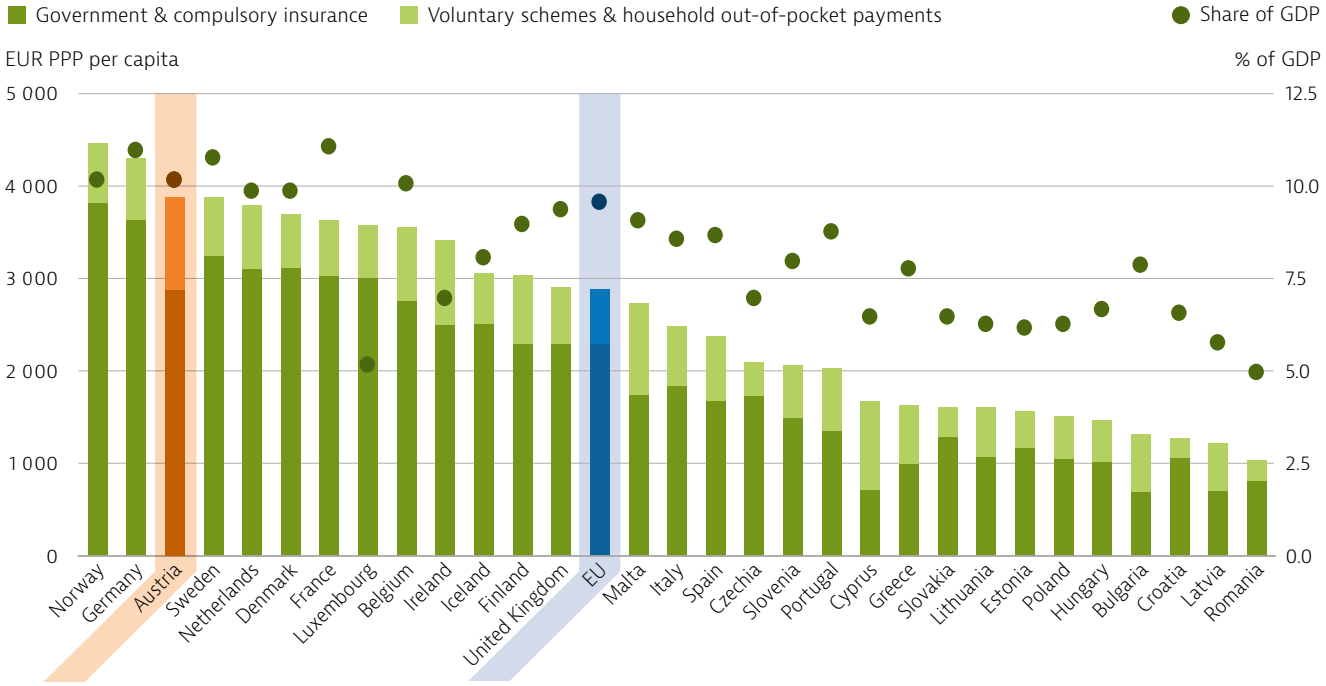
The first target-based governance agreement was concluded in 2013 and outlined a reform agenda for a four-year period (2013-16). In 2017, the B-ZK concluded a second agreement, which defines goals for 2017-2021 (BMASGK, 2018). Almost all ongoing health reforms in Austria – except the merging of SHI funds – are linked to these agreements.

The first agreement defined financial targets and targets for health care structures, processes and outcomes. The initial financial target was to bring down growth[2] of public spending on health to 3.6 % per year by 2016, followed by a reduction to 3.2 % by 2021 in the second agreement. Another important target was the development of a new primary health care approach, which ultimately led to the adoption of the 2017 Primary Health Care Act. The second agreement mandates the establishment of 75 multidisciplinary primary health care units and focuses on implementation, in addition to supporting health literacy and health promotion.

2: Growth rates are based on current prices and not adjusted for inflation.

coverage is determined by occupation and/or place of residence. Insurance contributions are set (for most people) at 7.65 % of gross income, shared between employer and employee (to a maximum monthly contribution of EUR 392 in 2018). All SHI funds cover broadly the same benefits, and several steps have been taken since 2017 to harmonise benefits further, but differences remain among funds for specific professions – for example, with regard to user charges or co-payments for medical devices (see Section 5.2).

Figure 7. Austria spends much more on health than most other EU countries

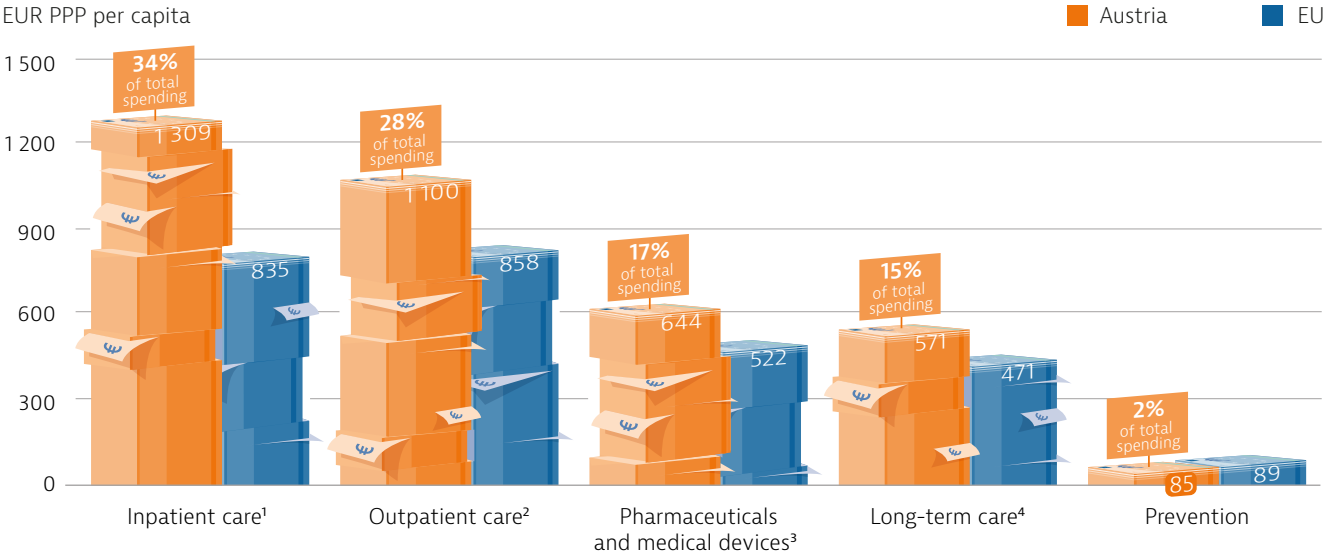


Source: OECD Health Statistics 2019 (data refer to 2017).

Spending on inpatient care is markedly above the EU average

Health spending is highly concentrated on inpatient care: Austria spends more than EUR 1 300 per capita, adjusted for differences in purchasing power (Figure 8) – far above the EU average (EUR 835) and exceeded only by Luxembourg. The share spent on inpatient care (33.8 % in 2017) has only declined by 0.8 percentage points since 2010, despite ongoing reforms to strengthen primary and ambulatory care. By contrast, Austria spends only EUR 85 per capita on prevention, slightly less than the EU average.

Figure 8. Austria spends almost EUR 500 per capita more on inpatient care than the EU average



Note: Administration costs are not included. 1. Includes curative-rehabilitative care in hospital and other settings; 2. Includes home care; 3. Includes only the outpatient market; 4. Includes only the health component.
Source: OECD Health Statistics 2019; Eurostat Database (data refer to 2017).

