European Commission



State of Health in the EU

Austria

Country Health Profile 2021

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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 Systems Performance Assessment (HSPA).

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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 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in September 2021, based on data available at the end of August 2021.

Demographic and socioeconomic context in Austria, 2020

Demographic factors	Austria	EU
Population size (mid-year estimates)	8 901 064	447 319 916
Share of population over age 65 (%)	19.0	20.6
Fertility rate[1] (2019)	1.5	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	36 972	29 801
Relative poverty rate[3] (%, 2019)	13.3	16.5
Unemployment rate (%)	5.4	7.1

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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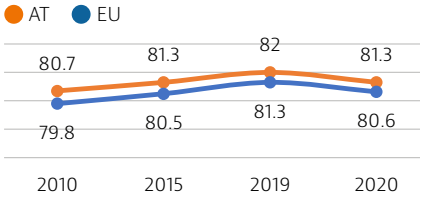
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1 Highlights

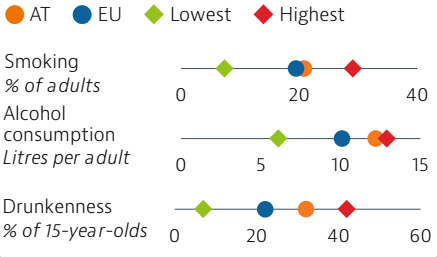
Life expectancy in Austria is higher than the EU average, but fell sharply in 2020 due to COVID-19 deaths. While the Austrian health system generally provides good access to high-quality care, the COVID-19 pandemic underscored some structural issues, including the need to pursue reforms to overcome fragmentation and strengthen primary care. A strong digital infrastructure offers Austria the potential to build a more integrated and resilient health system.



Life expectancy, years

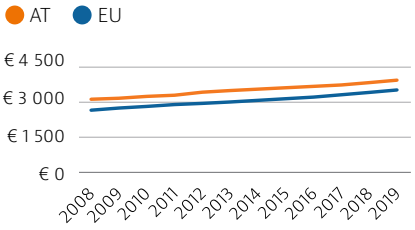
Health Status

Although life expectancy in Austria in 2020 was more than half a year higher than the EU average, it fell by 0.7 year compared with 2019 because of the COVID-19 pandemic. Even before the pandemic, gains in life expectancy in Austria had slowed considerably between 2010 and 2019.



Risk factors

About 40 % of all deaths in Austria in 2019 can be attributed to behavioural risk factors. Tobacco consumption among adults has fallen but remains slightly higher than the EU average. Alcohol consumption among adults in Austria is the second highest in the EU. Heavy alcohol consumption among adolescents is also higher than the EU average.



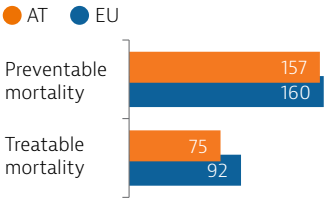
Per capita spending (EUR PPP)

Health system

Spending on health per capita in Austria was the third highest in the EU in 2019. Austria spends substantially more than most countries on hospital inpatient care, while spending on prevention is lower than average. It also has relatively high numbers of physicians and hospital beds. While three quarters of all health expenditure is publicly funded, direct out-of-pocket spending by households is higher than the EU average.

Effectiveness

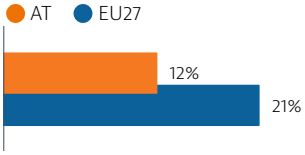
Mortality from preventable and treatable causes in 2018 was lower in Austria than the EU average. Nevertheless, Austria lagged behind many other EU countries on preventable mortality, suggesting that more could be done to scale up prevention and reduce risk factors for cancer and other leading causes of death.



Age-standardised mortality rate per 100 000 population, 2018

Accessibility

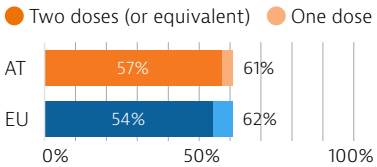
Access to health care is good in Austria, although COVID-19 created barriers to access. One in eight Austrians reported that they had forgone care during the first 12 months of the pandemic. Digital services helped to maintain access to care during the COVID-19 crisis: 35 % of Austrians reported that they used teleconsultation services during the first year of the pandemic, which was slightly lower than the EU average.



% reporting forgone medical care during first 12 months of pandemic

Resilience

Between March 2020 and August 2021, confirmed COVID-19 case numbers in Austria were similar to the EU average, although the death rate was lower. By the end August 2021, more than 60 % of the population had received at least one dose of a COVID-19 vaccine, and 57 % had received two doses or the equivalent. These proportions were close to the EU average.



Share of total population vaccinated against COVID-19 up to the end of August 2021

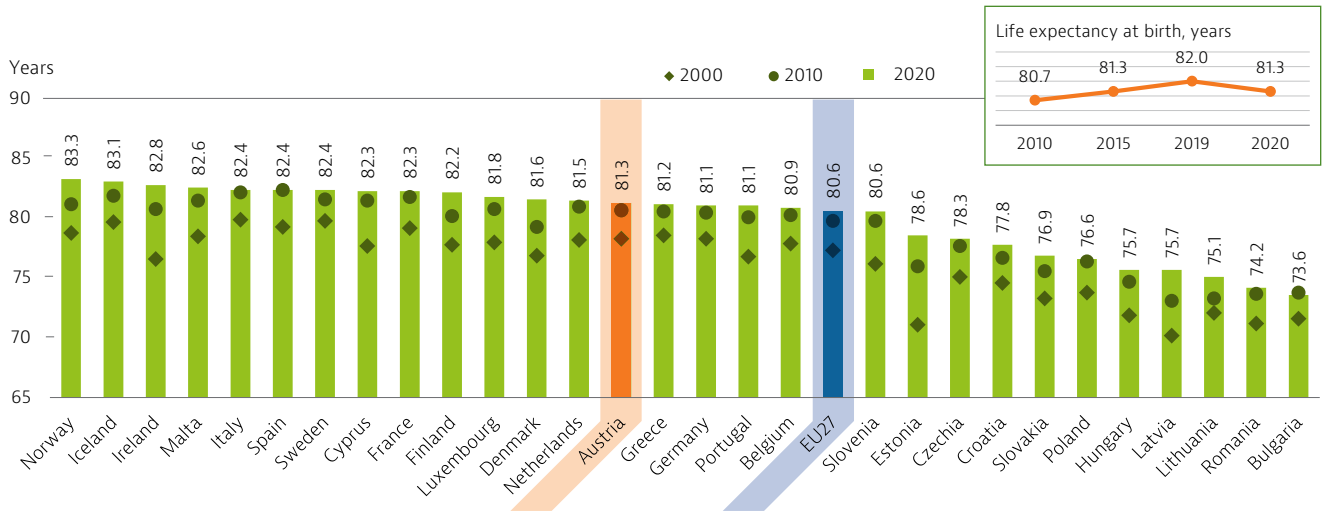
2 Health in Austria

Life expectancy is above the EU average, but fell by more than half a year in 2020 due to COVID-19

In 2020, life expectancy at birth in Austria was 81.3 years, which is higher than the EU average but about two years lower than in Norway and Iceland (Figure 1). Life expectancy in Austria fell by 0.7 year in 2020 due to the COVID-19 pandemic. This was the biggest reduction since the government began recording life expectancy in 1951.

Even before the pandemic, gains in life expectancy in Austria had slowed considerably between 2010 and 2019. This was also the case in several other western European countries. While the causes of this slowdown are not fully understood, it was in part related to increases in mortality rates from some respiratory diseases, Alzheimer's disease and diabetes among older people. The gender gap in life expectancy was 4.7 years in 2020 (78.9 years for men, 83.6 years for women), which is slightly less than the EU average (5.5 years).

Figure 1. Life expectancy remains above the EU average, despite the sharp reduction in 2020

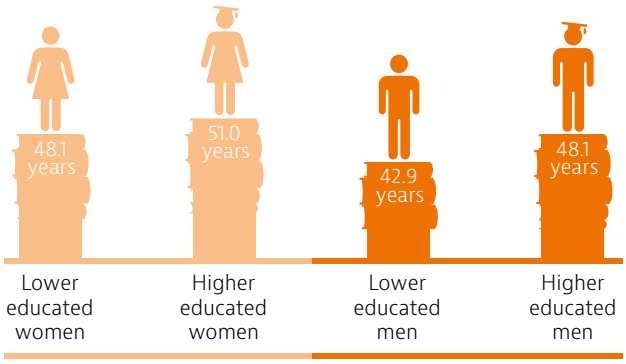


Note: The EU average is weighted. Data for Ireland refer to 2019.
Source: Eurostat Database.

Social inequalities in life expectancy are large

Inequalities in life expectancy exist not only by gender but also by socioeconomic status. At age 35, Austrian men with the highest level of education can expect to live more than five years longer than those with the lowest level, while the gap is nearly three years among Austrian women (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, including higher smoking rates and worse nutritional habits (see Section 3). This gap in life expectancy is also related to differences in income and living standards.

Figure 2. The education gap in life expectancy is over 5 years for men and about 3 years for women



Education gap in life expectancy at age 30:

Austria:	2.9 years	Austria:	5.2 years
EU15:	2.6 years	EU15:	6.1 years

Note: Data refer to life expectancy at age 35. 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 secondary education (ISCED 0-2).
Source: Statistics Austria (data refer to 2016/17).

Heart disease, stroke and lung cancer were the main causes of death before the pandemic

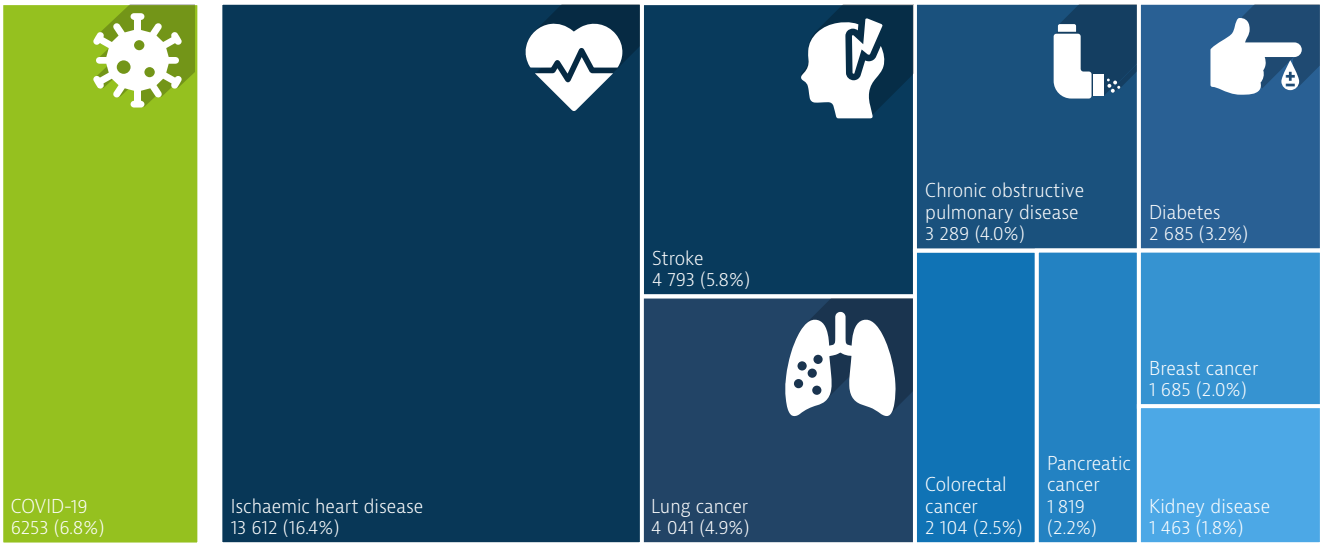
In 2019, circulatory diseases were the leading cause of death, accounting for about 32 600 deaths (39 % of all deaths). Cancers were the second most frequent cause of death, with about 20 700 deaths (25 % of all deaths).

