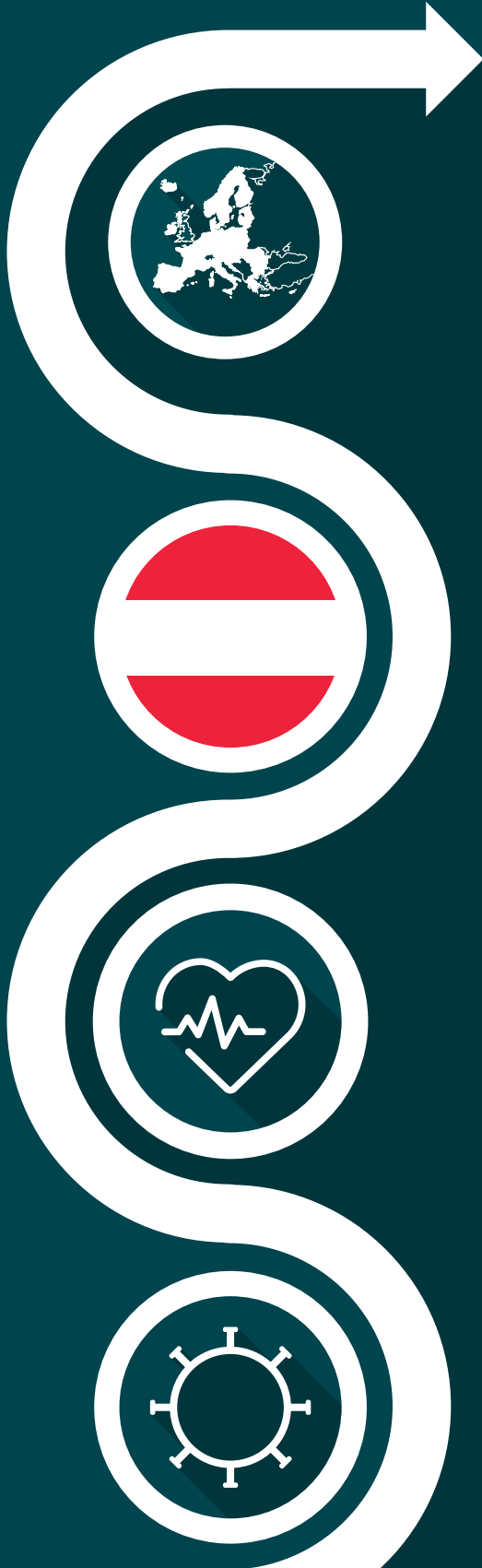




State of Health in the EU

Austria

Country Health Profile 2023

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 policy makers and influencers with a means for mutual learning and voluntary exchange. For the first time since the series began, the 2023 edition of the Country Health Profiles introduces a special section dedicated to mental health.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation 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 finalised in September 2023, based on data that were accessible as of the first half of September 2023.

Demographic and socioeconomic context in Austria, 2022

Demographic factors	Austria	EU
Population size	8 978 929	446 735 291
Share of population over age 65 (%)	19.4	21.1
Fertility rate ¹ (2021)	1.5	1.5
Socioeconomic factors		
GDP per capita (EUR PPP ²)	44 065	35 219
Relative poverty rate ³ (%)	14.8	16.5
Unemployment rate (%)	4.8	6.2

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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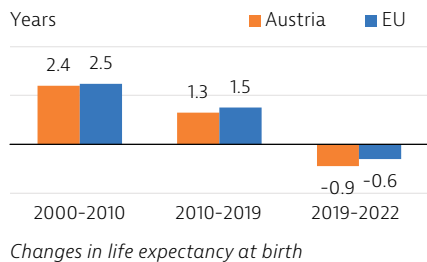
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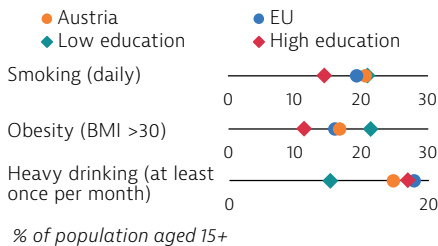
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1 Highlights



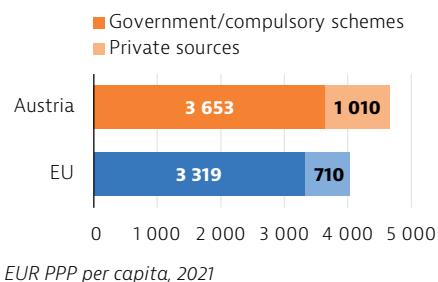
Health Status

Despite the sharp reduction of nearly 1 year in life expectancy in Austria between 2019 and 2022, it remained slightly higher than the EU average in 2022, at 81.1 years. Even before the pandemic, gains in life expectancy in Austria had slowed considerably between 2010 and 2019. Inequalities in life expectancy by socioeconomic status are substantial. At age 30, Austrian men with the highest level of education could expect to live 5.6 years longer than those with the lowest level in 2019, while the gap was 3.8 years among Austrian women.



Risk Factors

Many behavioural risk factors remain more prevalent in Austria than across the EU. Less educated groups are generally at higher risk, with the notable exception of heavy drinking. While overall alcohol consumption is among the highest in the EU, heavy drinking is less prevalent than in the EU among adults, but more prevalent among adolescents.

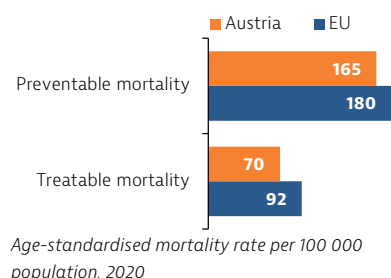


Health System

Health expenditure per capita was among the highest in the EU in 2021. Despite a declining trend, expenditure on inpatient care remains higher than the EU average. Three quarters of health expenditure come from public and compulsory schemes, which is less than the EU average, while the share of out-of-pocket spending is above the average. Despite high physician density, there are regional imbalances and few general practitioners.

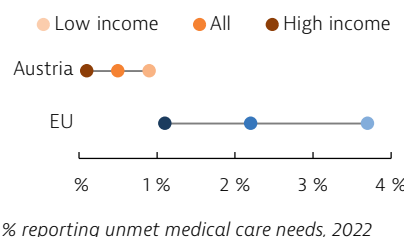
Effectiveness

Mortality from preventable and treatable causes was below the EU average in 2020. Nevertheless, Austria lags behind many other EU countries, suggesting room to improve prevention and healthcare, including prevention of circulatory diseases, cancers and other leading causes of death.



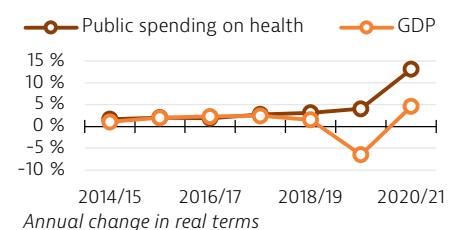
Accessibility

Austria has low levels of unmet medical needs. Social health insurance coverage is near-universal with only about 0.1 % of the population lacking insurance (e.g. undocumented migrants and people without stable employment or housing).



Resilience

With additional public funding allocated from the start of the COVID-19 pandemic, the annual growth in public health expenditure accelerated to reach 13 % in 2021 – well above national targets and GDP growth. Additional investments are now sustaining prior reform efforts in primary care and long-term care.



Mental Health

In 2019, the burden of mental ill health was estimated to be slightly higher in Austria than across the EU. Mental ill health is an increasingly recognised public health issue, and there are now several initiatives to provide easily accessible support and care – in particular for vulnerable groups, such as adolescents and women. However, provision of mental healthcare remains fragmented, and access barriers are generally more significant than for other types of care.

2 Health in Austria

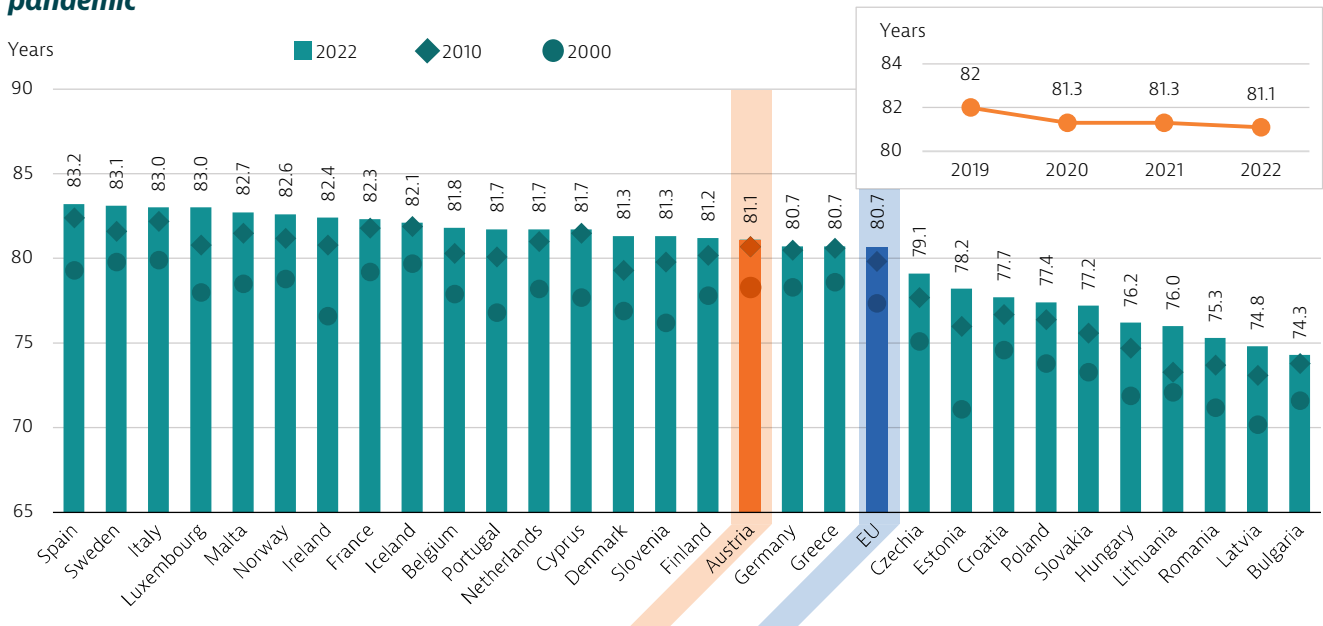
Life expectancy was above the EU average in 2021, although it fell by more than half a year during the pandemic

In 2022, life expectancy at birth in Austria was 81.1 years, 0.4 years higher than the EU average but two years lower than in Spain and Sweden, the two EU countries with the highest life expectancy (Figure 1). Life expectancy in Austria fell by

0.9 years between 2019 and 2022 due mainly to the COVID-19 pandemic. The reduction in 2020 was the biggest since the government began recording life expectancy in 1951.

The gender gap in life expectancy was below 5 years in 2022 (78.8 years for men, 83.5 years for women), which is slightly less than the EU average (5.4 years).

Figure 1. Life expectancy remains above the EU average, despite the sharp reduction during the pandemic



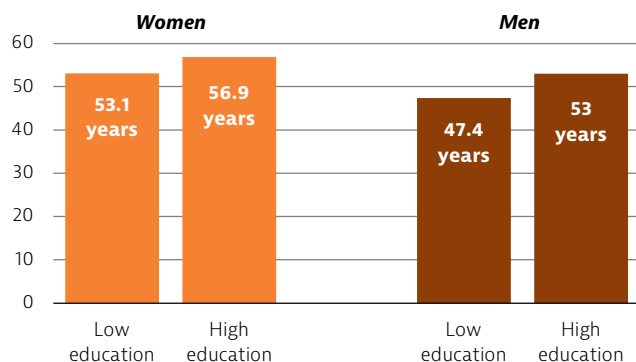
Notes: The EU average is weighted. The 2022 data are provisional estimates from Eurostat that may be different from national data and may be subject to revision. Data for Ireland refer to 2021.