Regional health funds pool resources for the financing of hospitals from federal authorities, the Länder and SHI funds, and pay hospitals using a variant of diagnosis-related groups (DRGs). SHI funds use a mixture of contact capitation and fee-for-service to pay office-based physicians with SHI contracts. Patients can also see physicians without SHI contracts, but must pay out of pocket and are reimbursed only 80 % of what SHI would usually pay a physician with a contract for the same service. The proportion of physicians without SHI contracts has increased in recent years and accounted for 55 % of all office-based physicians in 2018. Although reliable figures on activity levels are not available (many are also employed in hospitals and earn supplementary income from private practice), the increase in recent years raises concerns about social and regional inequalities (see Section 5.2).

Austria has the second highest numbers of hospital beds and of physicians in the EU

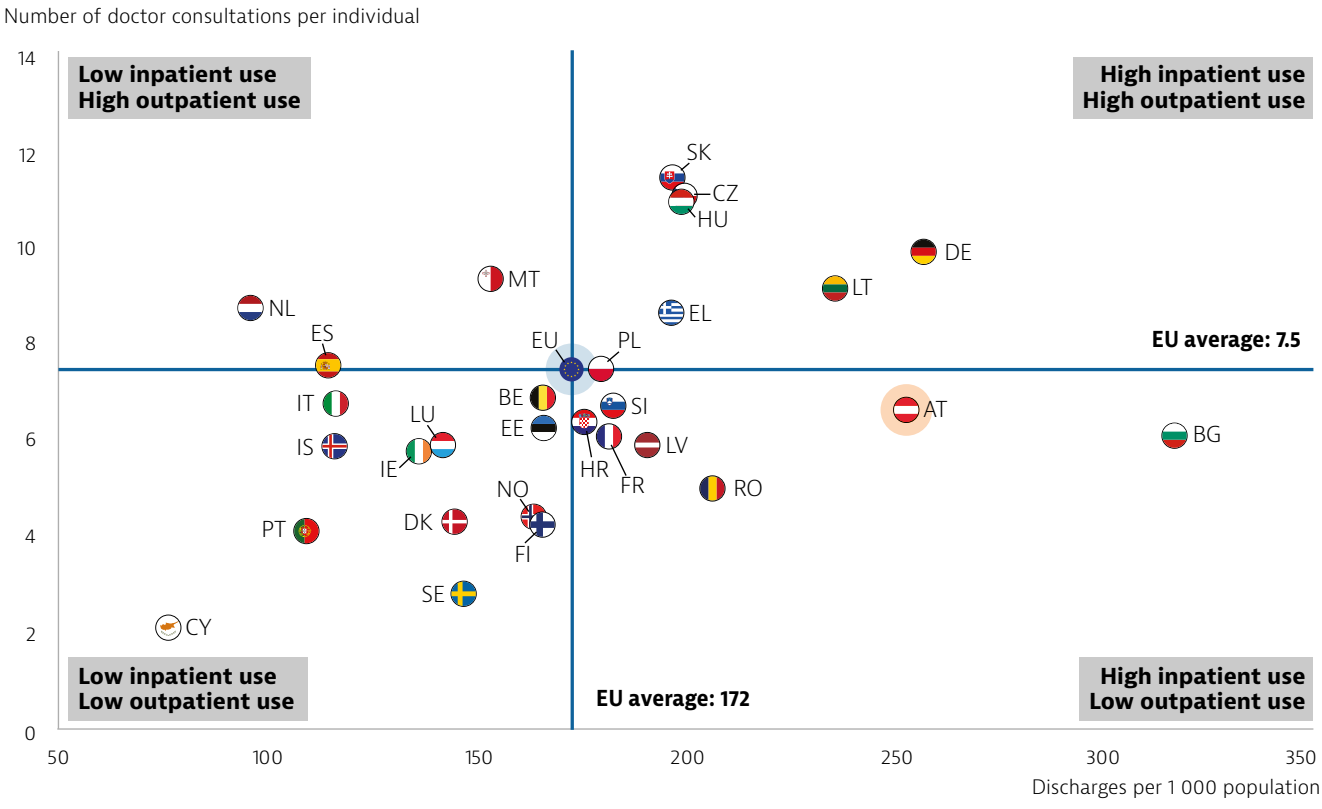
Austria had 7.4 acute care beds per 1 000 population in 2017, 46 % more than the EU average (5.1 per 1 000) and the third highest after Germany and Bulgaria. However, between the start of the target-based governance system in 2013 and 2017, bed numbers fell by 3.5 %, a reduction similar to the EU average. The density of major medical equipment (CT, MRI and PET scanners) is above average.

Austria has 5.2 physicians per 1 000 population – considerably more than the EU average (3.6 per 1 000) and the second highest after Greece. The number has increased by nearly 35 % since 2000, mainly driven by an increasing number of specialists, while the proportion of general practitioners (GPs) is now one of the lowest in the EU (15 % of all physicians). The number of medical graduates has declined by about one-third since 2007, posing challenges for sustaining accessibility of physicians (see Section 5.2). A quota system for medical studies, designed primarily to restrict the number of foreign students who may return to practice in their country of origin after graduation, could have contributed to this trend. Several measures have been taken in recent years to improve the skills mix and counter a further reduction in the share of GPs. However, these reforms are yet to produce effects.

Reforms are under way to reduce overreliance on hospitals and strengthen primary care

Provision of health services is characterised by free choice of provider and unrestricted accessibility of all levels of care (GPs, specialists and hospitals). Use of inpatient services is very high, and Austria has one of the highest hospital discharge rates in the EU (Figure 9). Important goals of the current federal target-based governance agreement are to reduce overreliance on hospitals and to strengthen primary care (see Section 5.3).

Figure 9. Austria has very high inpatient service use but below average outpatient service use



Note: For Austria, the number of consultations is underestimated as only consultations reimbursed by SHI are included; data for doctor consultations are estimated for Greece and Malta.
Source: Eurostat Database; OECD Health Statistics (data refer to 2016 or nearest year).

