

The Austrian Health Care System

Key Facts

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Facts and figures

Austria

Republic of Austria



Austria is a **democratic republic** in Central Europe covering a surface area of around **84,000 km²**. As a federal state, Austria consists of **nine provinces (Länder)** with **Vienna** as its capital.



Austria has been a member of the **United Nations** since **1955** and acceded to the **European Union** in **1995**.



Unemployment rate (2017): 5.5 % of the active population

GDP per capita (2017): EUR 42,060



Economic growth (real change to GDP in %)



Demography (2017)

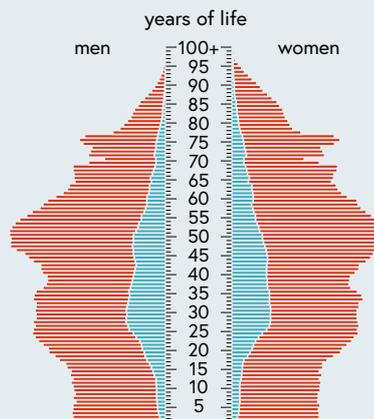
8.8 million inhabitants

Statistics Austria. Population pyramid according to country of birth 1.1.2017

- Austrians
- Non-Austrians



49.2 % men
16.4 % of men
 are 65 and above
20.4 % of men
 are under 20



50.8 % women
20.9 % of women
 are 65 and above
18.6 % of women
 are under 20

On average, women have **1.5 children**.

2.9 babies per 1,000 live births die within the first year of life.

Health status



Life expectation at birth (2017):

- Women just under **84** years
- Men over **79** years

of whom in (very) good health (2014) (health survey):

- Women just under **67** years
- Men just under **66** years



Subjective health status at birth (2014) (health survey):

- around **77** % of women describe their health status as (very) good
- around **80** % of men describe their health status as (very) good



Most common illnesses (2017)

(share of inpatient stays in non-profit acute hospitals):

- **13.8** % malignant tumours (ICD-10, C00-C97)
- **10.8** % cardiovascular diseases (ICD-10, I00-I99)



Most common causes of death (2017):

- **39.8** % cardiovascular diseases (ICD-10, I00-I99)
- **24.3** % malignant tumours (ICD-10, C00-C97)

Health care

Per 1,000 inhabitants the following resources are available:

Hospitals (2017):

- **7.4** beds in all hospitals (64,800 beds in 271 hospitals in total)
- **5.2** beds in non-profit acute hospitals (45,600 beds in 121 hospitals in total) (→ notes)

Practising doctors (2017):

- **1.6** general practitioners
- **2.7** specialists
- **0.9** doctors undergoing training
- **0.6** dentists

Supply of medicines (2017):

- **0.27** pharmacies (2,351 pharmacies in total) (→ notes)



The health care system is used as follows:

Hospitals (2017):

- **249** hospital stays per 1,000 inhabitants lasting 6.5 days on average in all hospitals
- **218** hospital stays per 1,000 inhabitants lasting 4.9 days on average in non-profit acute hospital (→ notes)

Contacts with doctors (2017):

- **13** contacts per inhabitant with doctors contracted to the health insurance funds (excl. hospital contacts) (→ notes)

Consumption of medicines:

- **26** packs issued per inhabitant (2017) which cost EUR 17.60 on average (2014) (social health insurance tariff)

Health expenditure (2017)



- **Current health expenditure as a share of GDP:** 10.4 %
- 74.0 % of current health expenditure is **public health expenditure**
- **Current per capita health care expenditure:** EUR 4,373 (current prices)

Sources: Statistics Austria, BMASGK, Austrian Chamber of Pharmacies, Pharmig, OECD

Health – a public task

The most important principle of Austrian health policy is to ensure access to high quality health care which is provided equally – regardless of the inhabitants’ age, gender, origin, social status or income – in a way which is suited to the target group, and barrier-free.