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 30, Austrian men with the highest level of education could expect to live 5.6 years longer than those with the lowest level in 2019, while the gap was 3.8 years among Austrian women (Figure 2). The education gap in longevity is partly explained by higher exposure to various behavioural risk factors among people with low levels of education, including higher smoking rates and poorer nutrition (see Section 3), but also related to differences in living and working conditions.

Figure 2. The education gap in life expectancy is nearly 6 years for men and 4 years for women



Notes: Data refer to life expectancy at age 30. 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).

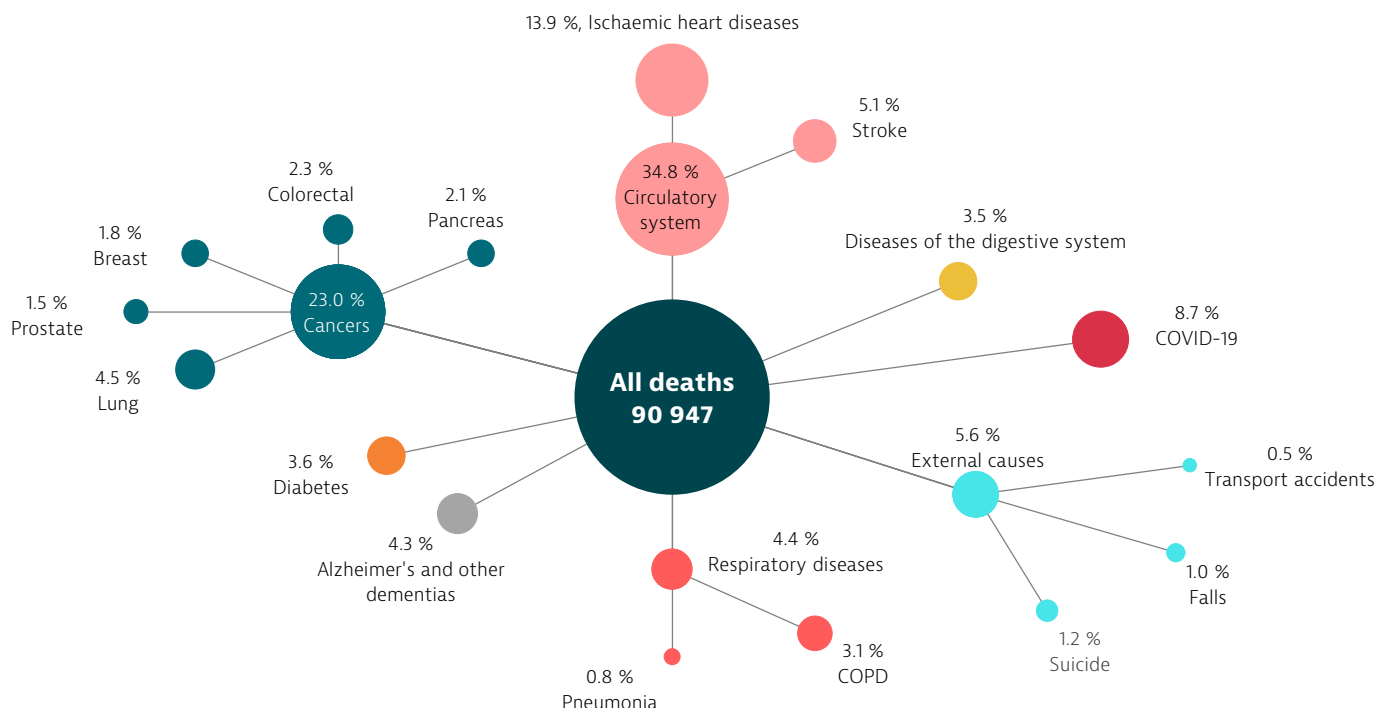
Source: Statistics Austria (data refer to 2019).

Circulatory diseases, cancer and COVID-19 were the main causes of death in 2021

In 2021, the leading causes of death in Austria were circulatory diseases (such as ischaemic heart diseases and stroke), cancer and COVID-19

(Figure 3). During the second year of the pandemic, COVID-19 accounted for 8.7 % of all deaths. Over 40 % of COVID-19 deaths during the first two years of the pandemic were among people aged 85 and over.

Figure 3. Circulatory diseases and cancer remained the leading causes of death in Austria in 2021, followed by COVID-19

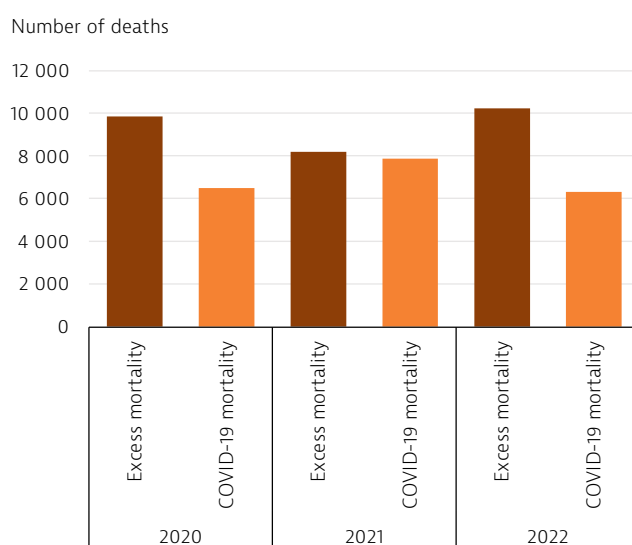


Note: COPD refers to chronic obstructive pulmonary disease.

Source: Eurostat Database (data refer to 2021).

The broader indicator of (all-cause) excess mortality shows that the annual numbers of deaths in 2020 to 2022 were between 10 % and 13 % above the average in the previous five years in Austria. This was slightly lower than the EU average. While excess mortality in 2020 and 2021 was driven mainly by COVID-19 deaths, in 2022 other factors such as the heatwave in the summer and an unusually deadly wave of influenza towards the end of the year also contributed to the higher number of excess deaths (Figure 4).

Figure 4. Excess mortality increased in 2022 despite a reduction in COVID-19 deaths



Note: Excess mortality is defined as the number of deaths from all causes exceeding the average annual number of deaths in the five years preceding the pandemic (2015-19).

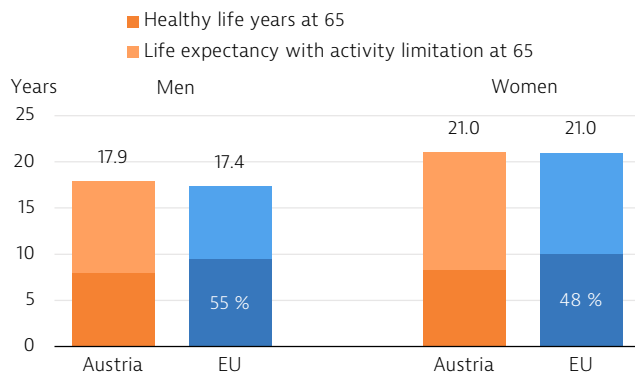
Sources: Statistics Austria (for COVID-19 mortality) and OECD Health Statistics based on Eurostat data (for excess mortality).

Women live a greater portion of their lives after age 65 with disabilities

As in other countries, the share of people aged 65 and over in Austria has grown over the past decades, from 15.4 % in 2000 to 19.4 % in 2022. This share is projected to increase to 28 % by 2050.

In 2020, women in Austria at age 65 could expect to live another 21 years, while men could expect to live nearly 18 years – a gap only slightly smaller than the EU average (Figure 5). However, the gender gap in healthy life years (defined as disability-free life expectancy) is much smaller because women can expect to live a smaller proportion of their lives free of disability (40 % compared to 45 % for men). Regional variation is also large, with shorter healthy life expectancy among people living in eastern than western parts of Austria (B-ZK, 2023).

Figure 5. Healthy life expectancy at age 65 was below the EU average in 2020



Note: Caution is required in comparing the data across countries as there are some variations in the survey instrument used to measure the "healthy" (activity limitation) part of this indicator.

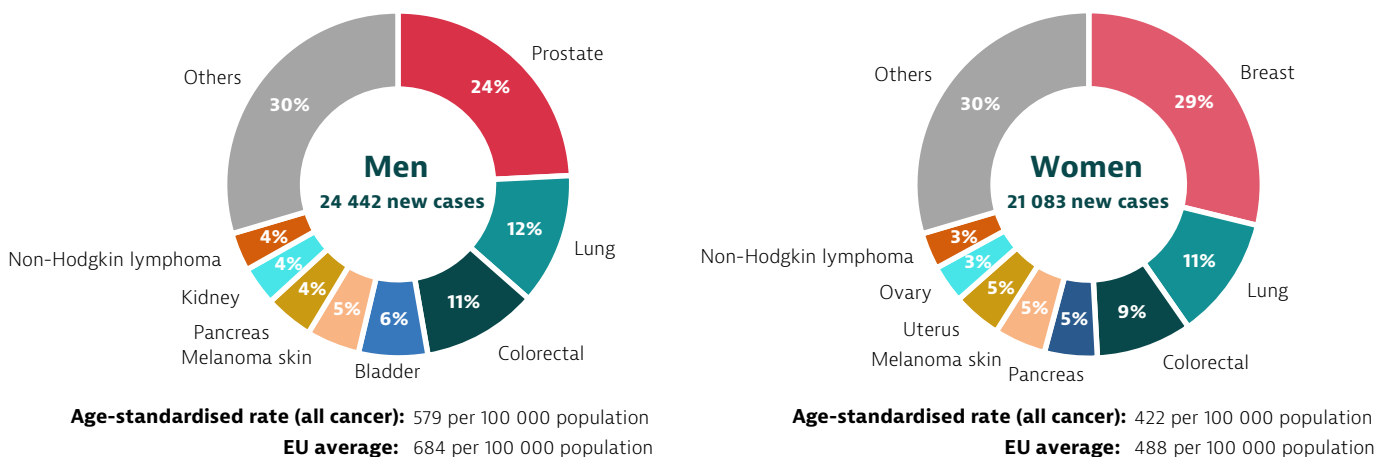
Source: Eurostat Database (data refer to 2020).

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

According to estimates from the Joint Research Centre based on incidence trends from previous years, more than 45 000 new cases of cancer were expected in Austria in 2022. However, cancer incidence were expected to be lower in Austria than the EU average among both men and women. Figure 6 shows that the main cancer sites among Austrian men are prostate (24 %), lung (12 %) and colorectal (11 %), while among Austrian women breast cancer is the leading cancer (29 %), also followed by lung (11 %) and colorectal cancer (9 %).

Policies to prevent cancer are guided by the national cancer framework plan, which sets reducing cancer incidence as the first of its six strategic goals. The plan aims to help the population makes healthy choices in areas such as smoking cessation, physical activity and reduced exposure to ultraviolet radiation from sunlight. The national online health portal publishes information on cancer to improve health literacy, including summaries of risk factors and prevention measures in plain language (OECD, 2023a).

Figure 6. More than 45 000 cancer cases were expected to be diagnosed in Austria in 2022



Notes: Non-melanoma skin cancer is excluded. Uterus cancer does not include cancer of the cervix.

Source: ECIS – European Cancer Information System.