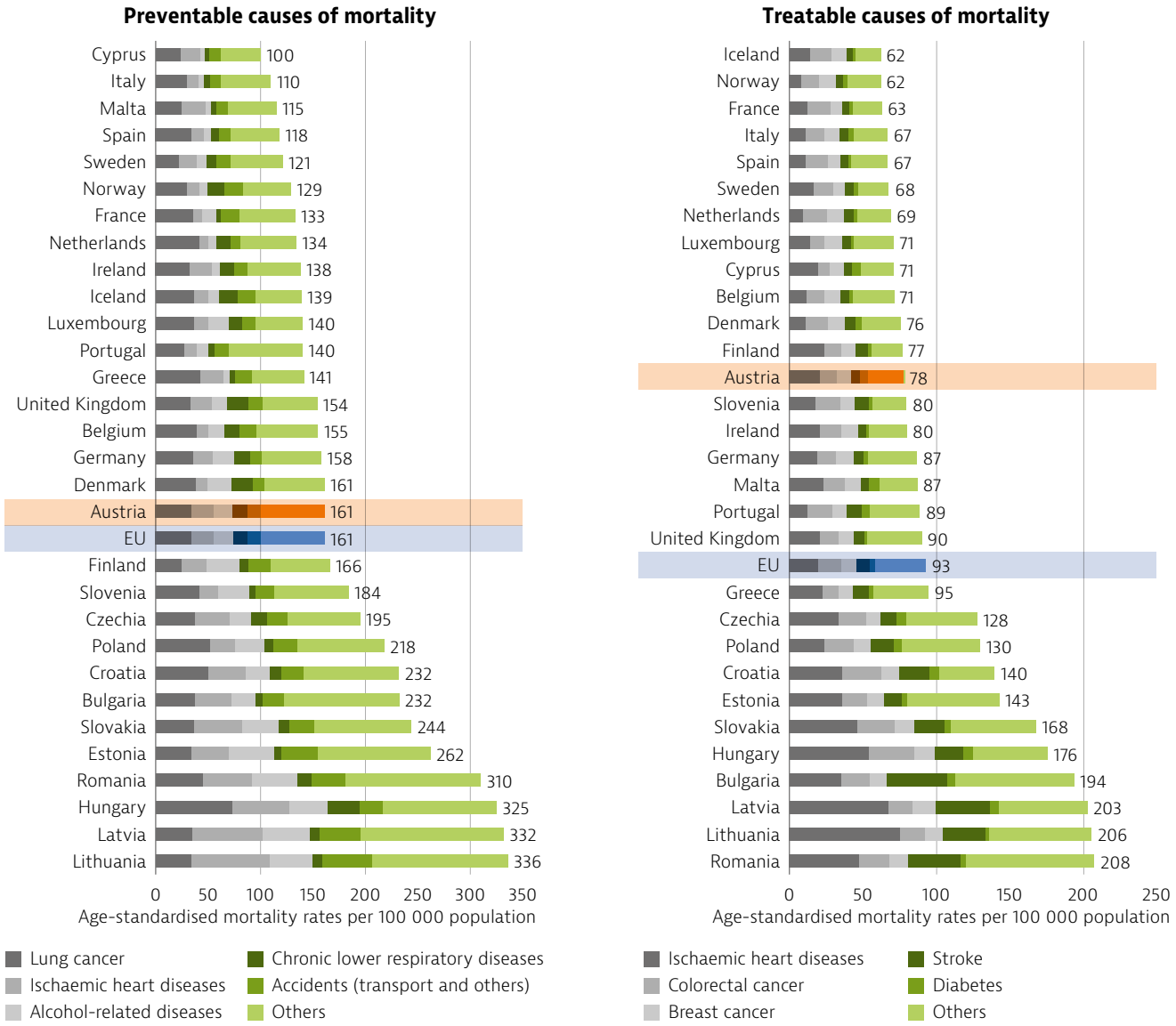
5 Performance of the health system

5.1. Effectiveness

Mortality from treatable causes is lower than in most EU countries

Austria reports low mortality from treatable causes (Figure 10), indicating that the general effectiveness of the health system is good. Nevertheless, more than 12 000 deaths could have been avoided in Austria in 2016 through effective public health and prevention interventions, and nearly 6 000 through more effective and timely health care. Lung cancer, ischaemic heart disease and alcohol-related conditions are the most important preventable causes of death.

Figure 10. Mortality rates from treatable causes are lower than in most other EU countries



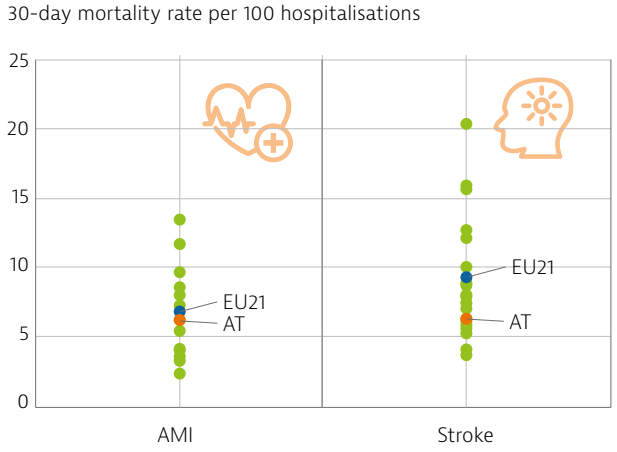
Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Mortality from treatable (or amenable) causes is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.
Source: Eurostat Database (data refer to 2016).

Austria performs well in acute care, but the number of avoidable hospitalisations remains high

Indicators suggest that acute care in Austrian hospitals is as or slightly more effective than in most other EU countries. While mortality following admission for acute myocardial infarction (AMI) has improved in recent years and is now close to the EU average, mortality following admission to hospital for stroke is substantially below the EU average (Figure 11). Austria also reports good performance of cancer care: five-year survival rates for people diagnosed with colon, lung, breast and prostate cancer are above EU averages.

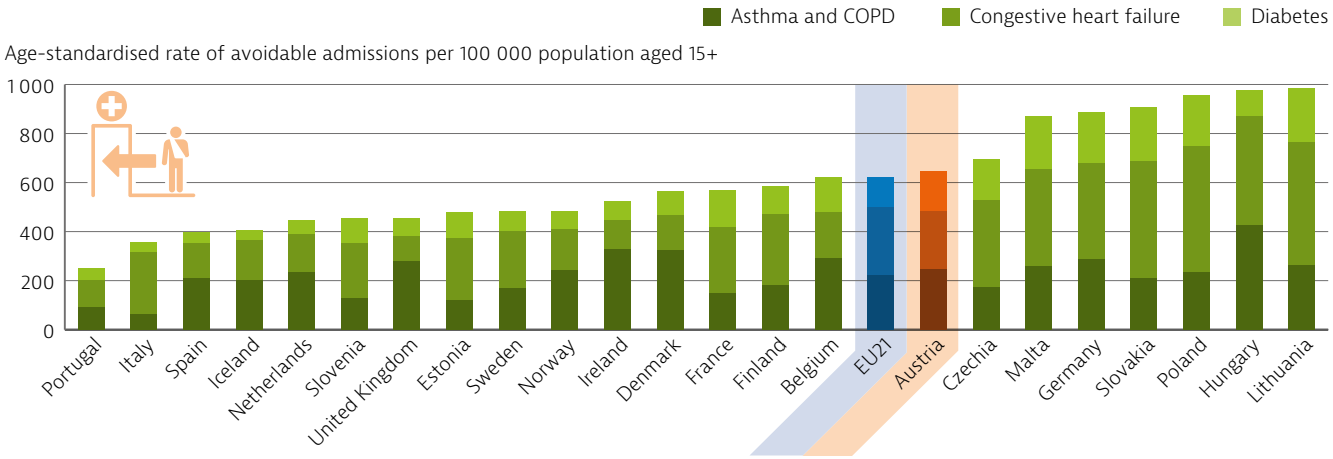
In contrast, Austria continues to have high rates of hospitalisation for chronic diseases amenable to primary care. In particular, admission rates for asthma, chronic obstructive pulmonary disease (COPD) and diabetes, which do not require hospital admission if well managed in primary care, are slightly above the EU averages (Figure 12). While admissions for asthma and COPD have decreased more rapidly than in the EU as a whole and admissions for asthma are now below the average, admissions for COPD are still above the average.

Figure 11. Hospitals provide high-quality treatment for people requiring acute care



Note: Figures are based on admission data and have been age-sex standardised to the 2010 OECD population aged 45+ admitted to hospital for AMI and ischaemic stroke.
Source: OECD Health Statistics 2019 (data refer to 2017 or nearest year).

Figure 12. Avoidable hospital admissions for chronic diseases remain slightly above the EU average



Source: OECD Health Statistics 2019 (data refer to 2017 or nearest year).