Looking at more specific diseases, ischaemic heart disease was the leading cause of mortality in 2019 (accounting for almost 16 % of all deaths), followed by stroke. Lung cancer remained the most frequent cause of death by cancer (Figure 3).

In 2020, COVID-19 accounted for about 6 250 deaths in Austria (an estimated 6.8 % of all deaths). An additional 4 500 deaths were registered in the first half of 2021. Most deaths were among people aged 60 and over. The mortality rate from COVID-19 up to the end of June 2021 was about 25 % lower in Austria than the average across EU countries (about 1 200 per million population compared with an EU average of about 1 660).

The broader indicator of excess mortality, defined as deaths from all causes above what would normally be expected based on the experience from previous years, suggests that the direct and indirect death toll related to COVID-19 could be higher. The number of excess deaths from March to December 2020 (around 9 500) was over 50 % higher than COVID-19 deaths, although several of these excess deaths may not be necessarily COVID-19-related.

Figure 3. Ischaemic heart disease, stroke and lung cancer were the main causes of death before COVID-19



Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2019. The size of the COVID-19 box is proportional to the size of the other main causes of death in 2019.
Sources: Eurostat (for causes of death in 2019); ECDC (for COVID-19 deaths in 2020, up to week 53).

Over 70 % of adults report being in good health, but nearly two in five have a chronic condition

In 2019, 71 % of adults in Austria reported being in good health – a proportion slightly higher than the EU average (69 %). However, as in other countries, people with higher incomes are more likely to report being in good health: 83 % of Austrian adults in the highest income quintile reported being in good health, compared with 62 % of those in the lowest.

Nearly two in five Austrian adults (37 %) reported having at least one chronic condition in 2019 – a proportion close to the EU average (36 %), according to EU-SILC. Many of these chronic conditions increase the risk of severe complications from COVID-19.

As with self-reported health, there are non-negligible differences in the prevalence of chronic diseases across income groups: 44 % of Austrian adults in the lowest income group reported having at least one chronic condition, compared with 31 % of those in the highest.

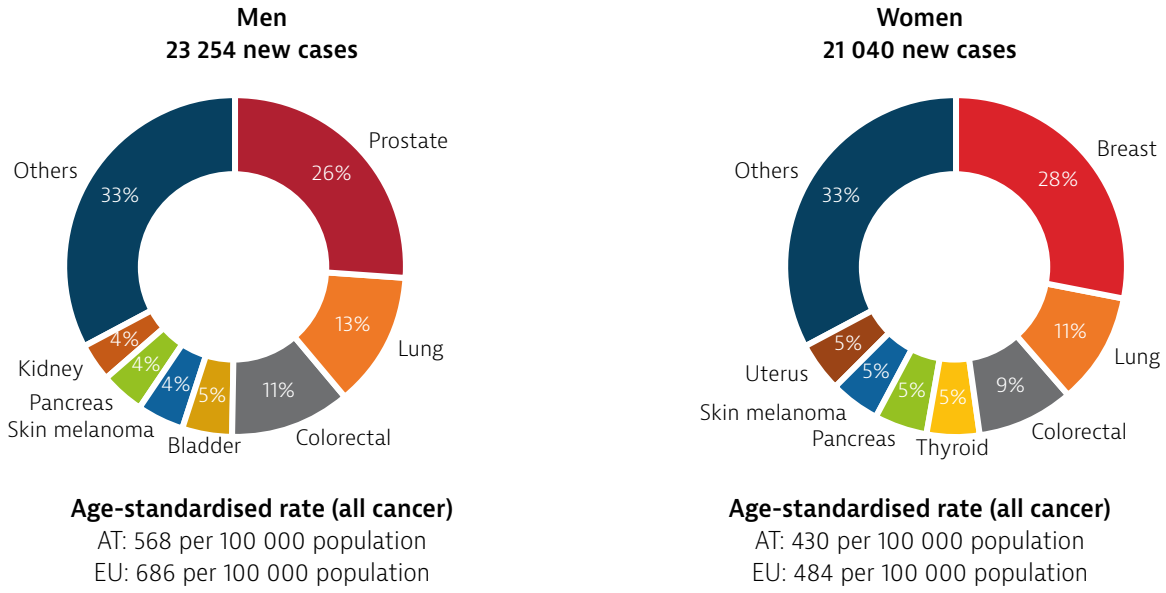
An emerging issue from the COVID-19 pandemic is the number of patients who experience persistent ill health for a long period after contracting the virus. "Long COVID", characterised by symptoms including chest and muscle pain, fatigue, shortness of breath, anxiety and cognitive dysfunction, can impede a return to normal life, with potentially lasting health and economic repercussions. In July 2021, the Austrian Society for General and Family Medicine issued practice guidelines for primary care physicians dealing with patients with Long COVID.

The burden of cancer in Austria is considerable, but lower than the EU average

About 20 700 people died of cancer in 2019, making cancer the second leading cause of death. According to estimates from the Joint Research Centre based on incidence trends from previous years, around 44 000 new cases of cancer were expected in Austria in 2020.

However, cancer incidence and mortality rates are lower in Austria than the EU average. Figure 4 shows that the main cancer sites among Austrian men are prostate (26 %), lung (13 %) and colorectal (11 %), while among Austrian women breast cancer is the leading cancer (28 %), followed by lung (11 %) and colorectal cancer (9 %).

Figure 4. More than 44 000 of new cancer cases were expected in Austria in 2020



Note: Non-melanoma skin cancer is excluded. Uterus cancer does not include cancer of the cervix.
Source: ECIS – European Cancer Information System.

3 Risk factors

Behavioural risk factors are a major driver of mortality in Austria

Around 40 % of all deaths recorded in Austria in 2019 can be attributed to behavioural risk factors such as tobacco smoking, dietary risks, alcohol consumption and low physical activity. Albeit to a relatively lower extent than the EU average, air pollution in the form of fine particulate matter (PM2.5) and ozone exposure alone is also linked to a non-negligible number of deaths in Austria each year (Figure 5).

Some 16 % of all deaths in 2019 (about 13 000 deaths) can be attributed to tobacco smoking (including direct and second-hand smoking) – a share close to the EU average. Dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption) are estimated to account for about 15 % of all deaths (12 600 deaths), compared with an EU average of 17 %. About 6 % (5 000) can be attributed to alcohol consumption, while about 3 % (2 300) are related to low physical activity. Air pollution in the form of fine particulate matter (PM2.5) and ozone exposure alone accounted for about 3 % of all deaths (2 700).

Figure 5. Tobacco and dietary risks are major contributors to mortality in Austria



Note: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to PM2.5 and ozone.
Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Smoking is more prevalent in Austria than in most EU countries

While the smoking rate among Austrian adults has fallen from 24 % of daily smokers in 2014 to 21 % in 2019, it remains higher than in most EU countries (Figure 6). Similarly, for adolescents, the proportion of 15-year-olds reporting that they smoked tobacco during the last month fell from 23 % in 2014 to 17 % in 2018, but it remains slightly higher than in most EU countries. At the same time, the use of e-cigarettes has become more popular: one in six 15- and 16-year-olds in Austria reported smoking e-cigarettes in 2019 – a higher proportion than the EU average, according to the ESPAD survey. The European Commission has set an ambitious goal of ensuring that less than 5 % of the population uses tobacco by 2040 under the Europe's Beating Cancer Plan (see Section 5.1). While policies to discourage smoking in Austria have lagged behind those in other European countries, a total ban on smoking inside restaurants was introduced in November 2019.

Alcohol consumption is higher than in many other EU countries

Overall alcohol consumption among adults has decreased since 2000, but it remains over 20 % above the EU average. Alcohol consumption among adolescents in Austria is also greater than in other countries: almost one third (32 %) of 15-year-olds reported having been drunk at least twice in their life in 2018, which is the second highest proportion among EU countries after Denmark.

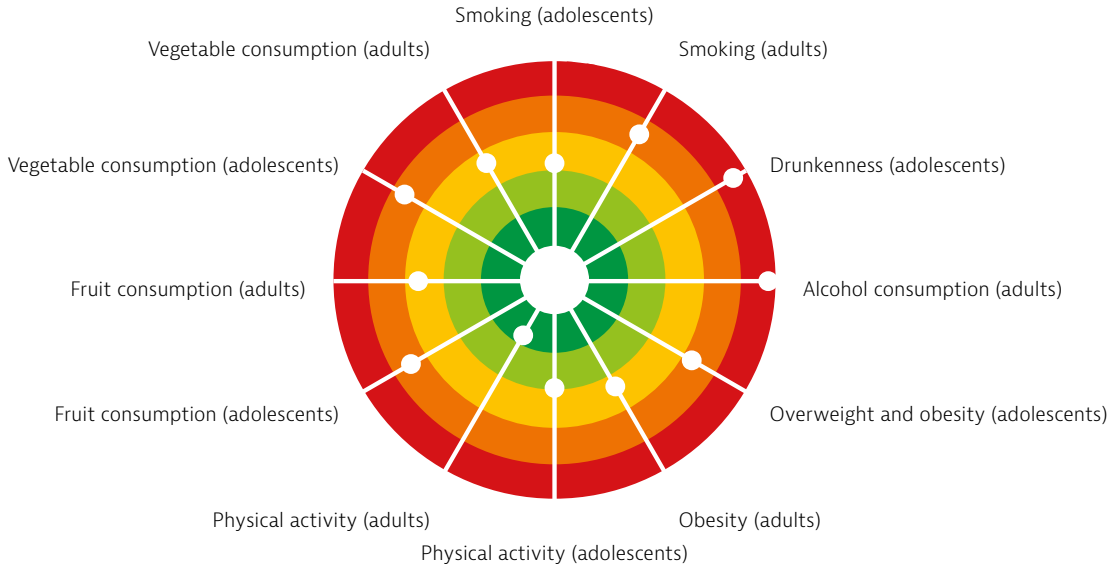
Overweight and obesity rates among adolescents in Austria are also relatively high

Obesity rates among adults in Austria increased to reach 17 % in 2019, which is slightly higher than the EU average of 16 %. Overweight and obesity rates among 15-year-olds also increased substantially over the past two decades, reaching 21 % in 2018. This was also slightly above the EU average of 19 %.