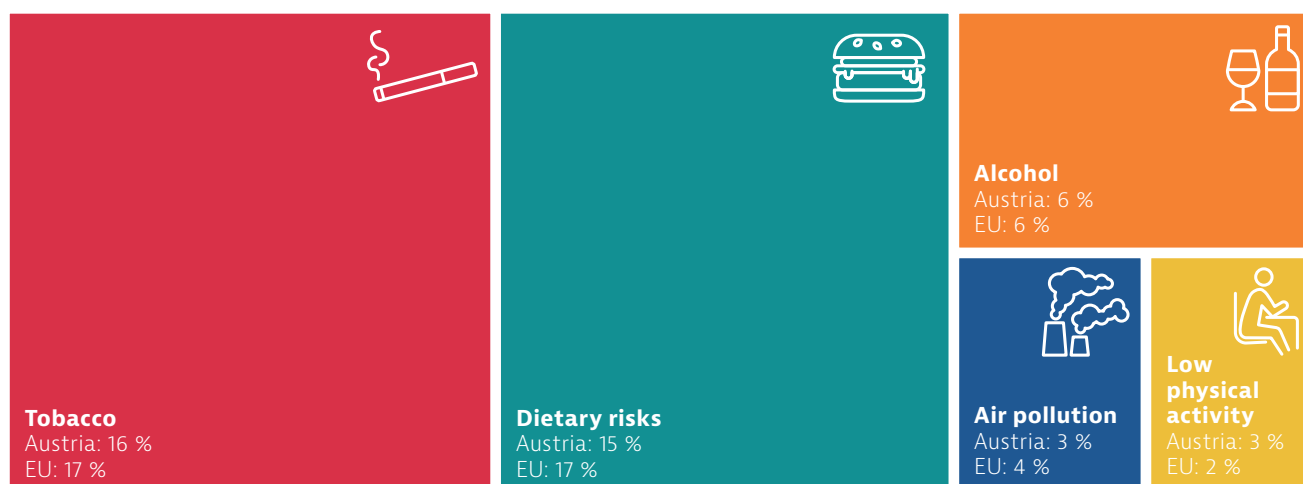
3 Risk factors

Behavioural risk factors are a major driver of mortality in Austria

Around 36 % 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 (PM_{2.5}) and ozone exposure alone is also linked to a non-negligible number of deaths in Austria each year (Figure 7).

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 to 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 (PM_{2.5}) and ozone exposure alone accounted for about 3 % of all deaths (2 700).

Figure 7. Tobacco and dietary risks are major contributors to mortality in Austria



Notes: 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 PM_{2.5} 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 proportion of daily smokers among Austrian adults fell from 24 % in 2014 to 21 % in 2019, it remains higher than in most EU countries. Similarly, the proportion of adolescents reporting that they smoked tobacco during the last month (based on HBSC surveys of 15-year-olds) fell from 23 % in 2014 to 19 % in 2022, but remains slightly higher than in most EU countries. At the same time, the use of e-cigarettes is similarly popular to other EU countries: more than one in seven 15- and 16-year-olds in Austria reported smoking e-cigarettes in 2019 – a proportion only slightly lower than the EU average, according to the ESPAD survey.

Policies to discourage cigarette smoking in Austria have lagged behind those in other European countries and a total ban on smoking inside restaurants and other hospitality businesses only became effective in November 2019. In the same year, the legal age for buying cigarettes was increased from 16 to 18 years. However, policies surrounding non-cigarette tobacco and nicotine products have been stringent. For example, the sale of chewing tobacco has been completely prohibited since 2017.

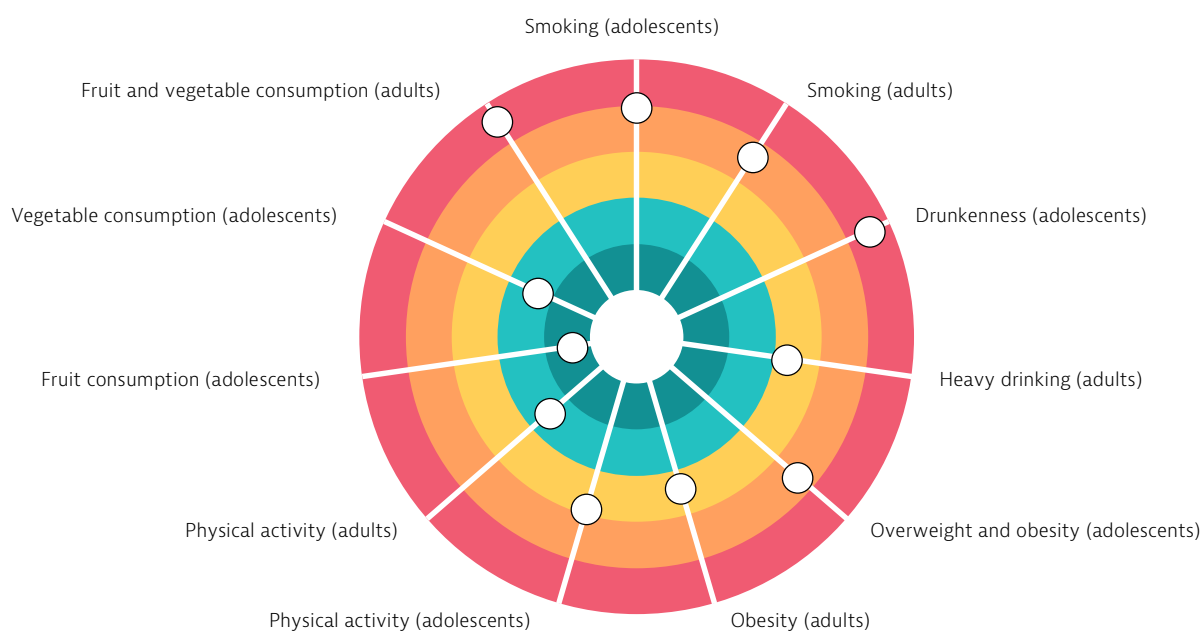
Alcohol consumption is higher than in many other EU countries

Overall alcohol consumption among adults has decreased since 2000, but it remained above the EU average in 2020. One in six adults (16 %) reported heavy episodic drinking in 2019, a proportion

higher than in many EU countries, although lower than the EU average¹. Alcohol consumption among adolescents in Austria is also greater than in other countries: in 2022, one third (33 %) of 15-year-olds

reported having been drunk at least twice in their lives according to the HBSC survey – the fourth highest proportion among EU countries (Figure 8).

Figure 8. Smoking, alcohol and overweight are important public health issues in Austria



Notes: 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 2022 for adolescents indicators; and EHIS 2019 for adults indicators.

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 23 % in 2022. This was also slightly above the EU average of 21 %.

As in many other EU countries, poor nutrition is the main factor contributing to overweight and obesity in Austria. In 2019, about 94 % of Austrian adults reported not eating at least 5 fruit and vegetables a day – the fourth highest proportion among EU countries. Among adolescents, in 2022, nearly two thirds of 15-year-olds reported not eating any vegetables as part of their daily diet, and about the same proportion reported not eating any fruit. While the proportion of adolescents eating fruit daily was higher than the EU average, daily vegetable consumption is comparable to the average.

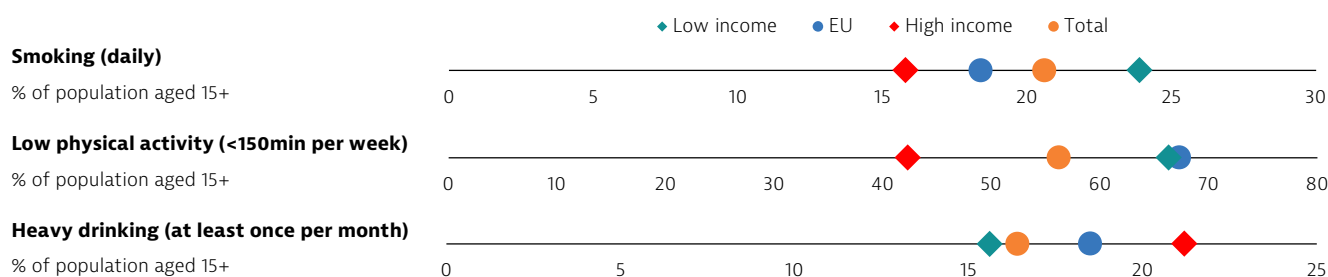
On the other hand, Austrian adults are among the most physically active in the EU, with 44 % of adults having reported at least 150 minutes of moderate physical activity per week in 2019, a share well above the EU average. However, only about 15 % of Austrian 15-year-olds reported engaging in moderate to vigorous physical activity every day in 2022 – a share close to the EU average.

Some risky health behaviours are more frequent among people with lower socioeconomic status

Some behavioural risk factors in Austria are more prevalent among people with lower education or income. In 2019, nearly one in four adults on low incomes (24 %) smoked daily, compared to only one in six (16 %) adults on high incomes. People at the lower end of the income distribution were also less physically active (Figure 9) and more likely to be obese. Conversely, alcohol consumption tends to be higher among people with high educational attainment and high incomes.

¹ Heavy drinking is defined as people having six alcohol drinks or more in a single occasion, each month, over the past twelve months.

Figure 9. People on low incomes are more likely to smoke and be less physically active



Note: Low income is defined as the population in the lowest income quintile, whereas high income is defined as the population in the highest income quintile.

Source: Eurostat Database (based on EHIS 2019).

4 The health system

The Austrian health system is structurally and financially fragmented

Responsibilities for health system governance are divided between the federal and state governments as well as corporatist stakeholders. The federal level sets the legal framework, including regulation of social health insurance (SHI), healthcare providers and most areas of care provision. The nine federal states (Länder) provide hospital care in their jurisdictions and fund capital expenditure in the hospital sector. Outside hospitals, healthcare providers are predominantly private, and negotiate collective contracts with SHI funds for the provision of outpatient care. Federal and state levels of government and SHI funds all contribute to funding.

SHI coverage is near-universal, with people assigned to SHI funds based on place of residence and/or occupation. Only about 0.1 % of the resident population lacked SHI coverage in 2021 (see Section 5.2). Private expenditure mainly takes the form of out-of-pocket (OOP) payments, while private insurance plays a limited role. OOP expenditure mainly finances benefits that are partly or not covered by SHI, including consultations of physicians without SHI contracts and copayments.

Reforms have attempted to overcome fragmentation, but progress remains slow

Major reforms aimed to address fragmentation of the health system. The main actors – the federal government, state governments and SHI funds – are now brought together in the target-based governance commission, which jointly establishes financial and health targets for 3-5-year periods,

codified in so-called “target-based governance agreements”, and monitors progress.

In 2020, a major reform reduced the number of SHI funds from 21 to 5, through a merger of nine regional and several company insurance funds into one major fund (Österreichische Gesundheitskasse – ÖGK), covering more than 80 % of the insured population, and mergers of the funds for self-employed people and farmers as well as the funds for civil servants and railway workers into now two funds. Although some steps have been taken towards convergence of benefits, differences still remain within the ÖGK and between funds, also because the merger did not change the legal framework for negotiation of contracts between SHI funds and state-level representations of healthcare providers. The reform was also criticised heavily for failing to provide mechanisms for achieving administrative cost savings of EUR 1 billion by 2023, which were announced as a major objective by the government at the time. In a recent report, the Federal Court of Auditors showed that administrative expenditure had in fact increased since the reform, at a rate comparable to a baseline scenario without the mergers (RH, 2022).