Cancer screening rates are relatively high, but gaps remain in vaccination coverage

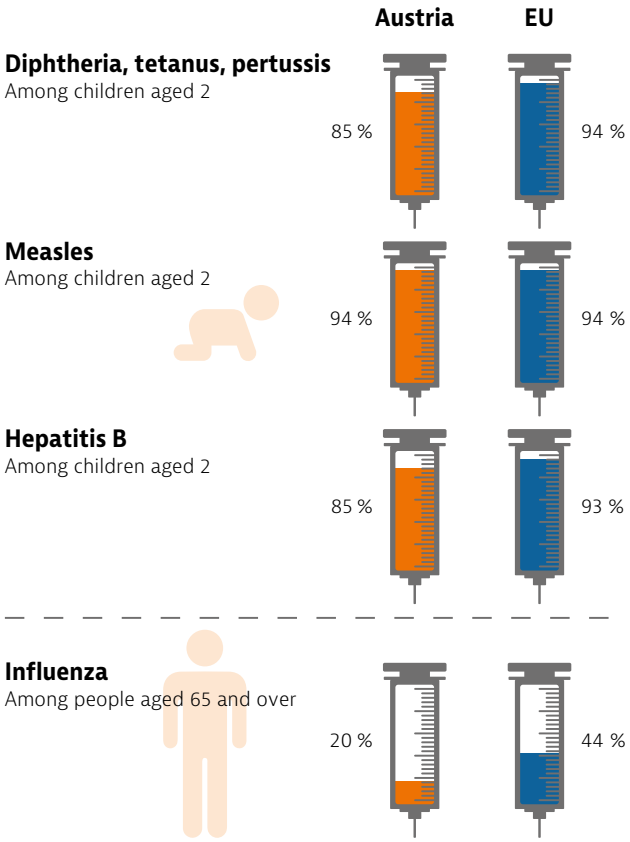
Austria generally performs relatively well in early disease detection. In 2014, 73 % of women aged 50-69 were estimated to have been screened for breast cancer within the past two years, well above the EU average of 61 % but below countries such as Spain and Portugal (which report screening rates of 80 % or more). In the same year, 87 % of women aged 20-69 were estimated to have been screened for cervical cancer, higher than in any other EU country.

Vaccination coverage among children aged 2 for diphtheria, tetanus and pertussis was well below the EU average in 2018 (Figure 13). The immunisation rate for measles among children aged 2 nearly met the WHO 95 % target but was below 95 % for the second dose. Coverage varies by age group but is generally lower for the second dose, despite availability of measles vaccines free of charge and without age restriction in public vaccination centres (BMASGK, 2019). In 2015, more than 300 cases of measles were reported (36 cases per 1 000 000 population); rates declined to 3/1 000 000 in 2016 but increased again to 9/1 000 000 in 2018. Data from 2014 suggest that only

20 % of people aged 65 and over were vaccinated for influenza. This is substantially below the EU average of 44 % and even further from the WHO target of 75 %.

Data on immunisation coverage are based on simulation models (BMASGK, 2019) and should be interpreted with caution, but may improve in the future with the introduction of electronic personal vaccination files. While the reporting of measles cases has sparked some debate about vaccination coverage, no changes to vaccination policy are currently planned.

Figure 13. Coverage is high for recommended childhood vaccines but low among elderly people



Note: Data refer to the third dose for diphtheria, tetanus, pertussis and hepatitis B, and the first dose for measles.
Source: WHO/UNICEF Global Health Observatory Data Repository for children (data refer to 2018); OECD Health Statistics 2019 and Eurostat Database for people aged 65 and over (data refer to 2017 or the nearest year).

Lifestyle-related risk factors remain public health concerns

Unhealthy lifestyles are an important risk factor in the Austrian population. Tobacco and alcohol consumption, in particular, remain above EU averages. Other concerns include the lack of physical activity and unhealthy diets, such as high consumption of sugar and salt, and related increases in obesity (see Section 3).

Policies to discourage smoking are more limited in Austria than in many other EU countries. The legal age for smoking was increased from 16 to 18 in January 2019. While tobacco advertising and smoking in cars in the presence of children are prohibited, a general indoor smoking ban in restaurants, bars and other establishments providing hospitality has been delayed. Initially enacted in 2015 and due to come into force in May 2018, it was subsequently reversed. The reversal allows establishments to continue to permit smoking indoors if they only have a single room for customers that is smaller than 50m² and is designated as a smoking area or, if this area threshold is exceeded, if they provide separate rooms for smokers and non-smokers. A new ban is due to come into force in November 2019.

As part of the Austrian health targets, the government defined a comprehensive action plan to encourage physical activity (BMGF, 2017). The plan laid out a broad range of measures for the general population and more specifically for four age groups (children, adolescents, adults and senior citizens), as well as process-related implementation indicators.

While Austria has high health expenditure, only 2.2 % of total expenditure was spent on prevention in 2017, compared with 3.1 % in the EU. However, spending on prevention grew at an average of 1.6 % per year between 2009 and 2017, slightly above the growth of 1.4 % for total health expenditure (in real terms).

5.2. Accessibility

Population coverage is near-universal

The Austrian health system provides near-universal population coverage, with 99.9 % of the population covered by SHI in 2017 (OECD, 2018) (see Section 4). SHI is mandatory for everyone in formal employment and self-employed people. Coverage also extends to dependent family members of those covered and children up to the age of 18 (or, if in full-time education, up to the age of 27), people who are retired and people registered as unemployed or receiving social security benefits. People without mandatory coverage, such as part-time workers with a monthly income below a threshold and students older than 27, may enrol voluntarily with one of the SHI funds. As a result of policies to extend coverage for people without stable employment, including registered asylum seekers and recipients of social security benefits, the number of uninsured people has declined in the past 15 years. However, a small number of people remain uninsured, including irregular migrants, students above the age limit for coverage with their parents and people without a history of formal employment (Fuchs, 2018).

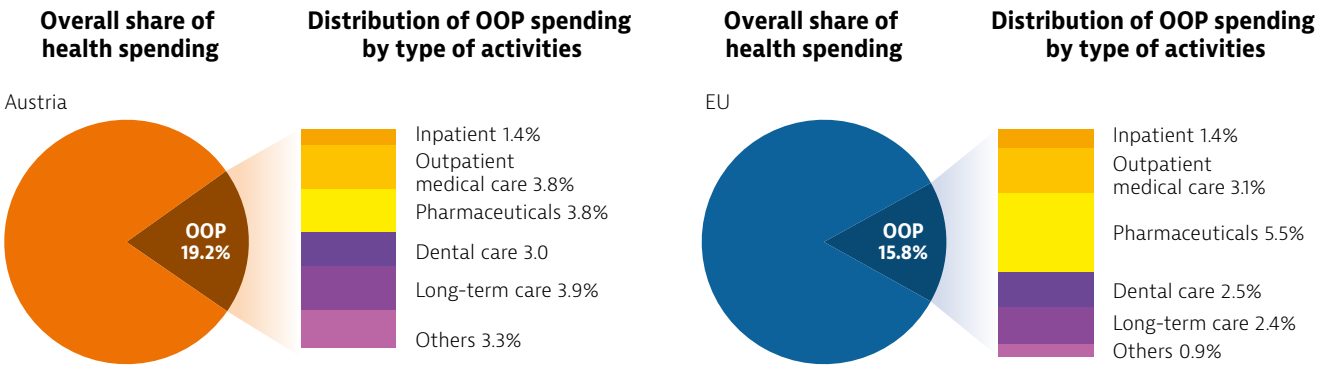
Unmet medical needs are low, despite comparatively high out-of-pocket expenditure

In 2017, OOP spending represented just under 19 % of total health expenditure in Austria, above the EU average (16 %; Figure 14) and higher than in other countries with similar levels of GDP, such as Denmark (14 %), Germany (12 %) and the Netherlands (11 %). Long-term care, medicines and outpatient medical care are the main drivers of OOP spending (representing nearly 4 % of total health spending each), followed by dental care (3 %).