As in many other EU countries, poor nutrition is the main factor contributing to overweight and obesity in Austria. In 2019, about 50 % of Austrian adults reported not eating any vegetables every day or not eating any fruit – a higher proportion than in most other EU countries. Among adolescents, in 2018, over two thirds of 15-year-olds reported not eating any vegetables every day, and about the same proportion reported not eating any fruit – also higher proportions than in most EU countries.

On the other hand, Austrian adults are among the most physically active in the EU, although more than a quarter did not meet the WHO recommendation of at least 2.5 hours of moderate physical activity per week in 2014. Only about 15 % of Austrian 15-year-olds reported doing moderate to vigorous physical activity each day – a share close to the EU average.

Figure 6. Smoking, alcohol and unhealthy diets are important public health issues in Austria



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 HBSC survey 2017-18 for adolescents indicators; and OECD Health Statistics, EHIS 2014 and 2019 for adults indicators.

4 The health system

Austria's health system has a complex governance structure

Responsibilities for health system governance in Austria are divided between the federal and the regional level. The federal government is responsible for regulating social health insurance (SHI) and most areas of health care provision. The nine states (Länder) regulate and plan hospital care in their jurisdictions, and are responsible for implementation, organisation and financing of inpatient and outpatient care in hospitals, as well as hospital investment. The SHI funds and providers play an important role, as they negotiate collective contracts that regulate ambulatory care, rehabilitative care and pharmaceuticals. Health care financing is mixed, with the federal level, the regional level (states and municipalities) and SHI funds all contributing to the budget.

Major reforms have attempted to overcome fragmentation

Two major reforms in 2012 and 2017 addressed the fragmentation of organisation and financing of the health system. The introduction of a new "target-based governance" system aimed to achieve more joint planning, governance and financing, by bringing together the federal and the state levels and coordinating these with SHI funds.

The Target-Based Governance Commission, established in 2013, brought together all important actors – the federal government, SHI funds and the states – to define financial and health targets jointly. The complex federal governance structure proved quite effective in the management of the COVID-19 pandemic in 2020, but also revealed shortcomings in the coordination of decisions across federal and state levels (Box 1).

A major reform consolidated social health insurance, but benefits are not harmonised yet

SHI funds finance the largest share of health expenditure (45 % in 2018). Direct government spending – mostly contributions by the states for inpatient care – also constitutes a large share (30 %). In 2020, a major reform merged the existing SHI funds into five funds: the nine regional SHI funds now form a single fund – Österreichische Gesundheitskasse (ÖGK) – which covers about 82 % of the insured population, while self-employed workers, farmers, civil servants and railway workers remain insured by two specialist SHI funds. All SHI funds cover broadly the same benefits, and several steps have been taken since 2017 to harmonise benefits further, but differences remain among the insured population of the ÖGK and between funds for specific professions (see Section 5.2).

Box 1. Governance of the COVID-19 response was divided between federal and state governments

In 2020, a pandemic crisis management system was set up under the leadership of the Federal Ministry of the Interior and its National Disaster and Crisis Management coordinating body. All relevant federal ministries, federal states and rescue organisations were represented in this Unit. The Federal Ministry of Social Affairs, Health, Care and Consumer Protection, which is responsible for technical leadership, set up a Coronavirus Task Force, which bundled expertise from the Ministry and external institutions. The Federal Ministry worked closely with state health authorities, while crisis management boards were also established at municipality and local levels.

The regulations adopted in response to COVID-19 empowered the Federal Minister of Social Affairs, Health, Care and Consumer Protection, the governors of the federal states and the district authorities to prohibit access to public places and business areas. According to the Epidemic Law, the federal government is responsible for taking measures against the pandemic, which the states then have to carry out. The states have some scope for decision making in the implementation of federal laws, but at the same time, the federal government can intervene by issuing instructions to the governor, which the latter must follow. The example of Tyrol reveals advantages and disadvantages of this system. While during the first wave, villages in Tyrol were quarantined swiftly, state-wide measures to prevent the spread of coronavirus mutations in early 2021 initially faced opposition from the regional government, resulting in delayed implementation.

Source: COVID-19 Health Systems Response Monitor.

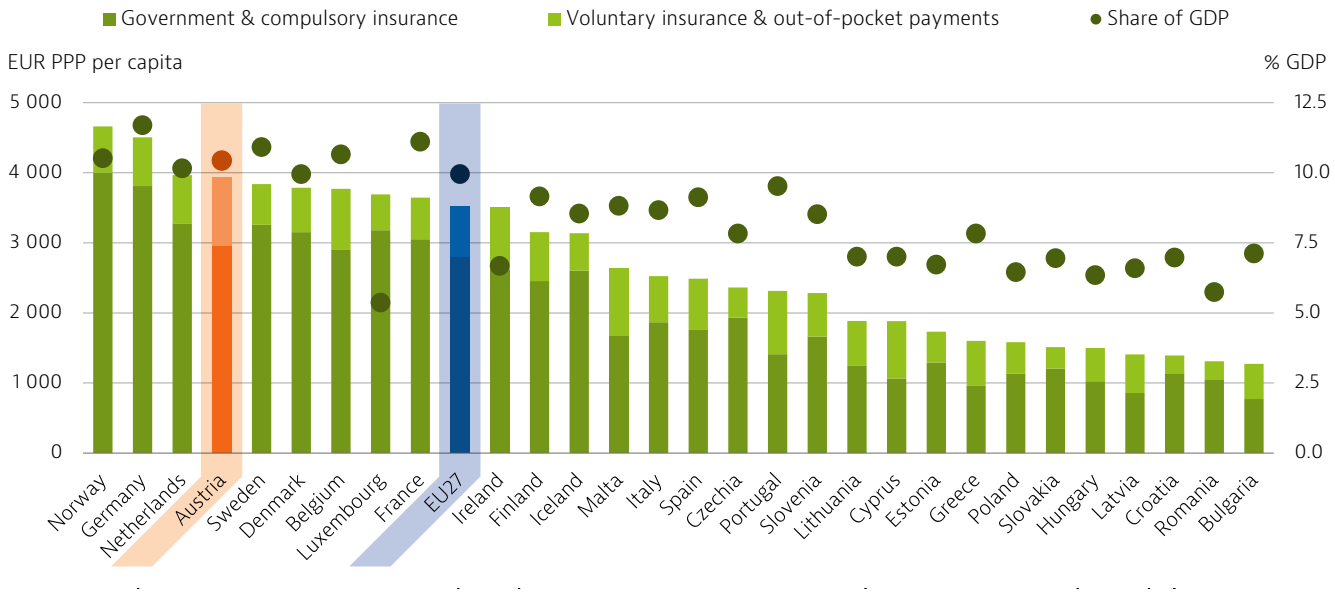
Austria has one of the most expensive health systems in the EU

When compared to other national health systems across the EU, Austria's health system is relatively expensive. In 2019, spending on health per capita (adjusted for differences in purchasing power) reached EUR 3 943, which was the third highest level in the EU after Germany and the Netherlands (Figure 7). When measured as a share of GDP, Austria's expenditure amounted to 10.4 % of GDP in 2019 – a level also above the EU average of 9.9 %.

Health expenditure from public sources accounted for 75 % of the total in 2019 – a share that has been stable over the past decade – but it remains below the EU average of 80 %. The share of out-of-pocket (OOP) payments has also been stable since 2010, and accounted for 18 % of total health spending in 2019, which is above the EU average (15 %). OOP spending is mostly on outpatient medical care, medicines, long-term care and dental care (see Section 5.2).

In 2020, additional public spending was allocated to the health and long-term care sectors to cover COVID-19 related expenses, including EUR 60 million for SHI funds.

Figure 7. Health spending in Austria is higher than the EU average, but the share of public spending is lower

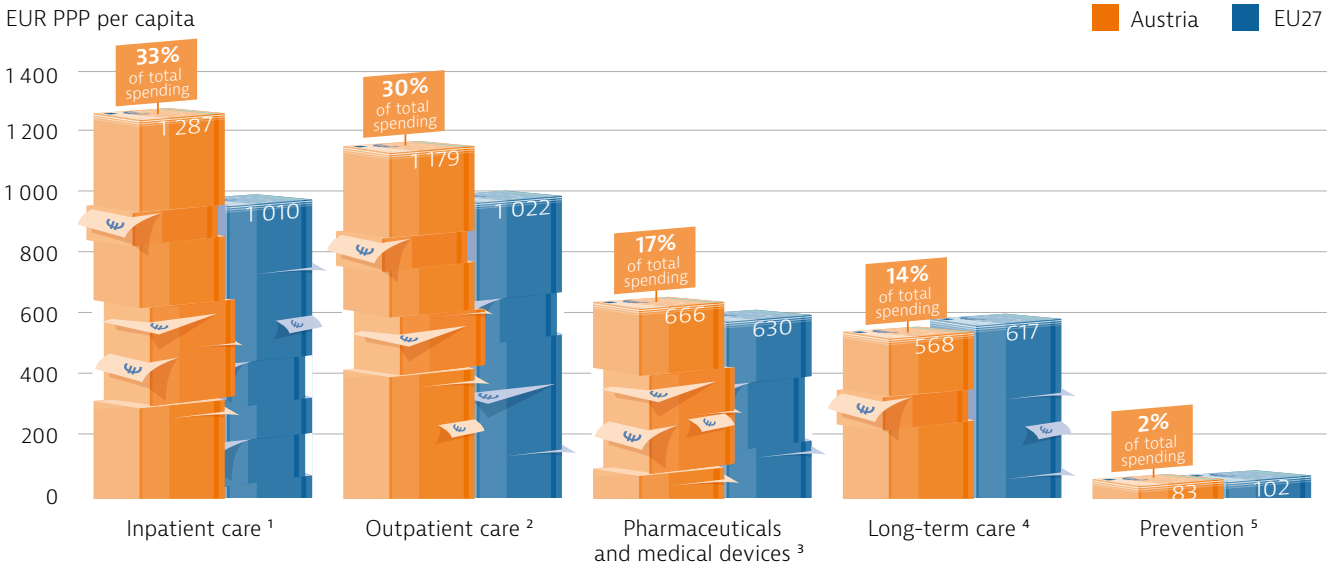


Note: The EU average is weighted.
Source: OECD Health Statistics 2021 (data refer to 2019, except for Malta 2018).