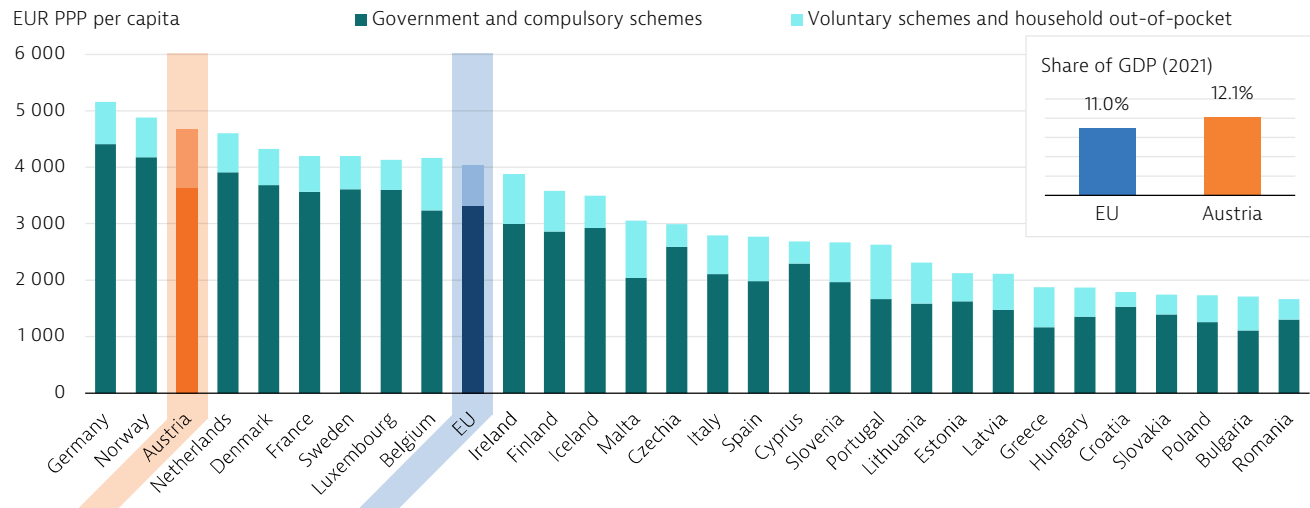
Austria has one of the most expensive health systems in the EU

In 2021, spending on health per capita (adjusted for differences in purchasing power) reached EUR 4 663 (compared to the EU average of EUR 4 028), which was the second highest in the EU after Germany (Figure 10). Health expenditure represented 12.1 % of GDP in 2021, which was also above the EU average of 11.0 % (on a weighted basis).

Starting in 2020, additional public spending was allocated to the health and long-term care sectors to cover COVID-19 related expenses. The target-based governance agreements include an explicit goal to keep the growth of publicly funded health expenditure aligned with GDP growth

and define annual spending targets. The latter were exceeded at the federal, state and SHI levels since the onset of the pandemic. However, the targets would have been exceeded even without extraordinary spending on COVID-19 (B-ZK, 2023).

Figure 10. Austria is among the EU countries with the highest health expenditure per capita



Note: The EU average is weighted.

Source: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

Health expenditure from government and compulsory coverage schemes accounted for 78 % of the total in 2021, with SHI financing the largest share, followed by general tax-funded government spending mostly for inpatient care. The share of expenditure financed from public and compulsory sources was stable in the years before the pandemic and increased during the pandemic, but remains below the EU average of 81 %. Conversely, the share of OOP payments accounted for 15.8 % of total health spending in 2021 (compared to an EU average of 14.5 %). Most OOP spending is on outpatient care, medicines, long-term care and dental care (see Section 5.2.).

Despite efforts to reduce the volume of inpatient care, it continues to absorb the largest share of health spending

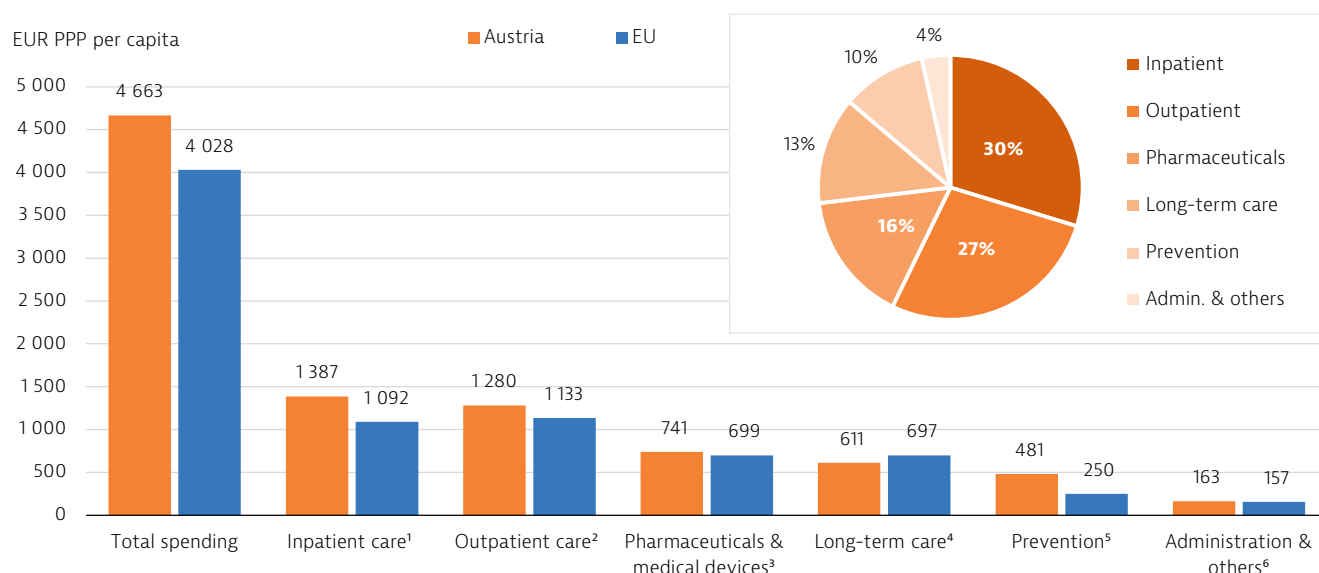
Although there has been a decreasing trend since 2010, Austria continues to spend the largest share of health expenditure and more than the EU average on inpatient care (30 % of the total in 2021 compared to an EU average of 28 %). In absolute terms, Austria had per capita expenditure on inpatient care of EUR 1 387 in 2021 compared to the EU average of EUR 1 092. Spending on prevention increased greatly during the pandemic and accounted for over 10 % of health spending in 2021 driven by COVID-19 testing and vaccination, a

much higher share than the only about 2 % before the pandemic (Figure 11).

The density of physicians is high compared to other countries but with regional and sectorial disparities

Austria had the second highest density of doctors in the EU in 2021, with 5.4 physicians per 1 000 population, up from 4.8 in 2010 and compared to the EU average of 4.1 (Figure 12). However, debate is continuing about a lack of doctors in certain specialities and sectors, in rural areas and certain federal states, with the density varying from 4 per 1 000 population in Burgenland to nearly 7 in Vienna (ÖÄK, 2023). Importantly, the proportion of general practitioners (GPs) has declined continually from 16 % in 2010 to less than 14 % in 2021, and is now one of the lowest in the EU. The density of nurses has increased in the past decade to 10.6 per 1 000 population in 2021, exceeding the EU average of 8.5.

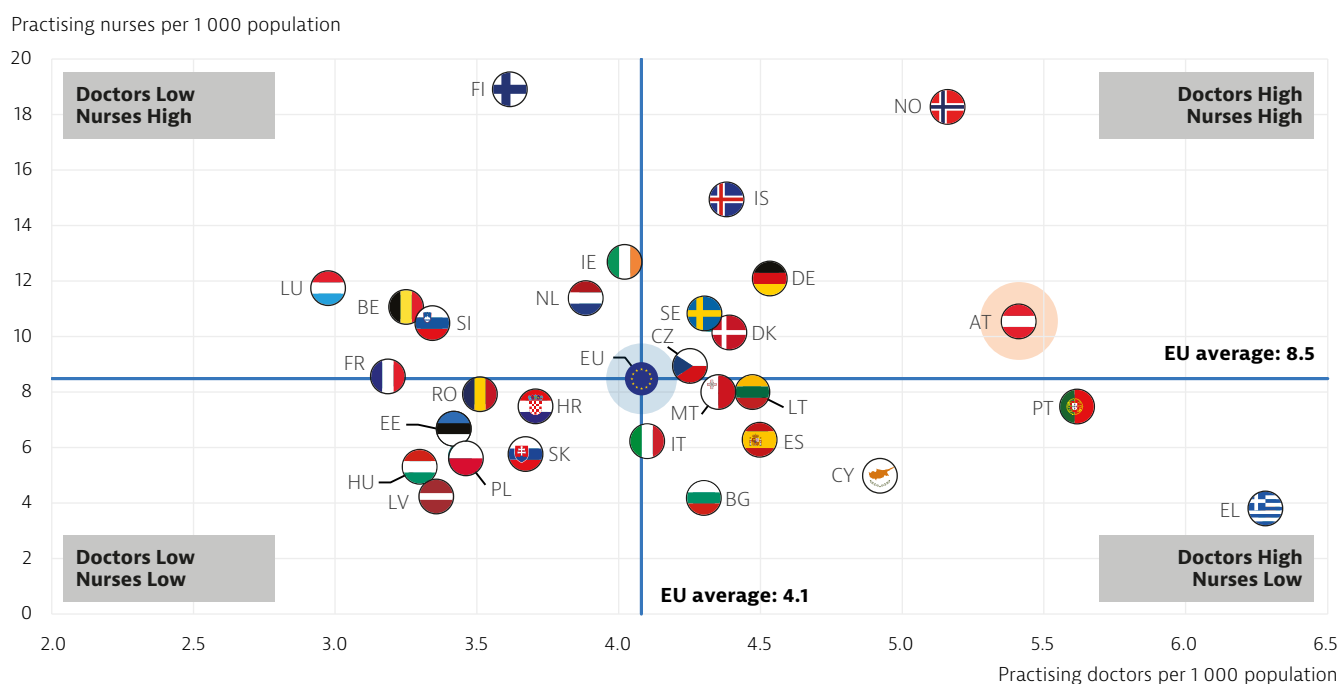
Figure 11. Austria continues to spend more on inpatient care than most EU countries



Notes: 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; 6. Includes health system governance and administration and other spending. The EU average is weighted.

Sources: OECD Health Statistics 2023 (data refer to 2021).

Figure 12. Austria has an above-average density of doctors and nurses



Notes: The EU average is unweighted. The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). 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: OECD Health Statistics 2023 (data refer to 2021 or the nearest available year).

5 Performance of the health system

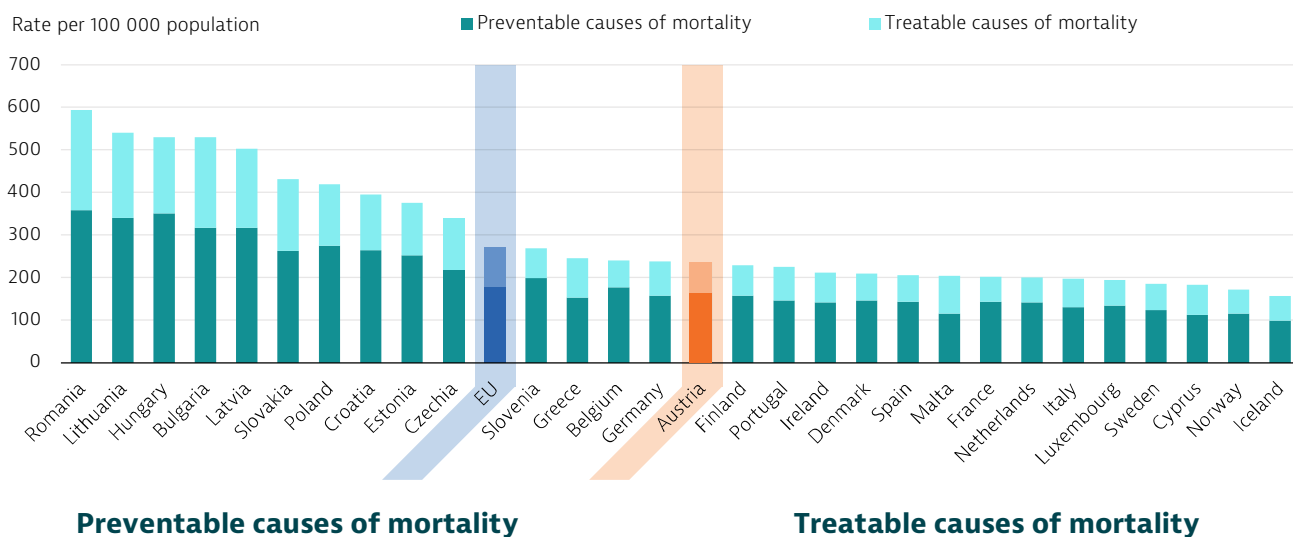
5.1 Effectiveness

Mortality from treatable and preventable causes could be reduced further

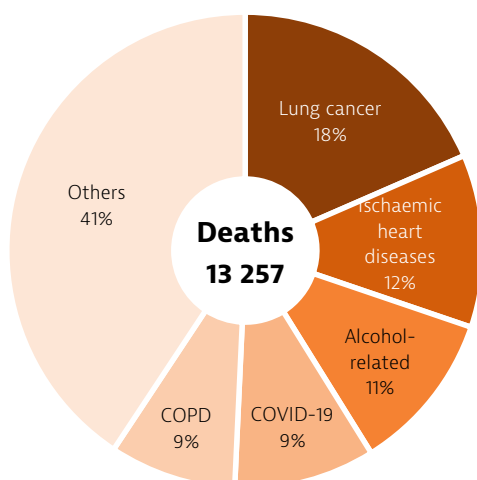
The health system in Austria is relatively effective in terms of avoiding deaths from causes that are treatable by timely and effective healthcare. However, although mortality from treatable causes was below the EU average in 2020, several EU Member States achieve even lower rates (Figure 13). Ischaemic heart disease, colorectal and breast cancers, and stroke were the main treatable causes of mortality, which could be reduced further through earlier diagnosis and timelier and more effective treatment.