Despite relatively high OOP spending, Austrians report one of the lowest levels of unmet medical needs due to costs, distance to travel or waiting times in the EU, with very little variation across income levels (Figure 15). This can be partly explained by various cost-sharing and prescription fee exemptions for vulnerable groups, such as patients with infectious diseases (e.g. hepatitis and HIV/AIDS), people on low incomes or receiving social security benefits and asylum seekers, as well as good accessibility of outpatient clinics in public hospitals. Further, the annual aggregate of prescription fees for medicines is capped for all at 2 % of personal income. However, the incidence of catastrophic OOP spending varies notably depending on the definition used.[3] When considering the 40 % of total household spending net of subsistence needs threshold, no more than 3 % of households report catastrophic spending on health, a proportion similar to other high-income EU countries. But 12 % of Austrian households faced OOP expenditure exceeding 10 % of their total household spending in 2015, an incidence of catastrophic spending above most high-income countries in the EU (Cylus, Thomson & Evetovits, 2018).

Orthodontic treatment, dental prostheses and oral hygiene treatment are poorly covered by SHI, leading to much higher income inequality in unmet needs for dental care than for other medical care, although coverage of serious orthodontic treatments for young people under 18 was expanded in 2014 (Czypionka, Röhrling & Six, 2018). Barriers to accessibility have also been identified for child and adolescent mental health services. Limited coverage of such services – leading to high OOP spending – is exacerbated by structural issues, such as low densities of some specialists, especially in rural areas.

Figure 14. OOP spending is mainly driven by outpatient pharmaceuticals and outpatient medical care

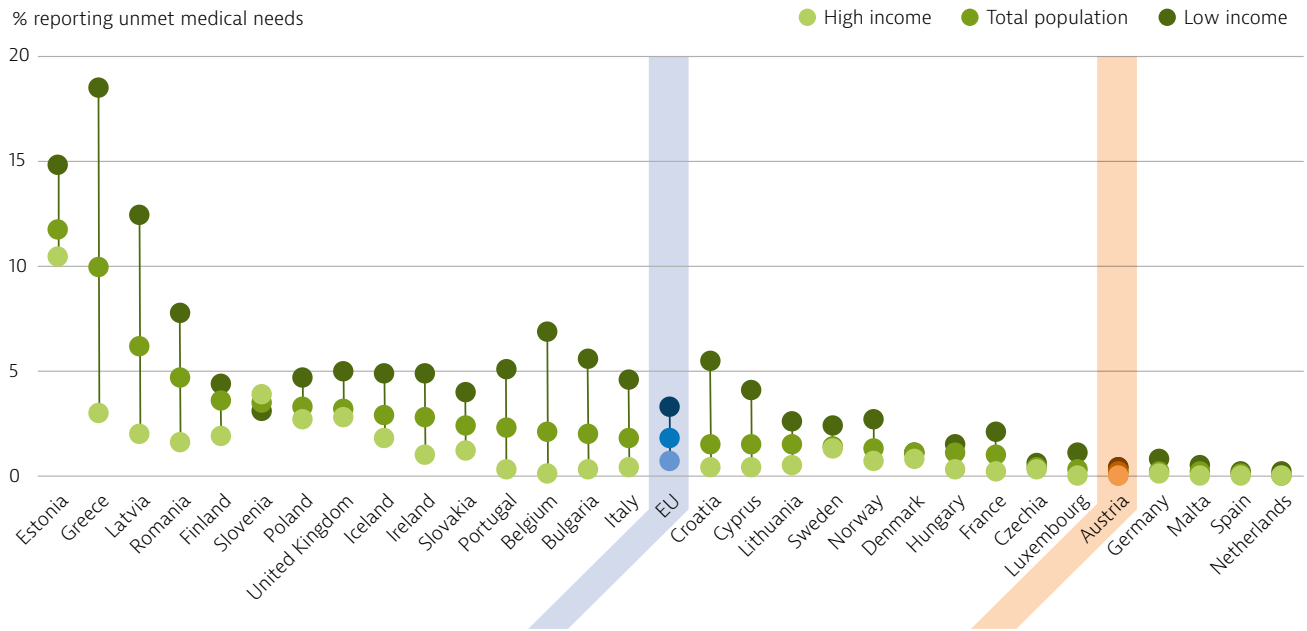


Source: OECD Health Statistics 2019 (data refer to 2017).

3: *Catastrophic expenditure is defined as household OOP spending exceeding 10% of the total household expenditure, or 40 % of total household spending net of subsistence needs (i.e. food, housing and utilities).*

Private voluntary health insurance (VHI) covered approximately 37 % of the population in 2017 (VVO, 2018), but accounted for only 5 % of total health expenditure. VHI is mainly supplementary, offering higher-quality accommodation in hospitals, increased provider choice and shorter waiting times for elective services. Although prioritisation of patients based on VHI status is not permitted, evidence shows that people with VHI access elective care in public hospitals more quickly (Czypionka, Röhrling & Six, 2018).

Figure 15. Austrian people report very low levels of unmet medical needs



Note: 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 2017).

Cost-sharing requirements constitute the main difference in coverage between SHI funds

Federal law defines the types of services covered by the minimum SHI benefit package, including a broad range of preventive, sickness and maternity benefits, so there is little variation in core service coverage between funds. There are no positive or negative lists. However, detailed catalogues of covered services provided outside hospitals are laid out in collective contracts between SHI funds and professional associations. These are specific to each collective contract, but are generally based on the guiding principle of the health system that services must be sufficient and appropriate but not exceed what is necessary. The most recent extension of the statutory benefit package was the repeal in 2017 of co-payments for children in hospitals. Although there is a list of covered medicines, SHI may also pay for medicines that are generally not covered, if approved for individual patients.