Inpatient care absorbs the largest share of health spending

The largest share of health spending in Austria continues to be on inpatient care. Per person, spending on inpatient care is the highest in the EU (EUR 1 287 in 2019). Spending on outpatient care and pharmaceuticals and medical devices is also above the EU averages (Figure 8). In contrast, per capita spending on long-term care and prevention is slightly below the EU averages.

Figure 8. Austria spends more than the EU average on inpatient care, but less in other areas



Note: The costs of health system administration are not included. 1. Includes curative-rehabilitative care in hospital and other settings; 2. Includes home care and ancillary services (e.g. patient transportation); 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes. The EU average is weighted.
Sources: OECD Health Statistics 2021, Eurostat Database (data refer to 2019).

The physician workforce is comparatively large but with a low share of general practitioners

Austria had the second highest number of doctors in the EU in 2019, with 5.3 physicians per 1 000 population compared to the EU average of 3.9 (Figure 9). This ratio has increased since 2000, when it stood at 3.9. However, the proportion of general practitioners (GPs) has declined continually over the same period, and is now one of the lowest in the EU (14 % of all physicians compared to 21 % in the EU in 2019). Furthermore, the physician workforce is ageing: the average age of GPs was 50 and that of specialists was 52 in 2019 (ÖGK, 2021). About 60 % of contracted GPs are expected to reach retirement age by 2025 (BMASGK, 2019). One of the main priorities of the Austrian Recovery and Resilience Plan is to make primary care more attractive in order to build more primary care centres (see Section 5.3).

The number of nurses per 1 000 population is also above the EU average (10.4 in Austria compared to 8.4 per 1 000 population in the EU in 2019).

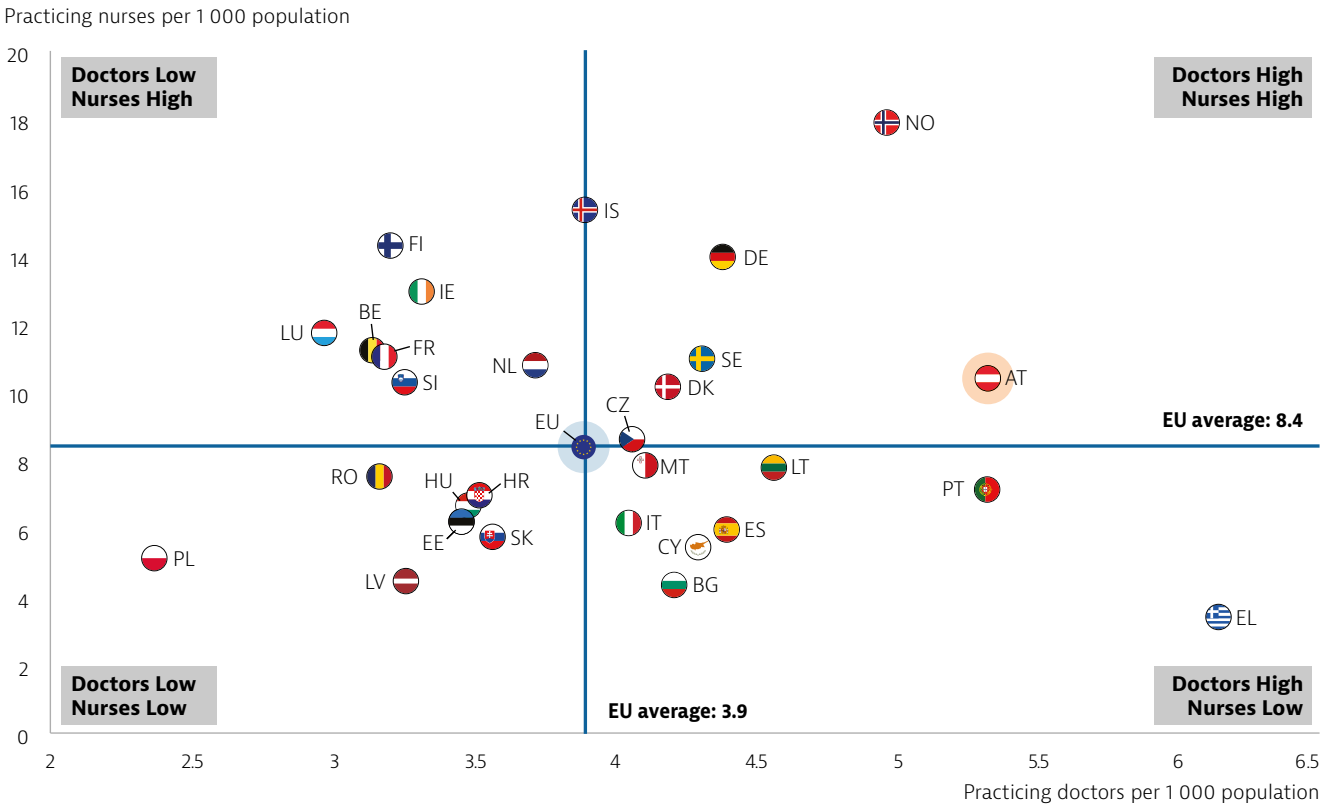
Health services provision remains very hospital-centric

The provision of health services in Austria is characterised by free choice of provider and unrestricted access to all levels of care (GPs, specialists and hospitals). Austria has a very large hospital inpatient sector, with 7.2 hospital beds per 1 000 population in 2019 – a ratio that is the third highest in the EU after Germany and Bulgaria, and well above the EU average of 5.3 beds per 1 000 population. Taken together, this helps to explain why hospital discharge rates and inpatient care expenditure in Austria are among the highest in the EU.

Austria has made further progress in the introduction of eHealth instruments

The universal electronic health record and its eMedication and eReport applications have made substantial progress since their introduction in 2014. The electronic health record was introduced in all federal states and was operational in nearly all Austrian pharmacies, 86 % of ambulatory practices and 76 % of hospitals in 2020. Furthermore, important progress was made with implementation of the electronic vaccination record, which was prioritised for the COVID-19 vaccination rollout (see also Section 5.3).

Figure 9. Austria has more doctors and nurses than the EU average



Note: The EU average is unweighted. In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: Eurostat Database (data refer to 2019 or the nearest year).

5 Performance of the health system

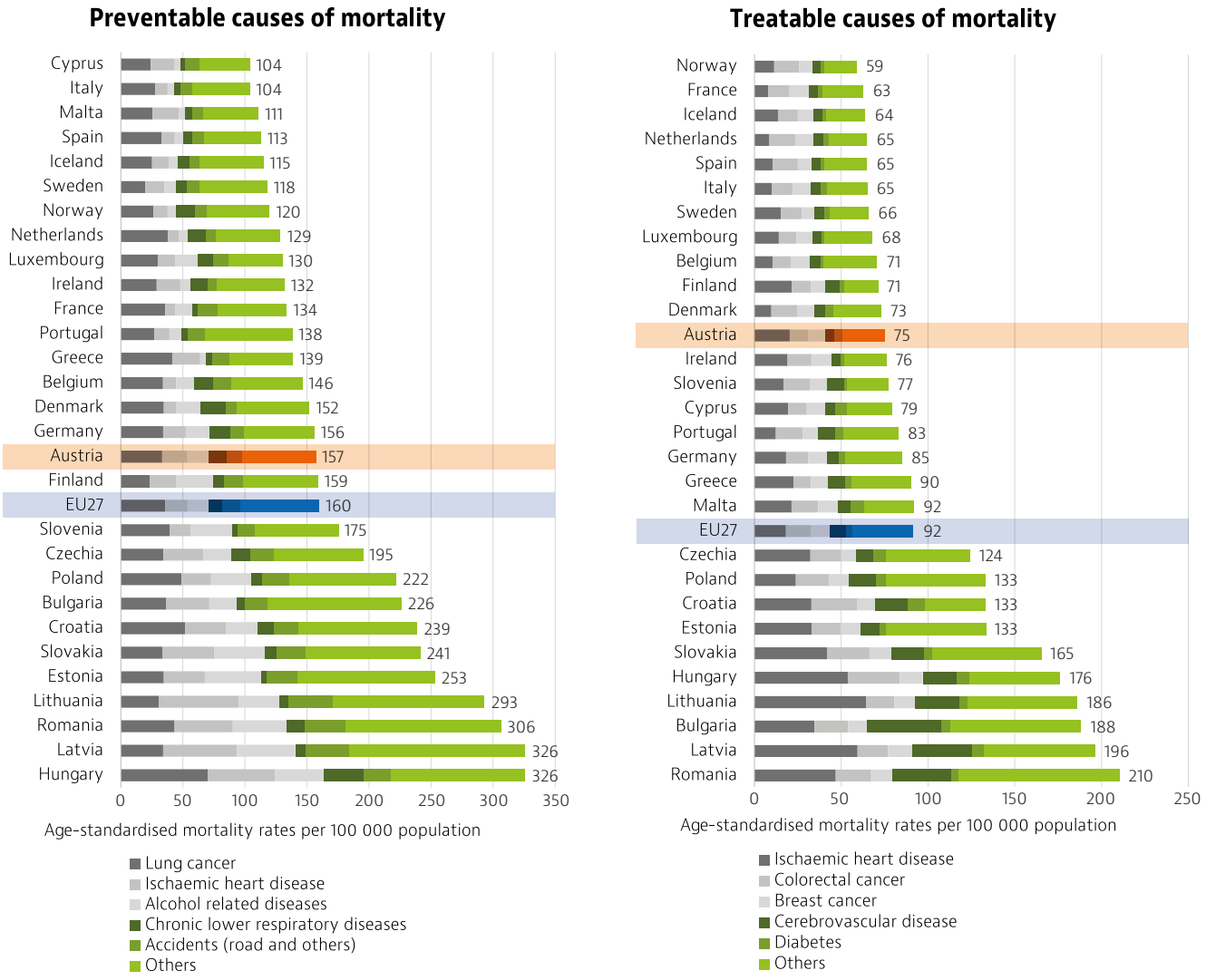
5.1 Effectiveness

Improvements in reducing mortality from treatable and preventable causes are possible

The Austrian health system is relatively effective in avoiding deaths from causes that are treatable in the presence of timely and effective health care. However, although mortality from treatable causes was below the EU average in 2018, several other western European countries have lower rates (Figure 10). Ischaemic heart disease, colorectal cancer and breast cancer were the main treatable causes of mortality, which could be reduced through earlier diagnosis and timely and effective treatment.