Preventable mortality in Austria was also lower than the EU average in 2020, but also still markedly higher than in the best-performing countries in the EU. The leading causes of preventable mortality are lung cancer, ischaemic heart disease and alcohol-related diseases, followed in 2020 by COVID-19. Chronic respiratory diseases are also a significant contributor to preventable deaths. The high prevalence of behavioural risk factors, including smoking, alcohol consumption and poor nutrition, contributes to these preventable deaths (see Section 3).

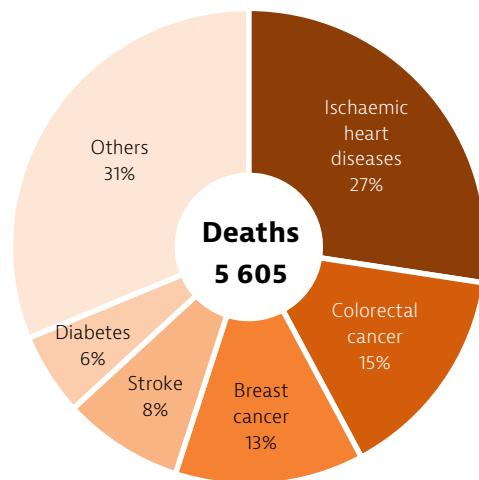
Figure 13. Treatable and preventable mortality are below the EU average but higher than in the best-performing countries



Preventable causes of mortality



Treatable causes of mortality



Austria

Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g. ischaemic heart disease, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death. COPD refers to chronic obstructive pulmonary disease.

Source: Eurostat Database (data refer to 2020).

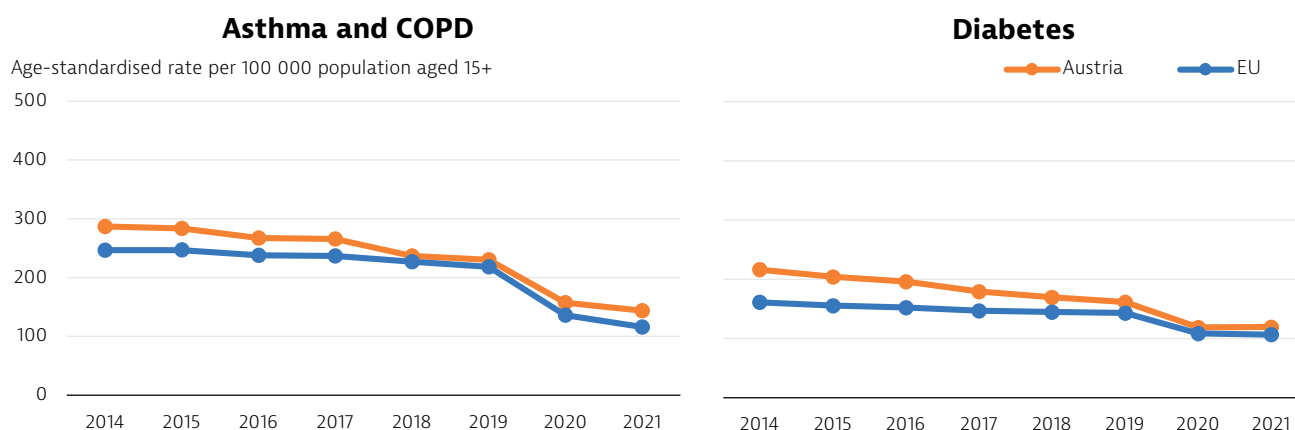
Quality indicators show improvements, but continued efforts are necessary to reduce hospital centricity

Potentially avoidable hospital admissions for chronic conditions have historically been higher in Austria than in most other European countries but have declined over the past decade and are now closer to the EU averages for some diseases. Nearly 145 admissions for asthma and chronic obstructive pulmonary disease (COPD) and 120 for diabetes were recorded per 100 000 adults in Austria in 2021, rates that remain slightly higher than the EU average. While the decline in the number of asthma and COPD admission rate between 2014 and 2021 was slightly slower in Austria (-50 %) than in the EU (-53 %), the rate of diabetes admissions declined more rapidly in Austria (-45 %, compared to -34 % across the EU) (Figure 14). The marked decline in admissions observed in 2020 should be interpreted in the context of the COVID-19 pandemic, which impacted non-COVID-19 hospital activity and modified healthcare-seeking behaviours (see Section 5.3). These declines cannot

therefore be understood as indicative of improved accessibility or quality of primary care for these chronic conditions in outpatient settings.

Despite continued reform efforts and a gradual shift towards more activity in outpatient sectors, Austria's health system remains hospital-centric. According to the latest report monitoring achievement of the goals in the national target-based governance agreement, the use of inpatient services increased from 2020-21 in the context of the COVID-19 pandemic, but this was preceded by a decline before the onset of the pandemic. There is consensus that primary care requires further strengthening, a goal which is mainly pursued through establishing multi-disciplinary primary care centres and networks. The number of primary healthcare units had increased to 40 by mid-2023, but still remains far from the target of 75 initially set for 2021 and subsequently extended to the end of 2023. Only 3.3 % of the population received primary care from such units (B-ZK, 2023).

Figure 14. Avoidable hospital admissions for diabetes have declined more rapidly in Austria than the EU average, but reductions in admissions for asthma and COPD were comparable



Note: Admission rates are not adjusted for differences in disease prevalence across countries.

Source: OECD Health Statistics 2023.

Although mortality from preventable causes remains significant, some progress is made in prevention-related indicators

Behavioural risk factors, including not only smoking but also unhealthy eating, alcohol consumption and low physical activity, continue to be a major driver of mortality in Austria (see Section 2). Greater public health and prevention efforts could help to reduce such mortality. Some progress has been made in Austria since the inception of the 2014 Health Promotion Strategy, agreed on by the national target-based commission and renewed in 2016. It was aligned with the

“Austrian Health Goals” – the overarching and long-term goals for health policy at the national level, which defined a number of strategic goals for prevention and health promotion and allocated additional funds for this purpose, including through the creation of state-level prevention funds. The strategy particularly emphasised prevention for children and adolescents and health literacy of working-age adults and older people. However, as a share of overall health spending, spending on public health and prevention still accounted for only about 2 % of overall spending before the pandemic.

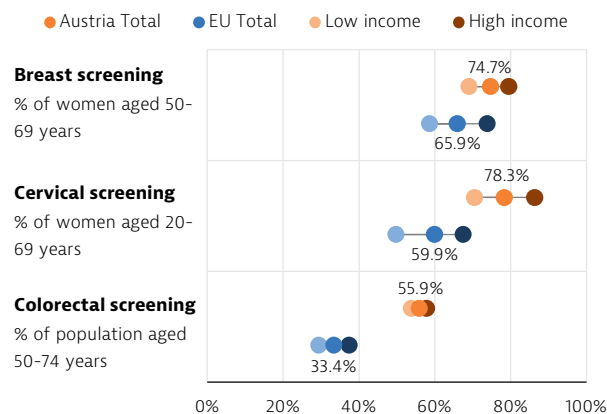
The Health Promotion Strategy has been criticised for having failed to improve health status measurably so far and for being too tentative, for example through relying too heavily on voluntary measures and not making longer-term funding commitments to sustain successful projects (RH, 2023).

A comprehensive cancer framework plan is in place since 2014

A national cancer framework plan is in place since 2014 and covers prevention, early detection, treatment and rehabilitation (OECD, 2023a). Austria generally performs better than many other European countries in terms of uptake of early detection services, although breast cancer is the only type of cancer for which a national organised screening programme has been implemented so far.

Socioeconomic disparities in uptake remain comparable to the EU as a whole (Figure 15). For example, in 2019 78 % of women aged 20-69 reported having undergone a recent test for cervical cancer (60 % in the EU), ranging from 71 % in the lowest to 86 % in the highest income quintile (compared to the range of 50 % to 68 % across the EU).

Figure 15. Cancer screening rates in Austria are generally higher than the EU average



Notes: Low income is defined as the population in the lowest income quintile, whereas high income is defined as the population in the highest income quintile. The proportions refer to people who report having undergone a test in the two years preceding the survey.
Source: Eurostat Database (EHIS 2019).

Screening rates declined drastically at the start of the COVID-19 pandemic, and in particular during the first lockdown in 2020, but rebounded quickly to pre-COVID-19 levels, so that the overall impact is expected to remain limited.

Vaccination rates are generally below the EU average

Vaccination rates for infectious diseases among children and older people are generally below EU average in Austria. Not even one in five of people aged 65 or above (18 %) were vaccinated against influenza in 2019, half the rate in the EU in this high-risk group. However, the COVID-19 pandemic contributed to an increase in demand for influenza vaccination in 2020.

The uptake in childhood vaccination is below the EU average for diphtheria, tetanus and pertussis (DTP) (85 % in Austria compared to 95 % in the EU in 2020) and hepatitis B. The same is also true for vaccinations against human papillomaviruses (HPV) among teenagers, infections that can be risk factors for cancer (OECD, 2023a).

5.2 Accessibility

Access to healthcare is generally considered good and there are only small gaps in insurance coverage

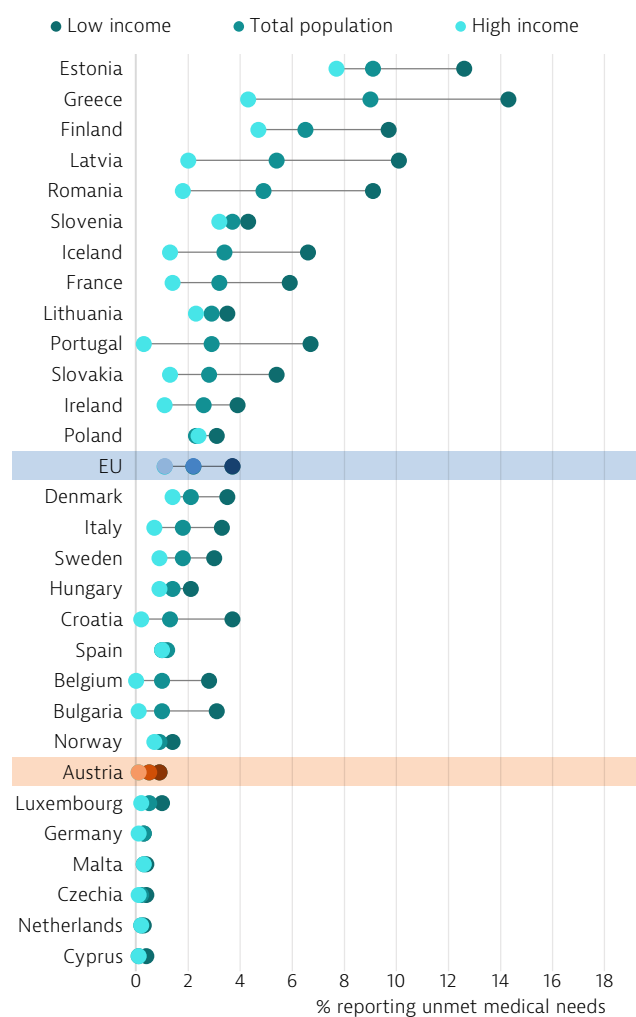
SHI is mandatory in Austria; it covers almost the entire population and offers a comprehensive benefits package, which included care for COVID-19 during the pandemic. As a result, access to healthcare is generally considered good, and Austria is among the EU countries with the lowest self-reported unmet medical needs (Figure 16).