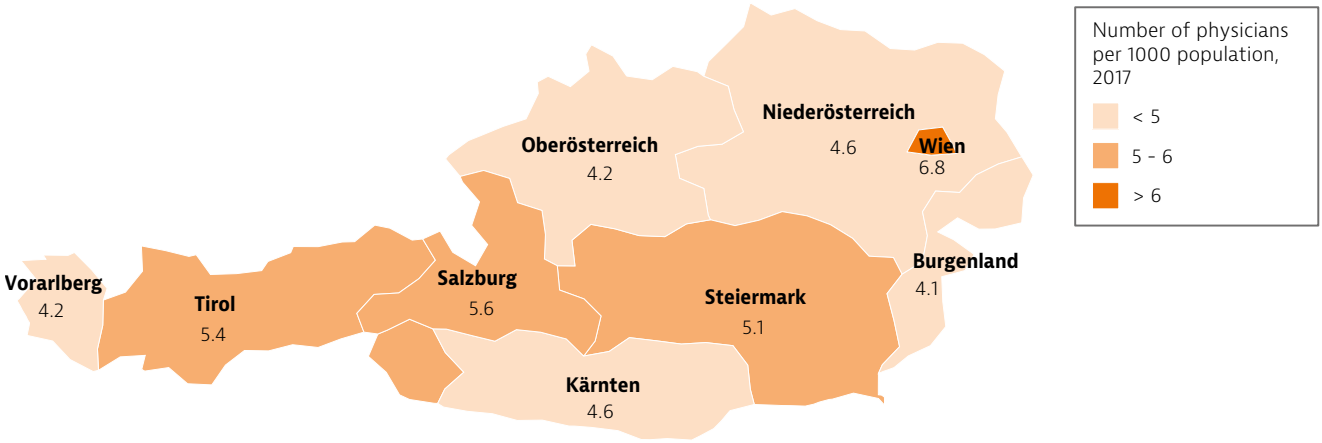
Cost-sharing requirements constitute the main difference in coverage between individual SHI funds. While cost-sharing is being harmonised among regional sickness funds, this has not yet been extended to the occupational sickness funds (e.g. for civil servants and self-employed people). Self-employed people generally face higher cost-sharing requirements than people insured with other SHI funds. User charges can also vary, for example, for therapeutic and medical aids, medical devices and psychotherapy. Beyond the minimum benefit package, insurance funds are also free to cover services such as cosmetic treatment, health consolidation measures and illness prevention or travel expenses of carers. Differences in service coverage between health insurance funds are expected to decrease further as a result of the merger of SHI funds (see Section 4) and a commitment to introduce a uniform collective contract between SHI and providers.

Workforce ageing and the increase in physicians without SHI contracts require action

Service availability and accessibility is generally very good. Self-reported unmet needs due to waiting times are close to zero. Also, the distribution of physicians is relatively well balanced across regions (Figure 16).

Geographic disparities mainly concern specialists with SHI contracts (e.g. neurologists, psychiatrists and radiologists), who tend to be concentrated in urban areas where their densities may be 2-3 times higher than in regions with the lowest density. Hospital outpatient departments partly counterbalance these disparities.

Figure 16. Physician densities are above the EU average, even in low-density regions

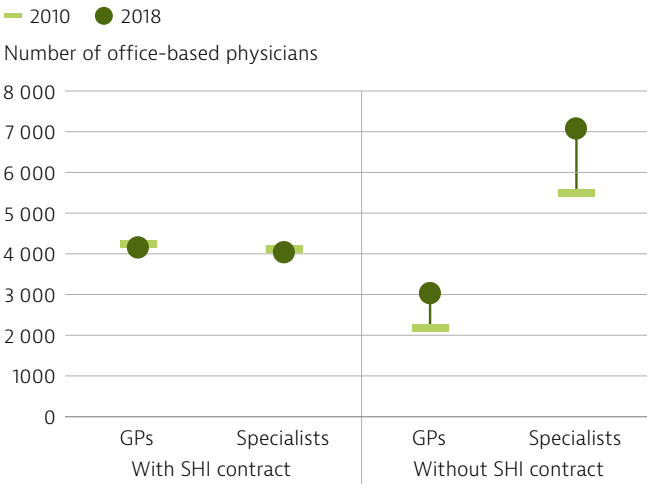


Source: based on Statistik Austria (2019) (data refer to 2017).

However, there are concerns that service availability will be negatively affected by the increasing number of physicians without SHI contracts and the stagnating number with contracts (Figure 17). This has been ascribed, among other reasons, to SHI cost-containment measures adopted in 2009. While SHI funds and medical chambers negotiate staffing plans for each region, physicians without SHI contracts can choose where to establish their practices. They can also set their prices freely, while SHI reimbursement for their services is limited to 80 % of the fee for physicians with SHI contracts. Increasing reliance on physicians without SHI contracts could therefore contribute to financial access barriers and geographical inequalities in service availability.

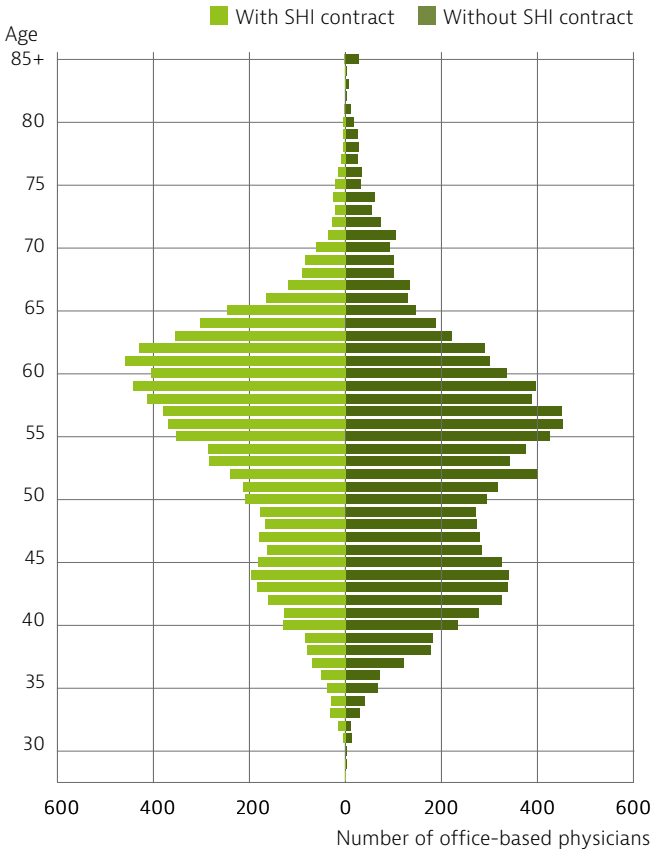
In addition, service availability could be negatively affected within the next 10-15 years by a wave of retirements among physicians. The current age distribution shows that many physicians – and especially those with SHI contracts – will retire soon (Figure 18).

Figure 17. The number of doctors with SHI contracts is stagnating



Source: based on Österreichische Ärztekammer (2019). Data represent the number of physicians registered on the last day of the year.

Figure 18. A large share of Austrian doctors will retire in the next 10 years



Source: authors based on Österreichische Ärztekammer (2019). Data refer to 31 December 2018.

Reforms aim to make primary care more effective and to attract more physicians

In addition to making primary care more effective, one of the objectives of the 2017 Primary Health Care Act (see Box 1 in Section 4) was to ensure equal and sustainable supply and distribution of physicians and other health care professionals and to make primary health care more attractive as a career offering multi-professional team work. Since 2017, a number of workforce policies have been put in place to address the unbalanced skill mix and open up opportunities for new models of service provision (Box 2).

A new register of health professionals was established in 2018, making registration mandatory for professionals that were previously exempted, including nurses and long-term care professionals. Data on the number and distribution of nurses working outside hospitals, which were hitherto lacking, are expected to become available in early 2020.

Box 2. Fostering collaboration and a skill mix in primary care for efficient provision

Austria relies strongly on GPs and specialists providing care in all settings. However, the ageing of physicians, the low number of medical graduates choosing general practice and the stagnating number of physicians with SHI contracts create a challenge for ambulatory care provision, in particular in primary care.

The 2017 Primary Health Care Act intended to overcome these imbalances by improving the skill mix and enhancing structural cooperation between GPs and other health care professionals. It aims to establish multidisciplinary primary health care units, which will comprise a core team of GPs, qualified nurses and practice assistants, responsible for patient orientation and coordination of care. The units may also include paediatricians and other professionals (physiotherapists or social workers). They may share physical premises or operate as networks of several distinct practices, cooperating closely with other providers (pharmacies, specialists, hospitals, nursing homes, schools, SHI etc.). By replacing solo practices with team-based care, working conditions are expected to improve (hours, flexibility, workload), attracting more health professionals to primary health care, and service provision to become more efficient.