Preventable mortality in Austria was also lower than the EU average in 2018, but the rate was around 33 % higher than those of the five best-performing countries. The leading causes of preventable mortality are lung cancer, ischaemic heart disease, alcohol-related diseases and chronic respiratory diseases. Stronger prevention policies and greater public health efforts could help to reduce preventable mortality.

Figure 10. More deaths could be avoided through effective prevention and treatment



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. 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 2018, except for France 2016).

Unhealthy lifestyles remain a key public health challenge

As noted in Section 3, tobacco and alcohol consumption in Austria remain above EU averages. Alcohol control policies in Austria include restrictions on marketing and fairly strict drink-driving sanctions, but policies are looser when it comes to restricting availability of alcohol to adolescents and minors.

Policies to discourage and reduce smoking were implemented more slowly than in many other EU countries, but long-planned reforms have recently come into place, including a total ban on indoor smoking in restaurants and bars that came into effect in November 2019 (Burki, 2019).

The 2014 Health Promotion Strategy put greater emphasis on prevention and health promotion, including the creation of health promotion funds in each state – supported by EUR 15 million per year until 2022 – that aim to strengthen health promotion and prevention. At least two-thirds of the funding must be spent on prevention targeting certain groups or activities, including early childhood (healthy nurseries, kindergartens and schools), strengthening health literacy and promoting the well-being of older people (BMASGK, 2019).

Influenza vaccination rates were lower than the EU average, but increased in 2020

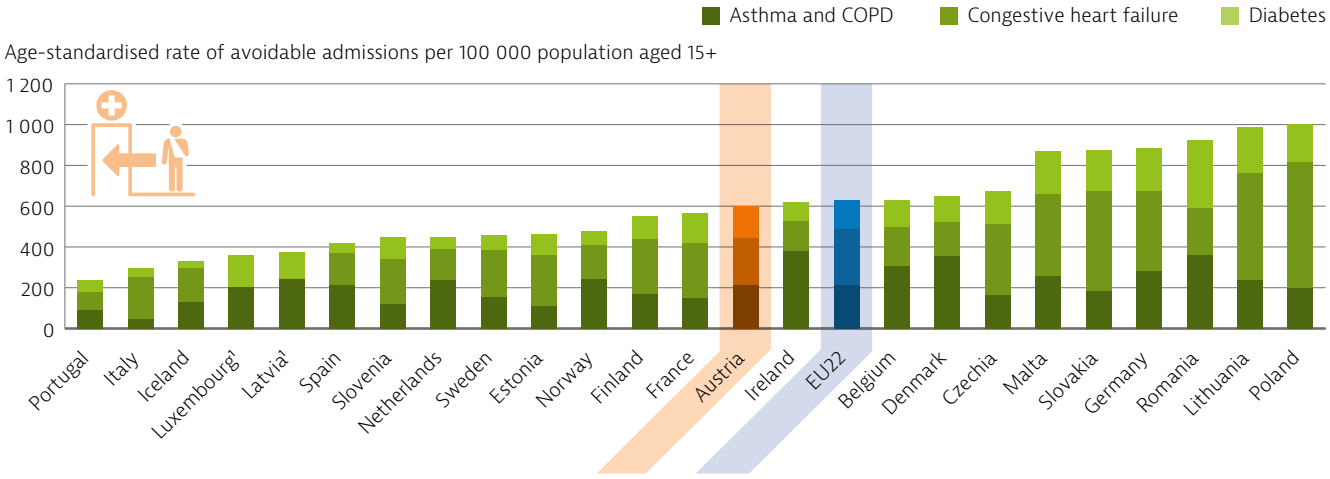
Austria's influenza vaccination rate among people aged 65 and over was one of the lowest across EU countries in 2019: not even one in five people in this higher-risk age group were vaccinated (18 %) – a figure less than half the EU average of about 40 %. However, a government survey conducted during the COVID-19 pandemic suggests that demand for flu vaccination hit record levels in 2020. The Federal Ministry of Social Affairs, Health, Care and Consumer Protection more than doubled the quantity of influenza vaccines ordered for the 2020/21 flu season compared with the previous season.

Primary care reforms are designed to improve care for people with chronic conditions

Austria's health system remains hospital-centric, and potentially avoidable hospital admissions for chronic conditions have traditionally been higher in Austria than in most other European countries. Nearly 600 admissions for asthma and chronic obstructive pulmonary disease (COPD), congestive heart failure and diabetes were recorded per 100 000 adults in 2019 (Figure 11). These higher hospital admission rates for chronic conditions suggest that there is room to improve primary care.

In 2017, a reform was put in place with the aim of strengthening primary care, including by developing multidisciplinary primary care centres. These are intended to meet the changing needs of the population – notably by providing more support for people with chronic conditions in terms of treatment options and opening hours. The reforms included financial and logistical support for setting up multidisciplinary care teams. As of mid-2021, 32 primary care centres had been established, with the goal of establishing 75 by the end of the year.

Figure 11. Avoidable hospital admission rates are relatively high in Austria



Note: 1. Data for congestive heart failure are not available in Latvia and Luxembourg.
Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

Cancer screening and survival rates are high, but screening declined markedly during the pandemic

Austria established its national cancer framework plan in 2014. The plan is structured around six strategic goals, with the intention of gradual implementation over 5-10 years:

1. prevention and health promotion to reduce the incidence of cancer;
2. timely early detection, diagnosis and treatment to reduce mortality and prolong survival;
3. improvement and maintenance of quality of life for cancer patients, family members and carers;
4. equal access to cancer care, regardless of socioeconomic status or background;
5. high-quality data and improved evidence-based information;
6. advancement of cancer research.

The Austrian National Cancer Framework Programme aligns closely with the key pillars of the new Europe's Beating Cancer Plan (European Commission, 2021a).

Austria generally performs better than many other European countries in cancer detection and care, with higher rates of breast cancer screening than the EU average and higher five-year net survival rates for prostate, breast, cervical, colon and lung cancers (Figure 12).

In 2019, 75 % of women aged 50-69 reported that they had been screened for breast cancer within the past two years – well above the EU average of 57 %. In the same year, 85 % of women aged 20-69 reported that they had been screened for cervical cancer – also a higher rate than in most other EU countries.

However, the COVID-19 pandemic dramatically reduced screening rates. For example, colonoscopy screenings fell by 34 % in the first half of 2020, compared with the first half of 2019 (Hinterberger et al., 2021).

Figure 12. Five-year net survival rates indicate good quality of cancer care



Prostate cancer
Austria: 90 %
EU23: 87 %

Breast cancer
Austria: 85 %
EU23: 82 %

Cervical cancer
Austria: 64 %
EU23: 63 %

Colon cancer
Austria: 64 %
EU23: 60 %

Lung cancer
Austria: 20 %
EU23: 15 %

Note: Data refer to people diagnosed between 2010 and 2014.
Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

5.2 Accessibility

Despite near universal coverage, small gaps still exist

Health insurance in Austria is mandatory, and administrative data suggest that coverage is very high, with 99.9 % of the population covered through one of the SHI funds in 2019. Care for COVID-19 was fully covered for everyone belonging to a health insurance fund. Nevertheless, despite near universal coverage, some population groups are at higher risk of being uninsured, including older students who cannot qualify as dependents, unregistered asylum seekers, unemployed people and those with severe mental health illness (Czypionka, Röhrling & Six, 2018; Fuchs, Hollan & Schenk, 2017).

Out-of-pocket spending is mostly on outpatient medical care, pharmaceuticals and long-term care

About 75 % of all health spending in Austria was publicly funded in 2019, while 18 % was paid out of pocket by households and the remaining 7 % was funded through voluntary health insurance and other voluntary prepayment schemes (such as enterprise and non-governmental organisation financing schemes). OOP spending was related mainly to outpatient medical care, pharmaceuticals, long-term care and dental care (Figure 13).

About 3 % of Austrian households experienced catastrophic spending on health in 2015.[1] Most of these were in the poorest quintile of the population (Czypionka, Röhrling & Six, 2018; Fuchs, Hollan & Schenk, 2017).

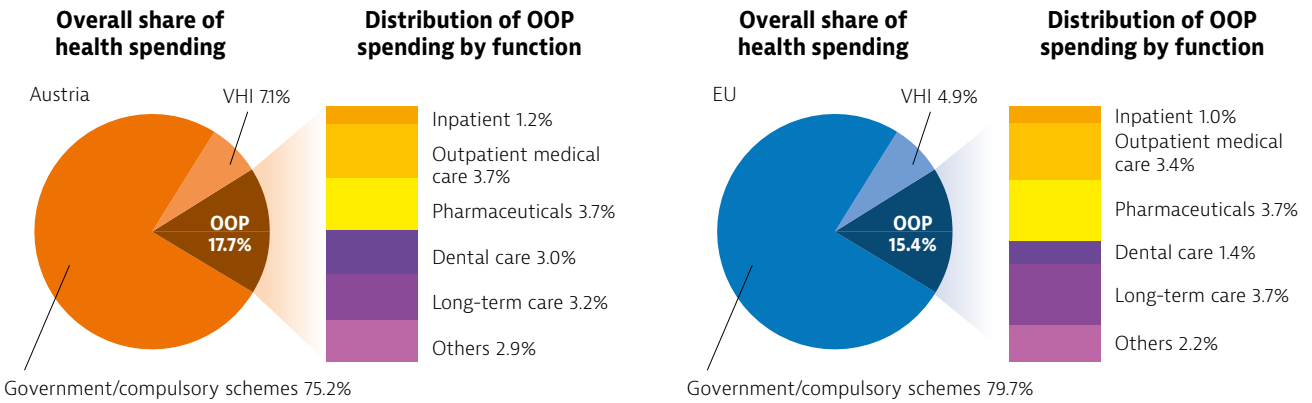
Despite recent reforms, benefit coverage has not been fully harmonised

The 2020 insurance reform that consolidated the previous 18 SHI funds into five (including the ÖGK, which covers 7.2 million people or 82 % of the population) was intended to reduce differences in coverage, including differences both between regions – through the merger of regional funds into the ÖGK – and between specialist SHI funds.

Despite this intention, benefit coverage has not yet been fully harmonised, and this process may take until at least 2024. While the benefits package of the new insurance fund was initially intended to be harmonised upwards – ensuring that no patients lost benefits they had previously enjoyed under their regional fund – agreements reached shortly before the merger took place in January 2020 did not cover all benefits. In particular, benefits related to psychotherapy services were initially excluded, despite significant variation in what services were covered and the reimbursement levels between regions and insurers. Reimbursement for psychotherapy services within the SHI for self-employed workers was nearly doubled in April 2020, for example: from EUR 21 to EUR 40 per session hour.