The benefits package is comprehensive but not fully harmonised between social health insurance funds

A basic principle of the law governing Austrian SHI is that insurance provides access to all healthcare that is appropriate but does not exceed what is necessary. The benefits package is comprehensive and includes in- and outpatient care in the hospital and ambulatory sectors, medicines, dental care and rehabilitation.

However, small differences in coverage remain between the distinct SHI funds and also within the principal fund ÖGK across federal states. Alignment of benefits was a stated objective of the 2017 SHI reform that reduced the number of funds effective from 2020, with the general objective of an “upward” alignment, that is, an expansion of the most generous coverage to the entire population insured by the new consolidated fund. This has not been achieved and differences remain, for instance, in the types of outpatient physician services covered, including for mental health, in copayment requirements and in coverage of health service related to accidents (RH, 2022).

Figure 16. Self-reported unmet medical needs are close to zero even in low-income groups



Notes: 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.

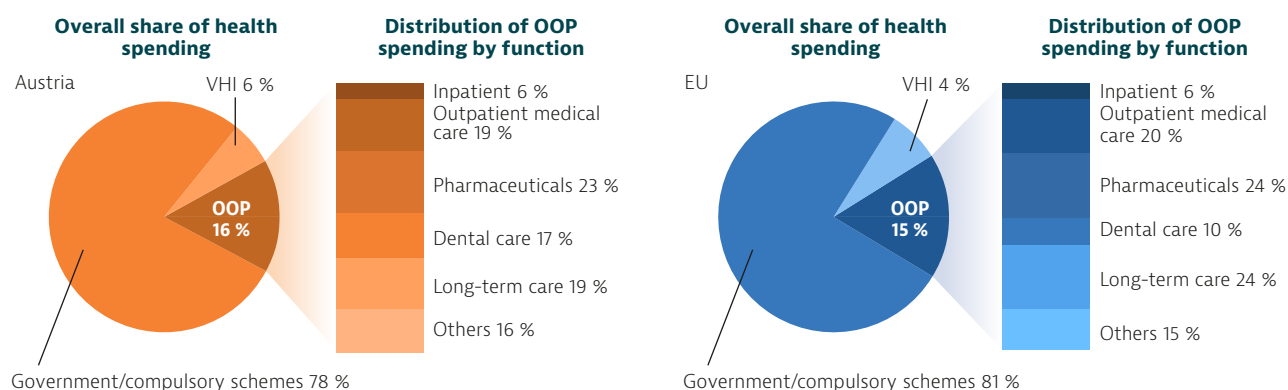
Source: Eurostat Database, based on EU-SILC (data refer to 2022, except Norway (2020) and Iceland (2018)).

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

Over three quarters (78 %) of all health expenditure in Austria was funded by government and the compulsory SHI scheme in 2021, while 16 % was paid out of pocket by households and the remaining 6 % was funded through voluntary health insurance and other voluntary prepayment schemes (such as enterprise and non-governmental organisation financing schemes). In absolute terms and adjusted for differences in purchasing power, OOP spending was the third highest among EU countries. Outpatient pharmaceuticals accounted for the largest share of OOP expenditure (23 %), followed by outpatient medical care and long-term care (19 % each) and dental care (17 %) (Figure 17).

Although private financing sources constitute a larger share of total health financing in Austria than in the EU (OOP payments make up 15 % and voluntary insurance schemes 4 % on average across the EU), financial access barriers are generally not considered a major issue in Austria. Exemptions from copayment requirements and safety nets for low-income households is one reason for this and the incidence of catastrophic household spending on health is below the EU average. For example, a flat fee (currently EUR 6.85) is charged for filling a prescription for outpatient medicine, but fees are subject to an annual cap and waived for people with an annual income below a defined threshold. Nevertheless, catastrophic spending on health affected an estimated 3 % of Austrian households in 2015, more than two thirds of which were in the poorest income quintile (Czypionka et al., 2018)².

Figure 17. The largest shares of out-of-pocket spending go to outpatient medicines and outpatient care



Notes: VHI refers to voluntary health insurance, which also includes other voluntary prepayment schemes. The EU average is weighted.

Sources: OECD Health Statistics 2023; Eurostat Database (data refer to 2021).

² Catastrophic expenditure is defined as household OOP spending exceeding 40 % of total household spending net of subsistence needs (i.e. food, housing and utilities).

Increasing private practice raises concerns

There are increasing concerns about the availability of certain health services and equity of access, particularly in the ongoing debate about imbalances in the physician workforce. The physician workforce is ageing, and an increasing proportion opt for private practice (without a contract with SHI funds). In 2022, only 58 % of office-based GPs and 28 % of specialists practising outside hospitals had a contract with the main SHI fund.

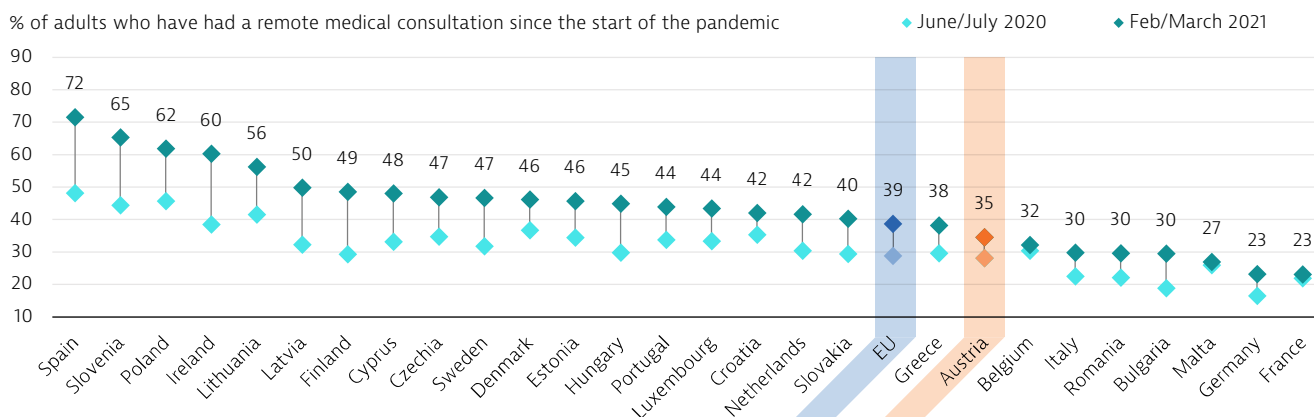
The trend towards private physician practice is also apparent in significant increases of SHI expenditure for consultations provided by physicians without SHI contract. Such consultations can entail significant OOP payments and may jeopardise equity of access in the longer run. Physicians can set their consultation fees freely in private practice and patients must pay the full fees upfront, but can claim reimbursement of 80 % of the corresponding rate negotiated by SHI for the same service, if covered. This means that there is a risk that access to outpatient medical treatment becomes increasingly dependent on ability to pay rather than underlying need. While the average physician

age was above 50 for both GPs and specialists, 8 % of physicians were above retiring age of 65 years and 37 % were expected to retire within 12 years (ÖÄK, 2023). Making primary care and practice with SHI contract more attractive is a stated policy goal.

Teleconsultations have increased more slowly than in most EU countries during the pandemic

Although the COVID-19 pandemic has catalysed the use of telemedicine, survey data suggest that uptake in Austria remains below the EU average. In early 2021, 35 % of the Austrian population reported having had a telemedicine consultation, an increase of 6.4 percentage points from the first months of the pandemic in 2020. Meanwhile, the share increased by 9.9 percentage points to 39 % in the EU, so that the gap widened (Figure 18). While temporary telemedicine policies introduced during the pandemic have been extended (such as electronic prescriptions, see Section 5.3), more general efforts to expand the effective use of telemedicine remain limited in Austria (OECD, 2023b).

Figure 18. Although the uptake of telemedicine increased during the pandemic, the increase was below the EU average



Notes: The EU average is weighted. Low reliability for 2021 data from Cyprus, Latvia, Luxembourg (and 2020 data) and Malta because of low sample size. Source: Eurofound (2022), Living, working and COVID-19 e-survey

5.3 Resilience

The COVID-19 pandemic was by far the largest shock to health systems in recent decades. The pandemic exposed some of the major vulnerabilities and challenges in countries' emergency preparedness strategies and in their capacity to deliver health services to their populations. Faced with the legacy of the pandemic

and other recent crises (e.g. the cost-of-living pressures and the impact of the war against Ukraine), countries are pursuing policies to address the ongoing impacts on provision of services, invest in health system recovery and resilience³, improve critical areas of the health sector and fortify their preparedness for future shocks.

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).

Overall, the Austrian health system may have been less affected by the COVID-19 pandemic than other countries because the relatively high availability of physical and human resources, including a large hospital sector, provided more capacity for absorbing COVID-19 patients than in other EU countries. At the same time, lockdowns and other restrictions were effective at containing COVID-19 and health services were not overburdened at any time early in the pandemic.

Health service delivery was affected heavily early in the pandemic but rebounded afterwards

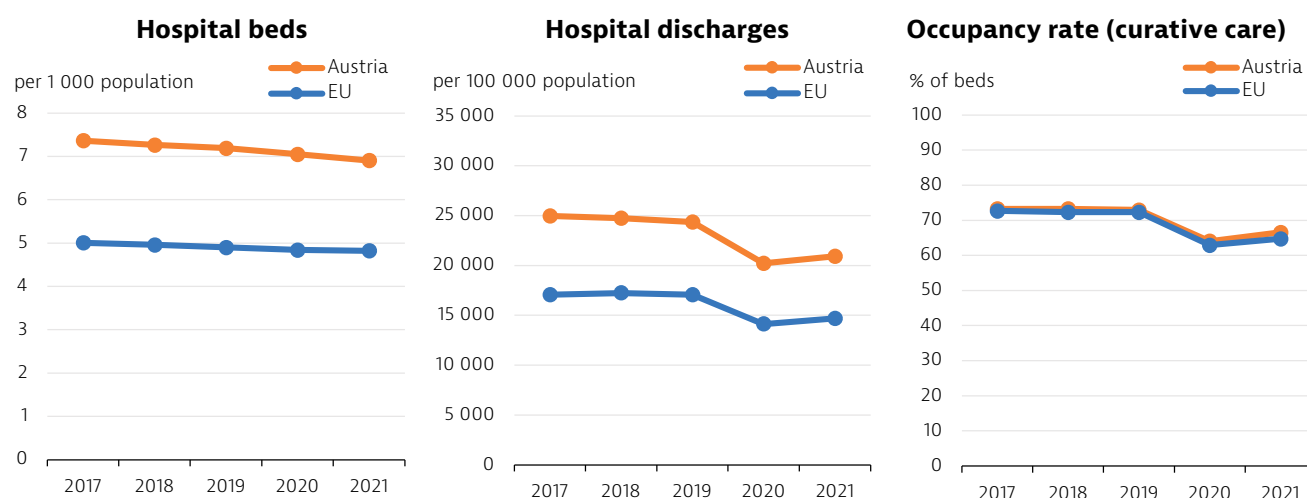
Hospital and intensive care unit (ICU) activity in Austria declined during 2020 while capacities remained largely unaffected during the first year of the pandemic. In line with existing reform efforts, the number of hospital beds continued to decline along the pre-2020 trend to 6.9 per 1 000 population in 2021 (compared to an EU average of 4.8 per 1 000), while ICU capacity remained constant. Meanwhile, the hospital discharge rate declined by 17 % and the occupancy rate by 12 % between 2019 and 2020; these are comparable to the declines in the EU as a whole, and remained below the pre-pandemic level despite a slight rebound in

2021 (Figure 19). Similarly, the volume of elective surgery such as hip and knee replacements declined by approximately 10 % in the first year of the pandemic, slightly less pronounced than the declines in the EU, followed by rebounds in 2021. The number of hospital discharges in Austria, however, remained more than 40 % higher than the EU average in 2021, and the levels of surgical activity also remained markedly above the EU average.