Another innovation was the introduction in 2016 of second-level nurse assistants as a new profession. Training for qualified nurses will take the form of a bachelor's degree, which will gradually be introduced at universities of applied sciences by 2024.

5.3. Resilience[4]

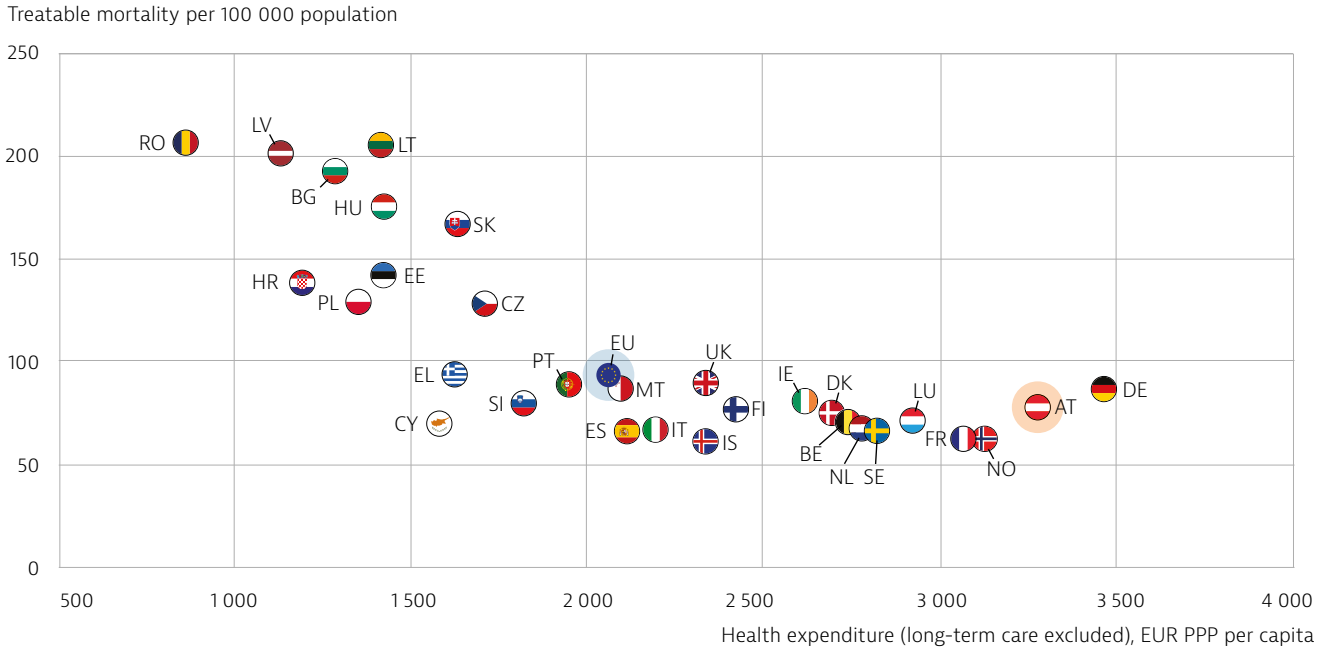
Population ageing will increase pressure on public spending on health and long-term care

As in other high-income EU countries, population ageing represents a medium- and long-term challenge to the fiscal sustainability of the Austrian health system (Council of the European Union, 2019). While spending on health and long-term care as share of GDP is expected to continue growing, the share of the working-age population to fund expenditure will decline. Accordingly, public spending on long-term care is projected to double as a share of GDP, from 1.9 % to 3.8 %, exceeding the EU average by nearly 1.1 percentage points (European Commission-EPC, 2018). Meanwhile, public spending on health care is projected to increase from 7 % of GDP in 2016 to 8.3 % by 2070. The proportion of the total population that is not of working age – i.e. children, young adults in education and senior citizens – on the other hand, will increase from about 30 % in 2015 to a projected 55 % by 2060. This is a similar trend to the EU average. Ensuring the sustainability of the health and long-term care sector is also part of the country-specific recommendation issued by the Council of the European Union in the context of the 2019 European Semester[5] (Council of the European Union, 2019).

Reliance on hospitals should be reduced and cost-effective use of medicines increased

Austria relies heavily on hospital services; this contributes to high levels of health expenditure relative to health outcomes achieved (Council of the European Union, 2019). In 2016, for instance, Austria reported the third highest number of hospital discharges per population among all EU countries, exceeded only by Bulgaria and Germany and about 50 % higher than the EU average. Inpatient care consumes a particularly high share of health spending (see Section 4). As a result, per capita health expenditure is high for the level of mortality from treatable causes (Figure 19). Many countries achieve similar or lower mortality rates at lower per capita cost, implying that efficiency gains are possible.

Figure 19. Austria has room to improve health system efficiency



Source: Eurostat Database; OECD Health Statistics 2019.

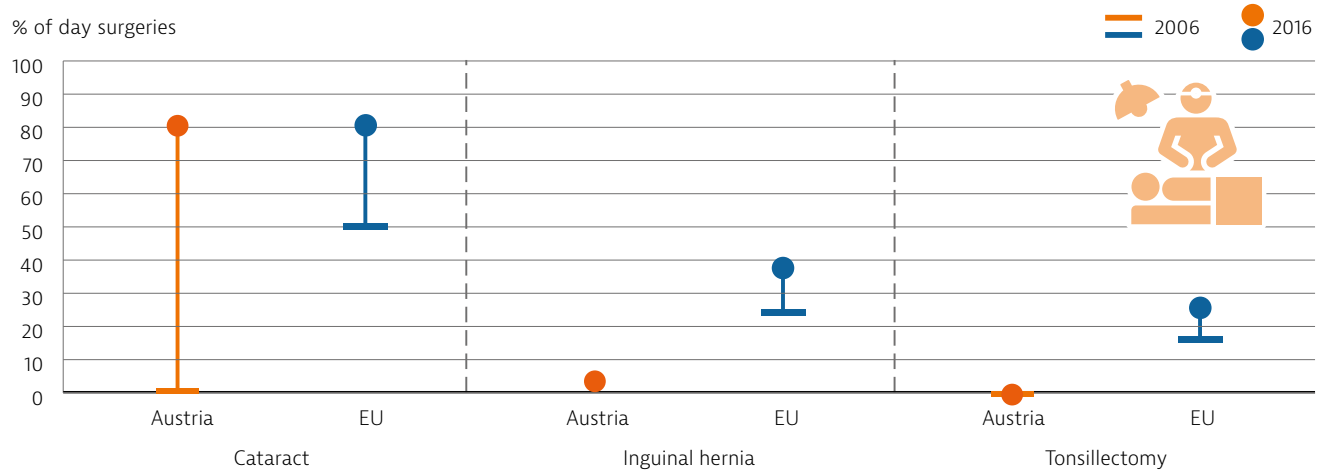
The high rates of avoidable hospitalisations for asthma, COPD and diabetes (see Section 5.1) suggest that improving primary care could contribute to reducing health expenditure costs. Another efficiency indicator is the share of outpatient and day-case interventions that can replace more expensive inpatient procedures without compromising health outcomes. The share of cataract surgeries performed as day surgery has increased markedly since 2000, closing the gap with the EU average (Figure 20), but the share remains below many other EU countries, where day surgery represents nearly all procedures.