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

Figure 13. Most out-of-pocket spending is on outpatient care, pharmaceuticals and long-term care



Note: VHI (voluntary health insurance) also includes other voluntary prepayment schemes. The EU average is weighted.
Sources: OECD Health Statistics 2021, Eurostat Database (data refer to 2019).

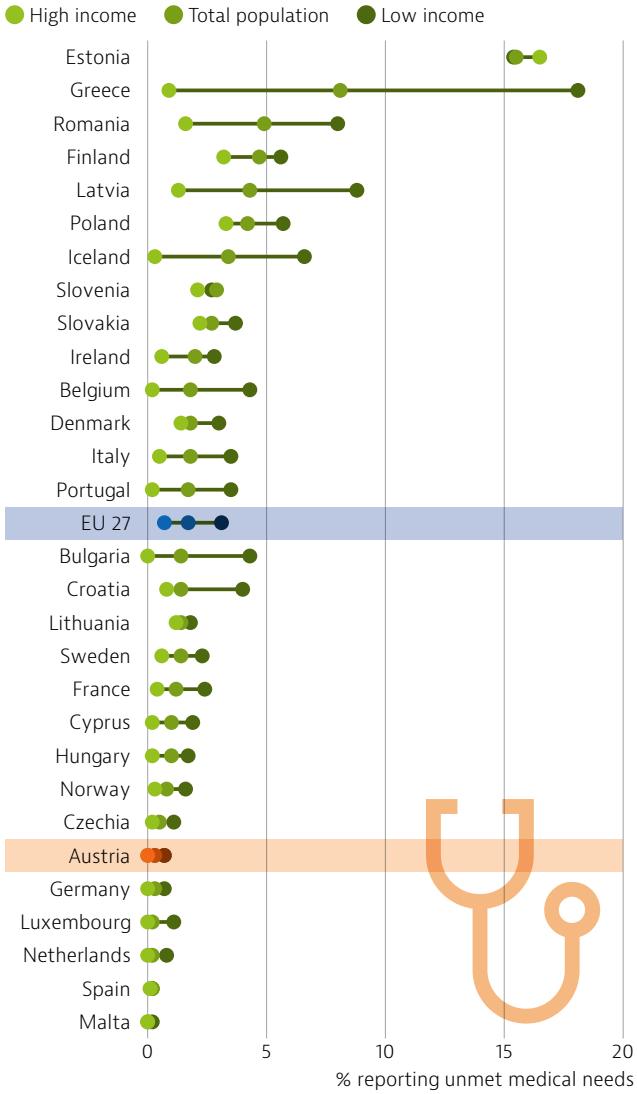
This reimbursement level is 43 % higher than that given to members of the ÖGK, which covers EUR 28 for the same service. In 2020, the ÖGK announced it would increase public capacity of psychotherapy services by 30 % in order to improve access in all regions.

Although the budget of the ÖGK remained balanced in 2021, deficits are projected for the coming years due to the COVID-19 pandemic and the resulting economic crisis. The insurance fund has looked for opportunities to consolidate its finances without reducing benefits to patients to address the funding shortfall. As a contract for future fee agreements for physicians is put in place, the ÖGK has begun to consider alternatives to harmonising all benefits upwards.

Unmet needs for care prior to the pandemic were low, with relatively small inequalities in access

Compared with most EU countries, Austria had low levels of unmet medical care needs before the pandemic, and small inequalities by socioeconomic status. Just 0.3 % of the population reported unmet care needs due to cost, distance to travel or waiting times in 2019 (Figure 14). The rate was slightly higher among adults in the lowest income quintile (0.7 %), but well below the EU average (3.1 %).

Figure 14. Austrians reported almost no unmet needs for medical care prior to the pandemic



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 2019, except Iceland 2018).

The COVID-19 pandemic led to delayed and forgone care, but also to a surge in teleconsultations

The demand for COVID-19-related care and the introduction of containment measures during the pandemic resulted in delayed consultations and treatments, as well as increasing levels of unmet needs. A Eurofound survey carried out in February/March 2021 found that 12 % of Austrian respondents indicated that they did not receive a medical examination or treatment when they felt they needed it during the first 12 months of the pandemic – a lower share than the EU average of 21 % (Eurofound, 2021).[2]

Although medical practices in ambulatory care were not closed during the first lockdown, the population was urged to see a doctor only when really necessary, which aimed to limit physical contact between patients and health care providers, in particular at the beginning of the pandemic. A nationally representative survey among working-age adults found that unmet health care needs due to closed doctor's practices became less important as the pandemic progressed (between June 2020 and January 2021). However, in January 2021, postponed surgeries were still reported as a reason for unmet medical needs by around 7-8 % of respondents.

At the same time, the use of teleconsultations was expanded. According to the Eurofound survey, 35 % of Austrians reported having received a medical consultation online or by telephone during the first 12 months of the pandemic – a lower share than the EU average of 44 %.

Access to pharmaceuticals has been hampered in recent years by shortages

Medicine shortages have increased in Austria in recent years, as has been the case in many other EU countries. About 700 notifications of medicines shortages were recorded between 2017 and 2019 – over three times more than in Germany. In April 2020, Austria put in place a mandatory national register – replacing a formerly voluntary register – to notify shortages, requiring at least two months' notice for foreseen shortages. Shortages of a minimum duration of at least two weeks must be reported to the register (Vogler & Fischer 2020).

Generic prescribing is an important driver to ensure affordable access to pharmaceuticals for the population and third-party payers. At 57 % of the total volume of medicines in 2019, the share of generics used in Austria was higher than the EU average of 49 %, but well below that of Germany (83 %) or the Netherlands (78 %). Generic substation by the pharmacists is not allowed. Moreover, doctors are not permitted to prescribe by International Non-proprietary Name, they always have to use the trade name (Gesundheit Österreich 2020). A prescription fee (currently EUR 6.30) is charged for all prescribed medications whose price exceeds the prescription fee, although the fee is capped if total prescription fees exceed 2 % of annual net income, and is waived for certain populations – including those who earn less than EUR 909 net per month (EUR 1 046 net for those with high medication needs) and those with notifiable communicable diseases.

During the COVID-19 crisis, Austrian SHI funds expanded the use of ePrescribing and telemedicine services to ensure the continuity of prescriptions for patients, allowing contracted physicians to prescribe without a physical visit and transmit the prescription electronically to pharmacies (OECD, 2021).

The general objectives of pharmaceutical policies in Austria align with the new EU pharmaceutical strategy for Europe to ensure access to affordable medicines for patients (Box 2).

2: *The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.*

Box 2. The European Commission has adopted a pharmaceutical strategy to improve access in Europe

In November 2020, the European Commission adopted a pharmaceutical strategy for Europe to ensure that patients have access to innovative and affordable medicines and to support the competitiveness, innovative capacity and sustainability of the EU's pharmaceutical industry (European Commission, 2020). The strategy is expected to enhance Europe's capacity to cover its pharmaceutical needs, including in times of crisis, through robust supply chains. It is formulated around four pillars:

- Ensuring access to affordable medicines for patients, and addressing unmet medical needs (e.g. in the areas of antimicrobial resistance, cancer, rare diseases)
- Supporting competitiveness, innovation and sustainability of the EU's pharmaceutical industry and the development of safe, effective and greener medicines
- Enhancing crisis preparedness and response mechanisms, and addressing security of supply
- Ensuring a strong EU voice in the world, by promoting a high level of quality, efficacy and safety standards

The strategy plans enhanced co-operation between national authorities on pricing, payment and procurement policies, with a view to improve the affordability and cost–effectiveness of medicines.

5.3 Resilience

This section on resilience focuses mainly on the impact of and responses to the COVID-19 pandemic.[3] As noted in Section 2, the COVID-19 pandemic had a major impact on population health and mortality in Austria in 2020 and the first half of 2021, as in most other EU countries. The restriction measures taken to contain the pandemic also had a huge impact on the economy. Austria's GDP fell by 6.6 % in 2020, which is close to the EU average, and is projected to remain below 2019 levels until 2022. The unemployment rate rose from 4.5 % in 2019 to 5.4 % in 2020, with a particularly large increase among young people.

A range of containment measures were implemented to control the pandemic

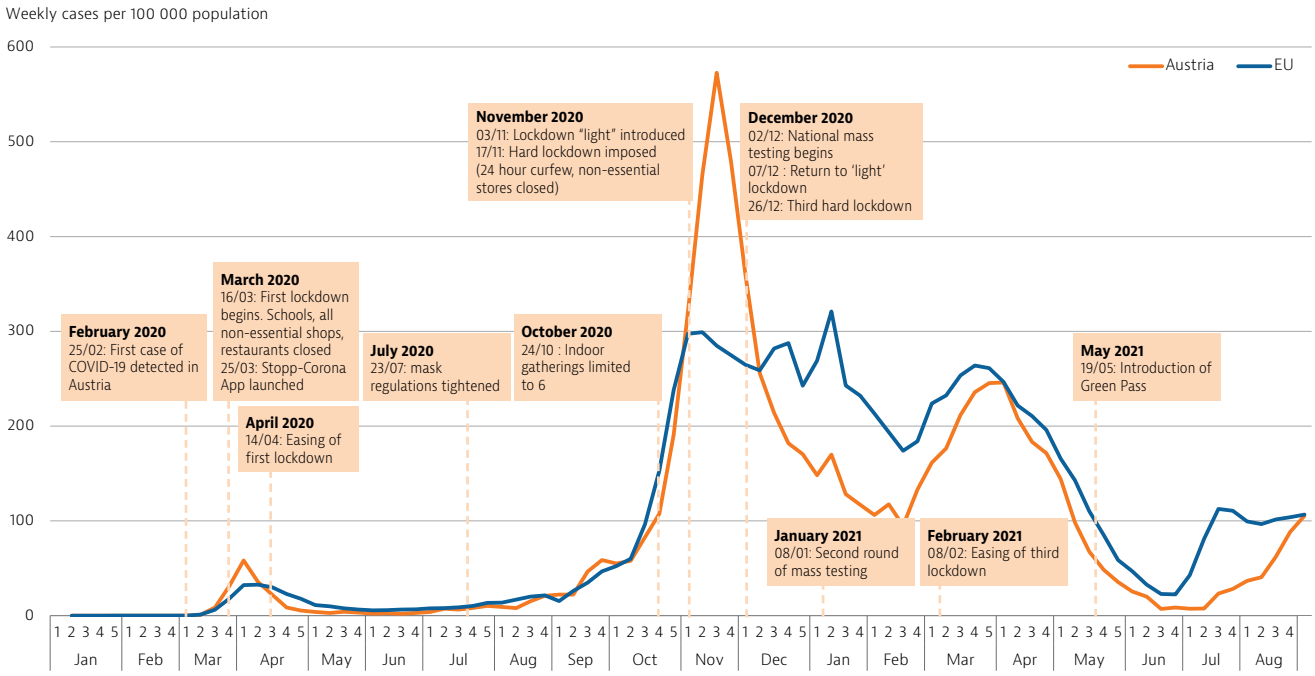
The first cases of COVID-19 in Austria were detected in February 2020 (Figure 15). The failure to control the outbreak in the ski resort of Ischgl is believed to have helped spread the virus to several other European countries. Authorities initially began communicating advice on physical distancing at the end of February and introduced stricter containment measures on 10 March, including implementation of controls at the Italian border, limiting the size of public events (initially to 500 people outdoors and 100 people indoors) and closure of universities, replacing in-person learning with online teaching.