An analysis of monthly data for 2020 by the National Public Health Institute showed that the effect of COVID-19 on ICU occupancy was most pronounced during the second wave of the pandemic in late 2020. By December 2020, approximately 30 % of ICU capacity was attributable to COVID-19 patients while non-COVID-19 occupancy had declined markedly.

On the other hand, monthly data showed that cancer screening and elective surgery came to a near-halt during the first lockdown in April and May 2020, with a less marked impact during the second wave later in the year, but rebounded quickly after the end of the severest restrictions (Eglau, 2021).

Figure 19. Health services were affected mainly in the 2020 waves of the COVID-19 pandemic



Note: The EU average is unweighted.

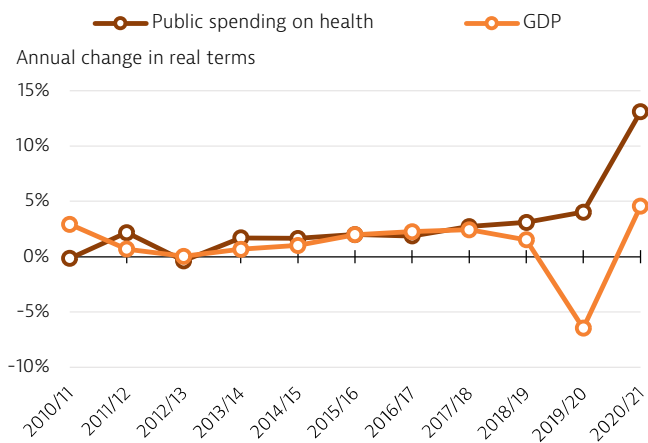
Sources: OECD Health Statistics 2022; Eurostat Database.

Additional investments in the health system are sustaining prior reform efforts in primary care and long-term care

With additional public funding allocated to healthcare from the start of the pandemic, the annual growth in public health expenditure accelerated to reach 4 % in 2020 and 13 % in 2021. Combined with the effects of COVID-19 on the

economy that led to a GDP contraction in 2020 and a partial recovery in 2021 (Figure 20), health expenditure as a proportion of GDP was much higher in 2021 than before the pandemic.

Figure 20. Growth in publicly funded health expenditure accelerated during the pandemic



Source: OECD Health Statistics 2023.

While the focus of the Austrian Recovery and Resilience Plan, adopted in 2021, is on digitalisation and environmental and climate policies in the wider economy, it also comprises additional funding through 2026 to continue ongoing reforms that aim to improve primary care (EUR 100 million), including through the establishment of multi-disciplinary primary care units (see Section 5.1.), and for long-term care (EUR 54 million). The establishment of easily accessible community nursing services is a cornerstone of the improvement of long-term care, with an initial goal of 150 community nurses to take up activity by the end of 2024.

COVID-19 also catalysed reform of the National Public Health Service, an effort that had already been under way for several years and comprised an update to the legal framework, widening responsibilities of the service and making public health a more attractive career choice for physicians and other health professionals. On the other hand, reform objectives of the current target-based governance agreement have so far remained substantially unchanged, with the extension of its validity to the end of 2023.

Efforts to enhance health system efficiency continue to focus on primary care, digitisation and pharmaceutical policy but progress is slow

Although behind schedule, establishment of interdisciplinary primary care units and efforts to improve integrated care continue to be the major reforms to increase health system efficiency. This is accompanied by targets to strengthen the hospital outpatient sector, increase the volume of day cases and treatment episodes in outpatient settings and reduce the number of admissions by 2 % annually. A slight increase of inpatient activity in 2021 during

the COVID-19 pandemic notwithstanding, efforts to increase outpatient and reduce inpatient activity are on track based on trends compared to the pre-COVID-19 period (B-ZK, 2023).

Austria continues to make progress in the uptake of digital health tools

Expanding the use of a universal electronic health record (Elektronische Gesundheitsakte – ELGA) and its e-medication and e-report applications has been a focus since its introduction in 2014, with implementation monitored as part of the national target-based governance agreement. By March 2022, ELGA was operational in 68 % of hospitals, including all publicly owned hospitals, 97 % of pharmacies, 94 % of physician offices with SHI contracts and 9 % of long-term care facilities. An electronic vaccination record was added to ELGA in 2021 and used as part of the COVID-19 vaccination rollout. SHI funds expanded the use of electronic prescriptions during the pandemic. However, the increasing preponderance of private practice is also a concern with respect to use of the electronic health record, as physicians without SHI contract have no obligation yet to use the record and have to self-fund investments in the necessary electronic infrastructure.

Despite the strong electronic infrastructure and progress in the primary use of data, health system governance and research could benefit from greater use of data. Secondary use of ELGA data is heavily restricted by legislation and existing routine health datasets are not frequently linked or analysed for research, statistical or monitoring purposes. As a result, Austria scores lower than a number of EU countries in terms of data governance and use – in particular, compared to Nordic and Baltic countries (Oderkirk, 2021).

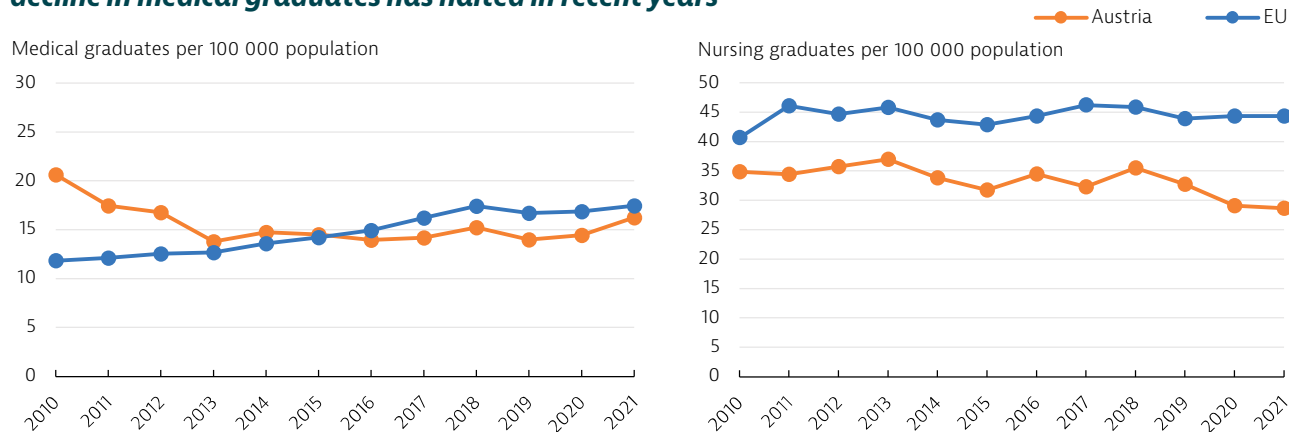
Pharmaceutical expenditure could be used more efficiently

There continues to be significant scope for increasing the efficiency of pharmaceutical expenditure in Austria. Prescribing by international non-proprietary name and generic substitution by pharmacists are prohibited with some exceptions, making Austria an outlier in the EU. At 36 % of the total volume of medicines in 2021, the share of generics used in Austria was well below that of Germany (83 %) or the Netherlands (79 %). Although the national target-based agreement comprises a target related to access to medicines, including a commitment to joint procurement and strengthening of health technology assessment, little progress had been made by 2021, and the deadline was extended to the end of 2023 (B-ZK, 2023).

Debates about the physician workforce dominate workforce planning

Health workforce planning in Austria is currently dominated by debates about growing imbalances in the physician workforce and longer-term sustainability. Both the density of doctors and nurses have increased over the past decade and are above the EU average (as shown in Figure 12 above), but the demand for healthcare is also growing due to population ageing.

Figure 21. The number of medical and nursing graduates in Austria has declined since 2010, but the decline in medical graduates has halted in recent years



Note: The EU average is unweighted.

Source: OECD Health Statistics 2023.

Monitoring of the national target-based agreement shows that the number of medical graduates in postgraduate training has increased rapidly in various specialties between 2016 and 2021 (+18 %), while the number in general practice has decreased (-14 %), but this reduction has halted since 2019 (B-ZK, 2023).

Reducing the risk of other public health threats: Austria's preparedness to antimicrobial resistance

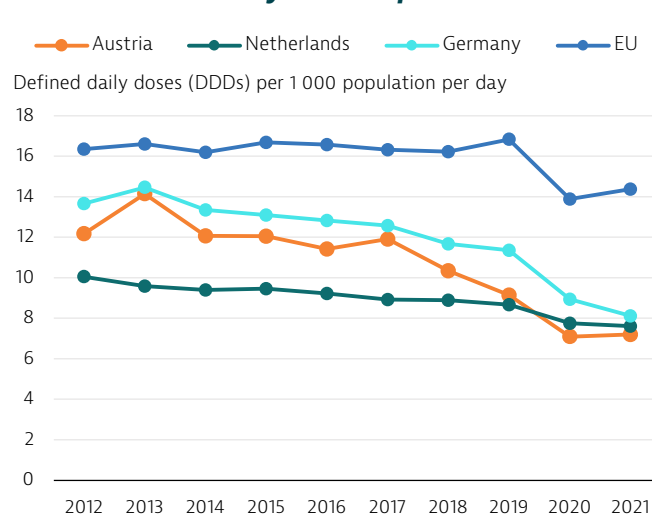
Antimicrobial resistance (AMR) is a major public health concern in the EU, with estimates of about 35 000 deaths in 2020 due to antibiotic-resistant infections (ECDC, 2022), and healthcare-associated costs of around EUR 1.1 billion per year (OECD/ECDC, 2019). Antibiotic overprescription and overuse in humans are major contributors to AMR.

Antibiotic consumption in Austria has fallen sharply since 2013 and was one of the lowest among EU countries in 2021 (Figure 22). AMR as measured by methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections was also among the lowest across EU countries in 2021 (ECDC, 2022). Since 2013, a national AMR action plan has been in place in Austria. It comprehensively covers, among other things,

The number of medical graduates relative to the population has declined since 2010, although there is a slight upward trend since 2020 reflecting decisions to increase student intakes about five years earlier. The past decline was related to deliberate efforts to limit the number of students in medical schools. The number of nursing graduates relative to the population has declined since 2010 and remains below the EU average (Figure 21).

actions to prevent infections, responsible use of antibiotics and stewardship as well as broad surveillance strategy across human and animal use of antibiotics, including in food products and the environment (BMSGPK, 2021).

Figure 22. Outpatient antibiotic use in Austria has declined steadily over the past decade



Note: The EU average is unweighted.