4: Resilience refers to health systems' capacity to adapt effectively to changing environments, sudden shocks or crises.
5: In July 2019, the Council of the European Union issued Austria a country-specific recommendation to 'ensure the sustainability of the health, long-term care, and pension systems'.

In contrast, 29 % of tonsillectomies and 41 % of inguinal hernia repairs are performed as day cases in the EU, while both procedures are nearly exclusively performed in inpatient settings in Austria.

Efficiency could also be improved in pharmaceutical spending. The share of generics in total volume of medicines has increased only slowly since 2005, to 53 % by 2016. This is slightly above the EU average but is still far below the top performers, such as the United Kingdom (85 %) and Germany (81 %). In contrast to many countries, Austria does not permit prescribing by international non-proprietary name or generic substitution by pharmacists, so patients only receive generics if a specific generic product is prescribed.

Figure 20. The share of day surgeries in Austria remains below the EU average



Source: OECD Health Statistics 2018; Eurostat Database (data refer to 2000 and 2016, or nearest year).

Although there are institutions in Austria that evaluate health technology, health technology assessment (HTA) is not yet institutionalised as a routine process to inform coverage and pricing decisions related to goods and services covered by SHI, including medicines. These issues are under debate as part of the current reform agenda. In an effort to improve preparedness for the introduction of new and expensive medicines, Austria has joined the international BeNeLuxA initiative on horizon scanning (Box 3), HTA and price negotiations.

Austria does not currently publish provider-level data or a comprehensive atlas of variation in health care to help to identify and reduce inappropriate and ineffective care. For example, Austria has one of the highest hip and knee replacements rates in the EU, suggesting that some implants may not be medically

Box 3. Horizon-scanning capacity in the BeNeLuxA initiative

The BeNeLuxA initiative was started in 2015 and currently comprises five countries: Austria, Belgium, Ireland, Luxembourg and the Netherlands. It aims to improve accessibility of innovative medicines at affordable costs by improving processes for assessment, pricing and reimbursement. Participating countries exchange expertise, recognise HTA mutually or negotiate jointly with pharmaceutical companies to increase the bargaining power of payers.

In 2018, BeNeLuxA launched the International Horizon Scanning Initiative, joined by countries beyond the initiative. The data sources for horizon scanning may include registries of clinical trials, information from regulatory authorities, scientific literature and input from industry. The instrument would assess upcoming products based on their anticipated impact on health outcomes, the organisation of health systems and their potential costs to public payers.

More detailed predictive information is becoming necessary to manage the increasing costs of medicines. To prepare managed entry agreements, plan budgets and facilitate international cooperation, payers need to be able to identify forthcoming products that may have substantial impacts on their health systems.

necessary. The Austrian Inpatient Quality Indicators project is an initiative that makes secondary use of routine data from the DRG payment system to evaluate the quality of selected inpatient services. Provider-level data, however, are currently not published.

System fragmentation still impedes care integration and efficiency gains

The health system relies heavily on decentralised decision-making and self-governance by corporate entities. This creates stability but also fragmentation in financing and system governance, and inertia in preparing for future challenges. Since 2013, the target-based governance system brings together the main decision-makers (see Section 4). Reforms rely on joint initiatives of stakeholders within this structure and are implemented by working groups who are required to report progress indicators.

Strengthening primary care has been on the agenda for many years, but progress was slow in the past. Following an initial effort in the 2013 target-based agreement, the 2017 agreement and Primary Health Care Act provided a legal basis and an earmarked budget of EUR 200 million to establish 75 multidisciplinary primary health care units by 2021. These aim to improve accessibility and coordination of care, reducing avoidable hospital admissions (see Box 2). By the end of 2018, nine units were operational. A collective contract on the establishment of the units was signed between the Austrian Medical Chamber and SHI in April 2019.

A top-down approach based on the latest target-based agreement remains the main cost-containment mechanism and continues to cap overall public spending on health. The annual growth[2] target was reduced from 3.6 % in 2017 to 3.2 % for 2021. The agreement also sets targets to increase the use of information technology to improve coordination and increase efficiency. These include increasing the eHealth functionalities of the Austrian Electronic Health Record (ELGA) and implementation of additional eHealth tools, such as ePrescriptions and an electronic personal vaccination file, as well as extending the adoption of ELGA beyond public hospitals.

Nevertheless, fragmentation remains a defining feature of the Austrian health system and changes are incremental rather than transformative. Separate responsibilities and financing flows between state governments for hospitals and SHI for non-hospital outpatient care impede progress. Initiatives to improve care for the increasing number of people with chronic diseases, for example through integrated care and case management for multi-morbid patients, remain underdeveloped. Also, there is currently only one disease-management programme for diabetes. A structural quality standard has been formulated recently for integrated care of stroke patients and additional quality standards are in preparation for heart failure, colonoscopy and back pain.

6 Key findings

- Life expectancy in Austria has increased in recent years and remains above the EU average. However, Austrians spend less of their lives in good health than people in many EU countries. About 70 % of the population report being in good health, but this proportion is smaller among the lowest income groups. While low mortality from treatable causes suggests that health care is relatively effective, preventable mortality is higher than in many other EU countries.

- Behavioural risk factors remain a major driver of morbidity and mortality in Austria. Smoking among adults has not declined over the past two decades, and is now more prevalent than in most other EU countries. Progress with restricting smoking in public places has been slow, and a smoking ban in establishments that provide hospitality was delayed again to late 2019. Although alcohol consumption has decreased since 2000, it remains above the EU average.

- Health care coverage is near-universal, and accessibility of services is generally good. Austria is among the countries with the lowest self-reported unmet medical needs in the EU. Nevertheless, there are concerns that a wave of physician retirements and a stagnant number of physicians with social health insurance contracts might reduce service availability and accessibility in the future. Meanwhile, the number of physicians without contracts is increasing, particularly in urban areas; this may increase financial barriers to accessibility and have a negative effect on equity.

- The Austrian health system is characterised by decentralised decision-making and self-governance by corporate entities. To some extent, the coordination challenge is being tackled by a new governance structure since 2013, which brings together the most important actors – the federal government, social health insurance funds and regional governments. A reform to reduce the current 21 health insurance funds to five will take effect in 2020. It is intended to reduce administrative costs, although doubts have been raised that this will be achieved. Structural and financial fragmentation – for instance between hospitals and care provided by office-based physicians – continues to impede greater integration of care and efficiency gains. Programmes for patients with chronic diseases and multi-morbidity remain underdeveloped.

- Despite some improvements over the past decade, the number of avoidable hospitalisations for chronic conditions remains above the EU average. Primary care reforms had made only slow progress until recently, but are now under way. Nine multidisciplinary primary health care units were operational by early 2019. By the end of 2021, 75 units will aim to reduce reliance on solo-practising physicians to improve accessibility and coordination of care.

- Overall, the Austrian health system is comparatively costly, and spending remains highly concentrated in inpatient care. Some efficiency gains may be achieved through the reform of primary care, if this successfully reduces the avoidable use of inpatient services. Budget caps agreed between the main actors in the new governance system are currently the main cost-control mechanism. So far, public expenditure on health care has remained below these ceilings, while growth in spending on prevention has somewhat accelerated. However, without structural reforms it will be difficult to comply with these spending limits in the future. Further efforts are necessary to reduce reliance on hospitals and expensive curative care, while improving health promotion and prevention.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT	United Kingdom	UK

European Commission

State of Health in the EU
Country Health Profile 2019

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles 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, in cooperation with the European Commission.

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/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

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

The Commission is complementing the key findings of these country profiles with a Companion Report.

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

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