The following week (16 March), further measures – including the closure of non-essential shops, restaurants, bars and cafes; the closure of all schools from kindergarten to university; and a curfew for the population – were imposed. Further restrictions followed, including limitations on opening hours for essential shops; a strong recommendation to telework where possible; the closure of long-term care facilities to most visitors; and mandatory mask-wearing in some indoor locations, including public transportation and shops. The success of the first lockdown led Austria to become one of the first countries in Europe to announce an easing of containment measures. The lockdown was gradually lifted from late April 2020, although certain measures – such as a mask mandate – remained in place.

Following the second wave of the pandemic in autumn 2020, a second strict lockdown was implemented in November 2020; a third lockdown began on 26 December 2020 and remained in place until February 2021. The later lockdowns helped to reduce the number of COVID-19 cases substantially, although the pandemic was never suppressed. From May 2021, proof of vaccination, recent negative testing, or a prior COVID-19 infection was required for entry into many public venues, including restaurants and bars, hotels, sports facilities and many entertainment venues.

3: *In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessments, 2020).*

Figure 15. Austria's three lockdowns helped push down cases of COVID-19

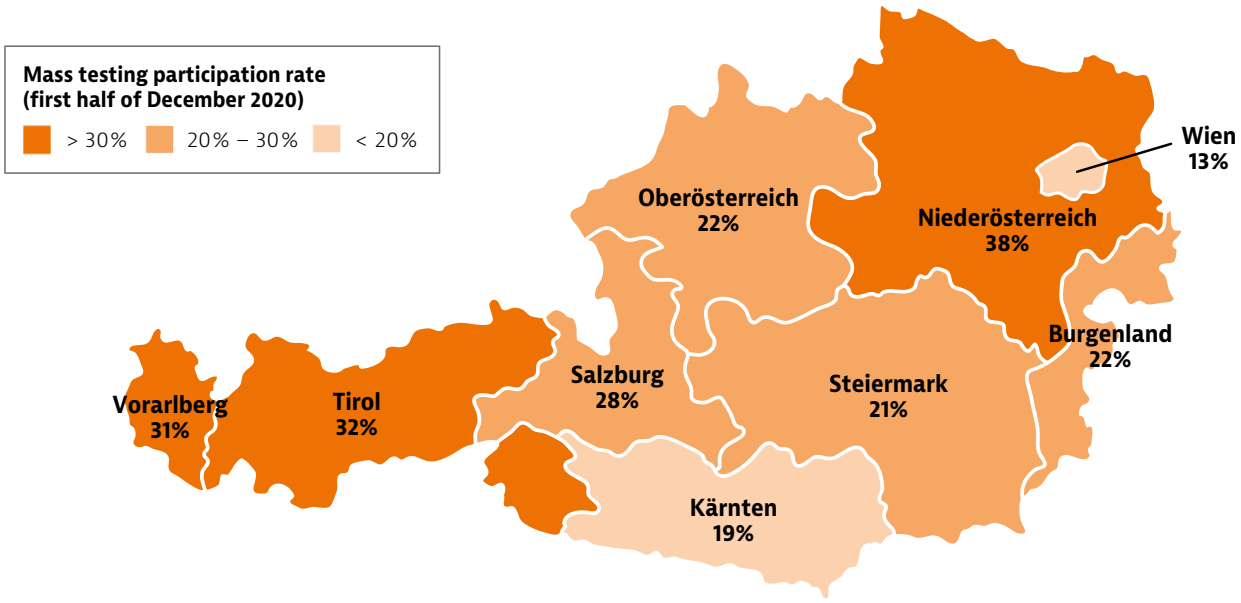


Note: The EU average is unweighted (the number of countries used for the average varies depending on the week). This figure does not reflect the new measures taken in November 2021 to contain the new wave.
Sources: ECDC for COVID-19 cases and authors for containment measures.

Testing formed a key pillar of Austria's COVID-19 containment strategy

Austria's testing intensity remained close to the EU average during the first months of the pandemic. As part of efforts to control the pandemic during the second wave, Austria introduced plans for mass testing earlier than many other EU countries, with mass testing rounds undertaken in early December 2020, and a second round of mass testing undertaken in mid-January 2021. However, testing rates varied significantly across different regions, and neither mass testing effort achieved the initial targets of reaching up to 60 % of the population (Figure 16).

Figure 16. Participation rates in the first mass testing campaign varied widely across regions



Note: Data refer to participation rates during the first mass testing campaign (2-13 December 2020).
Source: Universität Wien (2021).

Following the end of the third lockdown in February 2021, Austria adopted a three-pronged testing strategy:

- testing (at primary care facilities and permanent testing centres or through mobile testing teams) for symptomatic patients and their contacts;
- screening programmes for high-risk groups, using primarily rapid antigen tests; and
- widespread free testing, primarily using rapid antigen tests, including through permanent free testing centres and distribution of self-testing kits.

All insured adults were entitled to up to five self-administered testing kits per month, which were distributed free of charge through pharmacies until October 2021. Moreover, professional-administered free-of-charge testing was provided by pharmacies, physicians and specifically set up testing facilities. Pupils were tested at school three times a week until the summer holidays and were then subject to a new testing regime that combines PCR and antigen testing, where frequency and coverage is increased depending on incidence.

Uptake of the contact tracing app was limited

Local health authorities were responsible for contact tracing and enforcing quarantine, but the extent of traceability varied substantially between regions. Everyone who had come into contact with a confirmed case of COVID-19 was required to stay at home in isolation for 14 days. In addition to contact tracing by health offices, the Austrian Red Cross launched a mobile application, "Stopp Corona", on 25 March 2020, which was intended to notify the contacts of users who tested positive for COVID-19. As of 1 February 2021, the app had been downloaded 1.4 million times (about 15.5 % of the population). Most downloads occurred early in the pandemic. By 1 February 2021, 6 007 confirmed cases of COVID-19 had been recorded in the app – only about 1.5 % of the cases confirmed over that period (Box 3).

Acute care and intensive care capacities were stretched but not saturated during the initial waves of COVID-19

Before the pandemic, hospital and intensive care unit (ICU) capacity in Austria was among the highest across EU countries. With about 22 ICU beds per 100 000 population in 2019, Austria's ICU bed capacity was higher than in most EU countries. Like many other countries, Austria also boosted its ICU bed capacity to be able to respond to any peak in demand by transforming clinical wards into ICU units. During the second wave, regions in Austria were able to increase ICU capacity by 10-20 % on average, including up to 50 % where capacity was severely needed. The peak number of COVID-19 patients requiring intensive care reached 7.9 per 100 000 population in November 2020 (Figure 17).

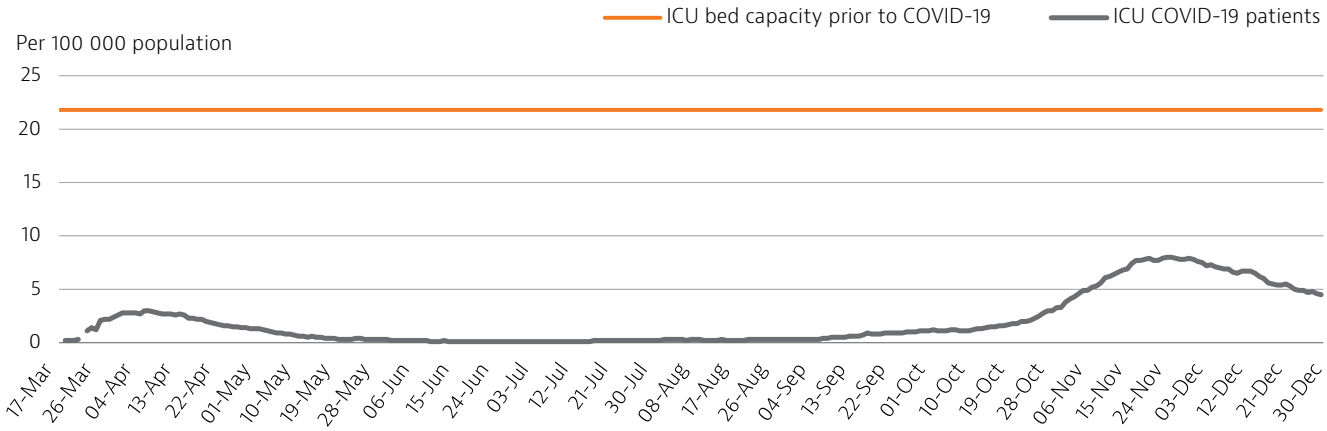
Box 3. Austria leveraged its strong digital health data infrastructure during the COVID-19 pandemic

Austria's health system is one of the most digitally advanced in Europe, with a universal electronic health record and strong linkages between different data sources. It is one of only six countries in Europe with the operational and technical capacity to use electronic health records to generate information, and one of ten that can link hospital and mortality data (OECD/EU, 2020).

Austria leveraged its strong health data infrastructure during the COVID-19 pandemic, including using pseudonymised electronic health record data for COVID-19 research and the creation of a central vaccination register and eVaccination passport, allowing patients to document their vaccination status. While participation in the universal electronic health record is voluntary, and about 300 000 people (3.4 % of the population) have opted out, certain services during the pandemic were initially covered only for those with an electronic health record – notably the distribution of up to five free self-testing kits per person per month.

Efforts to create an eHealth system in Austria align well with the creation of a European Data Space, which reflects one of the priorities of the European Commission for 2019-25 (European Commission, 2021b).

Figure 17. Austria had sufficient ICU capacity to respond to the demand from COVID-19 patients



Sources: Austrian Ministry of Health (ICU bed capacity prior to COVID-19); Austrian Agency for Health and Food Safety (ICU bed surge capacity and COVID-19 patients).

Additional policy changes were introduced to boost the supply of health workers during the pandemic

The Austrian authorities adopted measures to strengthen the health and long-term care workforce during the pandemic. Austria has the second highest physician density in the EU, and the density of nurses is also well above the EU average (see Section 4). To help accommodate increased demand for services during the pandemic, the government adopted policies to relax some of the regulations that normally define the roles of health and long-term care professionals for the duration of the pandemic. Compulsory registration in a mandatory health professional registry set up in 2018 was suspended, allowing retired professionals, those with formal training who work in separate sectors and carers without formal training to step in to support the existing workforce. Moreover, the tasks and responsibilities of health and long-term care workers were modified, giving more flexibility to the tasks undertaken by different professionals. Medical students were also enlisted, in exchange for school credit.