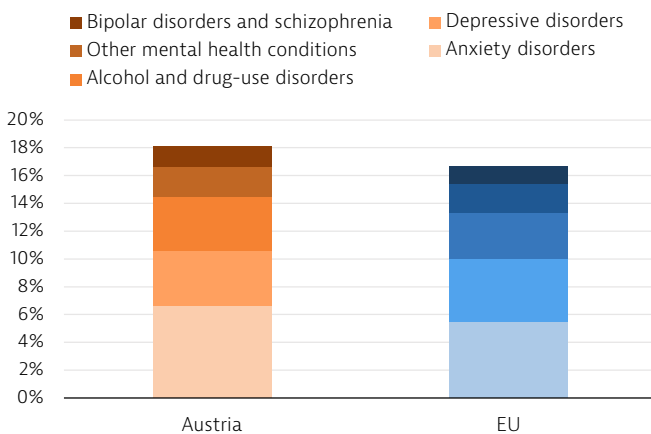
Source: ECDC ESAC-Net

6 Spotlight: mental health

Austria has a higher burden of mental health problems than the EU average

Mental health is an increasingly recognised public health issue in Austria, where the prevalence of mental health disorders is estimated to be slightly higher than the EU average. This is driven by a higher prevalence of anxiety, depressive and alcohol and drug-use disorders (Figure 23). The total costs related to mental ill health were estimated to represent 4.3 % of GDP (EUR 14.9 billion) in 2015, compared to 4.1 % in the EU as a whole (OECD/EU, 2018). This includes 2.5 % of GDP in direct costs to the health system and social programmes and 1.8 % in indirect costs to the labour market.

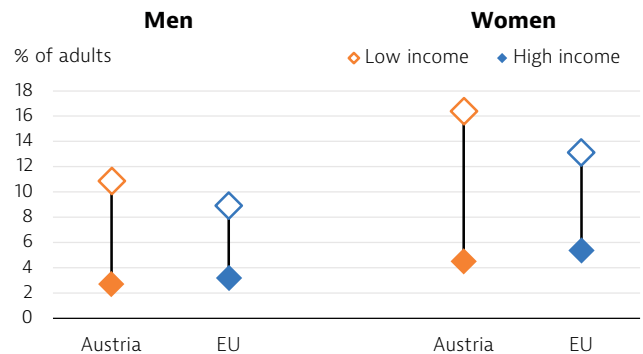
Figure 23. Anxiety, depressive, and alcohol and drug-use disorders are the main mental health disorders in Austria



Note: The EU average is unweighted.
Source: IHME (data refer to 2019).

Consistent with the trend observed in the EU as a whole, depression is more common among Austrian women than among men, with notable variations in its occurrence between individuals in the lowest and highest income quintiles. Based on survey data from 2019, approximately 16 % of women and 11 % of men in the lowest income quintile reported experiencing depression, in contrast to 5 % of women and 3 % of men in the highest income quintile (Figure 24). On the other hand, while there is a declining trend for both sexes, suicides continue to be more common among men. Despite a 35 % decline since 2005, the rate among men remained markedly above the EU average in 2020. Among women, it has almost halved to converge with the EU average (Figure 25).

Figure 24. Income-related disparities in the prevalence of depression are comparatively large



Note: High income refers to people in the top income quintile (20 % of the population with the highest income), whereas low income refers to people in the bottom income quintile (20 % of the population with the lowest income).

Source: Eurostat Database (based on EHIS 2019).

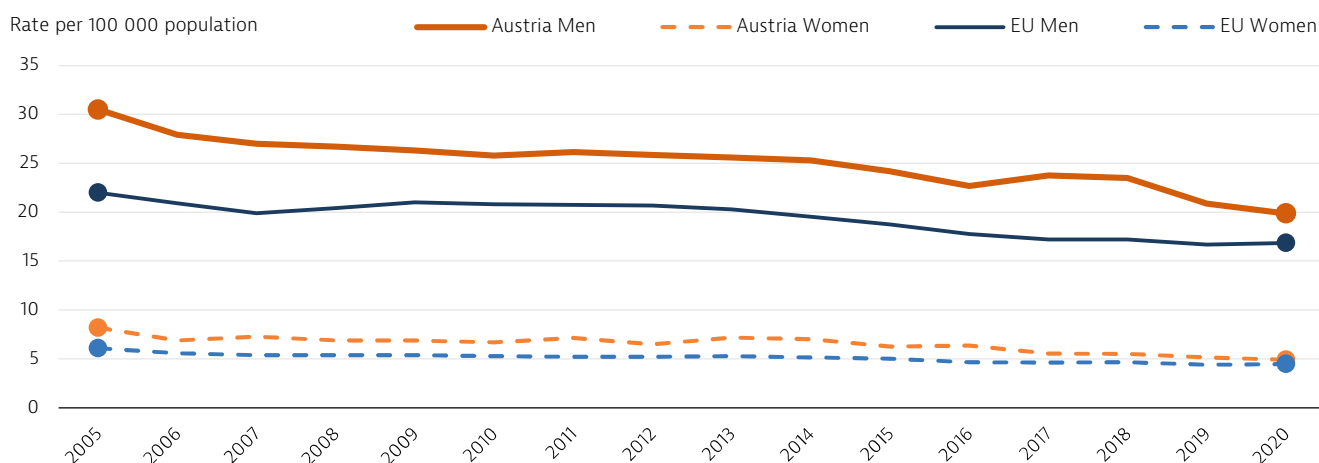
The mental health of adolescents has deteriorated since the COVID-19 pandemic

The COVID-19 pandemic has led to a deterioration of the mental health status of adolescents. According to the 2021-22 HBSC survey, 11- to 15-year-old girls report worse mental health than boys and this gender gap has widened since 2017-18. In the 2021-22 wave of the survey, 31 % of girls and 19 % of boys aged 11 to 17 reported not being happy in their lives, a disparity that does not exist in the youngest age group but widens with increasing age. Some 29 % of girls aged 11 to 17 reported being afraid frequently compared to 9 % of boys in the same age group, and 66 % and 43 % reported feeling lonely most or all of the time (GÖG, 2023).

Mental health services are available through various routes but access lags behind other health services

The fragmentation of the health system also manifests itself in the provision of mental health services, provided by a diverse set of actors. Together with a workforce shortage, this results in access issues. While primary care units can provide basic mental healthcare, specialised outpatient services are also available without referral. Psychotherapy services are accessible via care associations, counselling centres, in socio-psychiatric settings and private practice. Patients can claim reimbursement upon referral by a physician,

Figure 25. Despite the declining trend, suicide rates remain above the EU average for men



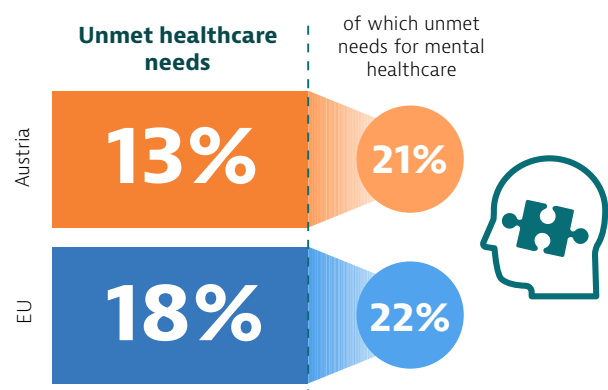
Source: Eurostat Database

but sessions are partially funded by SHI and coverage is limited to particular providers, so OOP payments are common.

Psychiatric care is usually fully covered if it is provided by a physician with SHI contract. However, outpatient services are affected by the low density of contracted specialists in some regions, particularly rural areas. In addition, OOP payments are more frequent due to a limited number of contracted physicians in child psychiatry, which causes a socioeconomic disparity in access to paediatric mental healthcare.

While a survey during the COVID-19 pandemic found markedly less unmet healthcare needs in Austria than in the EU in general, a comparable proportion of people reported that such unmet healthcare needs were related to mental healthcare (Figure 26).

Figure 26. One in five people with unmet healthcare needs during the pandemic said this was related to mental healthcare



Note: Survey respondents were asked whether they had any current unmet healthcare needs and, if so, for what type of care, including mental healthcare.

Source: Eurofound (2021; 2022).

Policies are focusing on the mental health workforce and targeted support for vulnerable groups

Austria's national mental health strategy plan was launched in 2018 and defines five main targets for prevention of mental health problems in the general population. Alongside the national plan, there are specific strategies targeting vulnerable groups, in particular for women and children and adolescents. The Health Promotion Strategy (2014) set out a framework for promoting early childhood interventions and psychosocial well-being among elderly people.

The well-being of children and adolescents is a high priority, and various initiatives are under way to enhance support for these age groups. These include regional networks of non-governmental organisations involved in early childhood interventions, additional funding for an emergency hotline for children and young people, a post-COVID-19 mental ill-health prevention project, a website to provide easily accessible information for services that support psychological health literacy for children, adolescents, young adults and their families, and an initiative to provide support to girls and young women from underprivileged groups in strengthening self-esteem.

The government has been following several approaches to support the health workforce with addressing mental health, such as enhancing home treatment or promoting psychiatry training among physicians. A scholarship programme by the main SHI fund ÖGK aims to attract medical students to work in underserved areas for at least five years, and includes psychiatry and psychotherapeutic services as options.

7 Key findings

- Life expectancy at birth in Austria was 81.1 years in 2022, which is 0.4 years higher than the EU average but about 2 years lower than the levels in the EU countries with the highest longevity. As in most other EU countries, life expectancy fell between 2019 and 2022, mainly because of COVID-19. The gender gap in life expectancy remained marked in 2022, but was slightly less than the EU average.
- Circulatory diseases and cancer are the main causes of death in Austria, followed by COVID-19 in 2020 and 2021. The burden of cancer is increasing in an ageing population. Screening and other opportunistic diagnostic testing came to a near standstill during the first months of the pandemic in 2020, but it rebounded quickly so that the overall impact remained limited.
- Unhealthy lifestyles and behavioural risk factors remain important drivers of mortality in Austria: about 36 % of deaths in 2019 could be attributed to smoking, dietary risks, alcohol and low levels of physical activity. 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 2021, and spending is also high relative to GDP. Despite an increase in the public share of spending since the onset of the pandemic, the share of out-of-pocket payments remains above the EU average. Nevertheless, access is generally not considered an issue, and Austria has low levels of unmet medical needs.
- Despite recent reforms to strengthen primary care and improve coordination and the efficiency of the multi-layered administration of the health system, progress is slow, and the health system remains structurally and financially fragmented. Ongoing efforts are successfully reducing the volume of hospital inpatient activity in favour of outpatient treatment, but establishment of 75 multi-disciplinary primary care units across the country is behind schedule. The health system remains hospital-centric, with the highest share of spending still devoted to inpatient care.
- Austria had the second highest density of doctors in the EU in 2021, but the proportion of general practitioners is one of the lowest in the EU. The number of practising nurses is increasing, but the demand for healthcare is also growing due to population ageing. There are ongoing debates about imbalances between regions, medical specialities and an ageing physician workforce. Efforts are under way to increase the number of medical students and to make less popular career choices – including general practice, public health and practice in rural areas – more attractive.
- Health services were heavily affected during the first wave of COVID-19 between April and June 2020, and to a lesser extent during the second wave in late 2020, but rebounded afterwards. COVID-19 contributed to an increase in the use of telemedicine and digital health services, such as electronic prescribing. Additional investments since the pandemic continue to focus on prior efforts in primary care and long-term care. Despite the strong electronic infrastructure and progress in primary data use, secondary use of data for health system governance and research remains limited.
- The prevalence of mental health disorders is estimated to be slightly higher in Austria than the EU average, driven by anxiety, depressive, and alcohol and drug-use disorders. Mental ill health is an increasingly recognised public health issue in Austria, and there are now several initiatives to provide easily accessible support and care – in particular for vulnerable groups, such as adolescents and women. However, provision of mental healthcare remains fragmented, and access barriers are generally more significant than for other types of care.

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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		

State of Health in the EU

Country Health Profile 2023

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2023 edition of the Country Health Profiles provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- For the first time in the series, an account of the state of mental health and related services within the country.

Complementing the key findings of the Country Health Profiles is the Synthesis Report by the European Commission.

For more information, please refer to: ec.europa.eu/health/state

Please cite this publication as:

OECD/European Observatory on Health Systems and Policies (2023),
Austria: Country Health Profile 2023, State of Health in the EU,
OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

ISBN 9789264841031 (PDF)

Series: State of Health in the EU

SSN 25227041 (online)