Despite these policy changes, the pandemic nevertheless affected the mental well-being of health and long-term care workers. In May 2020, 46 % of care workers assessed their job as mentally stressful – a much higher percentage than the 11 % average among those in other occupations (Schmidt et al., 2020).

The response to COVID-19 in the long-term care sector improved, but some challenges remain

In Austria, long-term care (LTC) residents accounted for 44 % of all COVID-19 deaths by the end of January 2021 – a higher percentage than in Germany (29 %) and several other EU countries.

Most of the COVID-19 response for long-term care was taken at the regional level. While Austria did not have an emergency preparedness plan for the LTC sector prior to COVID-19, the sector quickly set up processes to develop various protocols, especially on infection prevention and control. However, some recommendations were difficult to implement, especially those related to the isolation of suspected or confirmed cases. Complete isolation was very difficult in nursing homes, in part because of double rooms.

The share of deaths among LTC residents was much lower in those regions where regional governments applied more stringent measures in LTC facilities from the onset of the pandemic. For example, in the Vienna region, measures including screening and visit restrictions to public spaces in nursing homes were more successful in reducing mortality than the specific "Corona traffic lights system" used in other regions that introduced graded measures according to the level of infections in the local context. By November 2020, restrictions in nursing homes were intensified across all regions, although some regional differences remained (Schmidt et al., 2020).

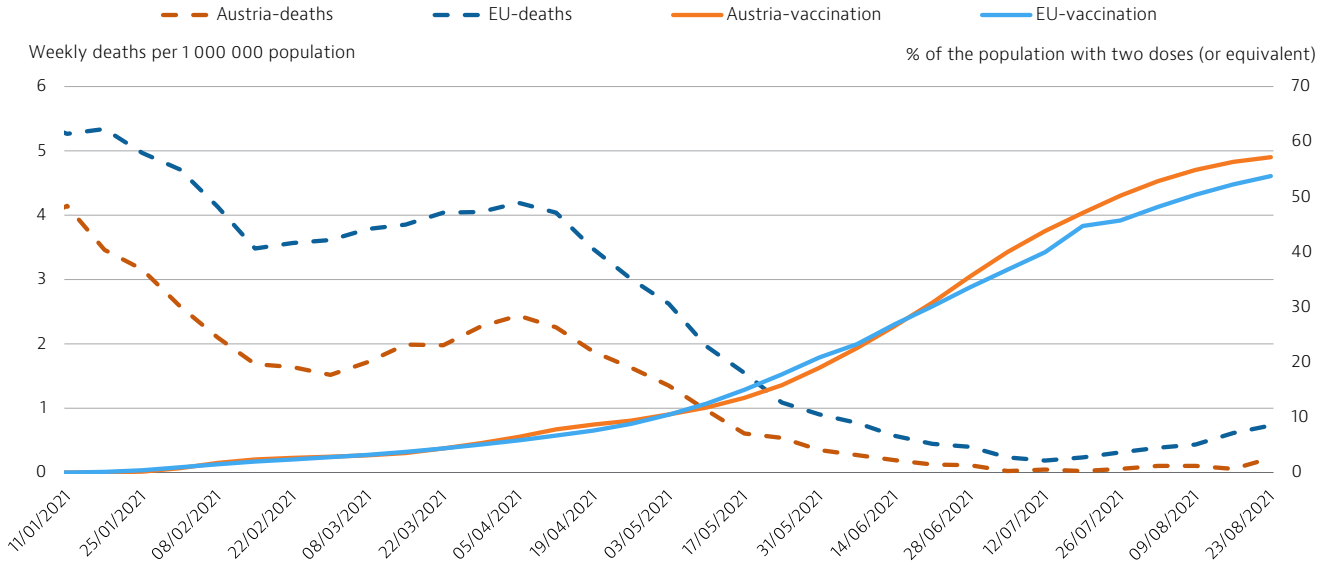
Austria launched its COVID-19 vaccine campaign at the end of December 2020

As in other EU countries, the COVID-19 vaccination campaign in Austria started at the end of December 2020. A three-phase campaign was developed, identifying priority groups for early vaccination based on risk of exposure and risk of severe complications or fatal outcomes from infection. Priority groups included older adults, adults with co-morbidities, health care workers, workers in long-term care facilities and workers in essential societal infrastructure, including those working in schools (ECDC, 2021).

As of the end of August 2021, over 60 % of the entire population had received at least one shot, and 57 % had received two doses (or the equivalent).

The increase in the percentage of people who had received two doses (or equivalent) since March 2021 was accompanied by a sharp reduction in deaths from COVID-19 (Figure 18).

Figure 18. Progress in vaccination has been accompanied by a sharp reduction in COVID-19 deaths since spring 2021



Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Sources: ECDC for COVID-19 cases and Our World in Data for vaccination rates.

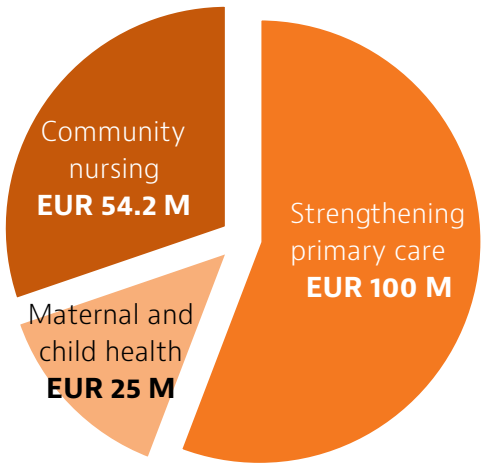
Additional public funding was made available to combat the COVID-19 pandemic

To help fight the COVID-19 pandemic, Austria's federal government increased the funds available to its health system, setting up separate accounts specifically for COVID-19 spending. EUR 28 billion in additional funding was allocated to address the COVID-19 crisis in 2020, of which at least EUR 579 million was allocated to the health sector, primarily for the purchase of personal protective equipment and medical supplies, and for research (OECD/EU, 2020).

In 2021, the health sector was allocated a further EUR 696 million to address extra costs related to the COVID-19 pandemic. This includes EUR 150 million for purchasing equipment and supplies and to support the creation of additional care facilities such as field hospitals; EUR 426 million to support testing, screening and the health workforce; and EUR 120 million to support the vaccination campaign (Bundesministerium Finanzen, 2021). Support for the influenza vaccination campaign also increased by EUR 8.6 million. At the same time, federal hospital financing will decline by EUR 129 million in 2021 compared with 2020, due to declines in federal tax revenues.

Austria's EU-funded Recovery and Resilience Plan (RRP) was adopted in June 2021. The Plan includes proposals to strengthen the sustainability and resilience of the health system. EUR 179.2 million over five years has been allocated to establish a further 70 primary health units and to improve the attractiveness of primary care; to increase support to disadvantaged populations – especially pregnant women, mothers and children; and to implement a community nursing programme to deliver care closer to people's homes (Figure 19).

Figure 19. The Recovery and Resilience Plan is allocating EUR 179.2 million for investment in the health sector



Source: Bundesministerium Finanzen (2021).

6 Key findings

- Life expectancy in Austria was 81.3 years in 2020 – above the EU average but nearly two years below the levels in the best-performing countries. Gains in life expectancy had slowed in Austria over the past decade, even before the COVID-19 pandemic led to the largest reduction since records began in 1951. In 2020, COVID-19 accounted for over 6 000 deaths.

- While most Austrians report being in good health, nearly two in five adults report at least one chronic condition. The burden of cancer in Austria is considerable: about 20 700 people died from cancer in 2019. Lung cancer remained the leading cause of cancer death. The COVID-19 pandemic led to sharp reductions in cancer screening rates; for example, colonoscopy screening fell by 34 % in the first half of 2020 compared with the first half of 2019. It will be important to assess the longer-term effects of the pandemic on timely diagnosis and treatment of cancers, and any negative impacts on survival rates.

- Risk factors and unhealthy lifestyles remain important drivers of mortality in Austria: about 40 % of deaths in 2019 can be attributed to smoking, dietary risks, alcohol, low physical activity and air pollution. Smoking and alcohol consumption among adolescents and adults in Austria remain above the EU averages.

- Austria has one of the most expensive health systems in the EU. Health spending per capita was the third highest in the EU in 2019. Out-of-pocket payments on health are higher than the EU average. Despite this, Austria has low levels of unmet medical care needs for financial or other reasons.

- The health system in Austria remains highly hospital-centric, with the highest share of health spending devoted to inpatient care. Recent reforms have aimed to reduce the complexity and fragmentation in the health system, including by strengthening primary care services. While 99.9 % of the population is covered through a social health insurance fund, benefits are not yet fully harmonised across funds.

- The number of physicians per capita was the second highest in the EU in 2019. However, the proportion of general practitioners is one of the lowest in the EU, and an ageing physician workforce remains a key challenge in Austria. The average age of physicians is over 50, and 60 % of contracted general practitioners are expected to reach retirement age by 2025.

- Austria reacted quickly at the start of the first wave of the COVID-19 pandemic, and was initially able to avoid the high number of cases and deaths experienced by many other European countries. The high capacity of the hospital system, including a relatively high number of intensive care unit beds, meant that hospital capacity was not saturated during the first wave. Additional measures were taken to mobilise resources to fight the pandemic, including scaling up the number of intensive care unit beds and expanding the health workforce.

- The three waves of the pandemic were met with a range of measures to contain the virus, including a series of strict lockdowns, imposition of a curfew, regulations related to mask-wearing indoors and travel restrictions. Testing also formed an important pillar of the Austrian strategy against COVID-19, with a series of mass testing events undertaken in December 2020 and January 2021 and widespread free-of-charge availability of antigen and PCR tests. From May 2021, a “Green Pass” was required to access certain public venues, including restaurants, bars and sports facilities.

- As in other EU countries, the vaccination campaign against COVID-19 started at the end of December 2020. As of the end of August 2021, over 60 % of the population had received at least one shot, and 57 % had received two doses (or equivalent). The increase in vaccination rates was accompanied by a sharp reduction in COVID-19 deaths.

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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		

European Commission

State of Health in the EU
Country Health Profile 2021

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

Please cite this publication as: OECD/European Observatory on Health Systems and Policies (2021), *Austria: Country Health Profile 2021, State of Health in the EU*, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

ISBN 9789264879645 (PDF)
Series: State of Health in the EU
SSN 25227041 (online)

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a partnership hosted by WHO