Solidarity, affordability and universality

The social health insurance system covers **99.9 % of all people** in Austria



Health care is based on a **social insurance model** founded on **compulsory insurance**. Access to individual services is regulated by social insurance law. All of the insured have a legal right to services, which are financed on the basis of solidarity.

Austrian social insurance is based on the principle of solidarity and self-administration and is mainly financed via social insurance contributions. The Main Association of Austrian Social Security Institutions coordinates a total of 21 social insurance funds in the branches of health, accident and pension insurance, of which 18 solely or also provide health insurance (as of 2018). From 2019 the number of social insurance institutions will be significantly reduced via mergers.

The Austrian social insurance system

The Austrian social insurance system – NEW structure

Main Association of Austrian Social Security Institutions			Umbrella association		
Accident insurance	Health insurance	Pension insurance	Accident insurance	Health insurance	Pension insurance
General Accident Insurance Fund (AUVA)	9 Regional Social Health Insurance Funds	Pension Insurance Fund (PVA)	General Accident Insurance Fund (AUVA)	Austrian Social Health Insurance Fund (ÖGK)	Pension Insurance Fund (PVA)
	5 Company Social Health Insurance Funds				
	Social Insurance Fund for the self-employed (trade, commerce, industry)				
Social Insurance Fund for the Austrian Railway and Mining Industries			Social Insurance Fund for the self-employed (trade, commerce, industry, farmers) (SVS)		
Social Insurance Fund for Farmers					
Social Insurance Fund for Public Service Wage and Salary Earners					
		Insurance Fund for Austrian Notaries	Social Insurance Fund for Public Service Wage and Salary Earners (including Austrian Railway and Mining Industries) (BVAEB)		

Sources: Austrian social insurance funds, BMASGK Link (in German): [Structural reform of social insurance funds](#)

Compulsory insurance leads to an insurance relationship based on the law. This insurance relationship usually starts when employment is taken on. The self-employed and those who insure themselves voluntarily have to apply to join the community of the insured.

The level of **contributions** in the social health insurance system is independent of the individual health risk of the insured. The fact that people who have a greater or lesser need for protection, or who earn (and thus contribute) more or less, and who are employed or unemployed, are all entitled to the same services at no extra cost signifies solidarity and creates affordability. The large number of insured persons also spreads the risk. In the year 2017 a total of 8.7 million people were entitled to services from the social health insurance system, of whom around 6.7 million were contributors and the remainder were co-insured, particularly children. For the majority of those covered by health insurance, the contribution is 7.65 % of their gross wage (charged up to a maximum level of gross income of EUR 4,980 in 2017 or EUR 5,130 in 2018). Contributions are paid in almost equal parts by the employer and the employee.

Austrians normally cannot choose their health insurance institution, but are assigned to one primarily on the basis of their occupational group. The insurance institutions can, however, also be defined by the place where they work or live. The **social insurance institutions** are thus **not in competition with each other**. There are exceptions – with regard, for example, to multiple insurance in the case of several jobs or opting out in the case of freelance workers – which can provide a choice between social insurance institutions or a private insurance company.

There are a **large range of health care services available** to the population. There is a **free choice of doctors**. With a few exceptions there is no obligation to obtain the consent of the health insurance institution before using the services of doctors contracted to social health insurance, outpatient clinics or general practitioners.

health protection health provision prevention
screening examinations vaccinations
treatment by doctors maternity services
curative massage physiotherapy ergotherapy logotherapy
psychotherapy basic dental treatment
medicines medical devices
treatment in hospitals ... rehabilitation
emergency and ambulance transports... nursing care at home

Divided competences in the health care system

Due to the federalist structure of the state and the system of compulsory insurance, the Austrian health care system is characterised by the interaction of numerous actors from the different legislative and administrative levels (federal government, provinces, districts, local authorities) and from the self-administration sector (social insurance).



Source: BMASGK

Responsibility for **legislation** and enforcement in the health care system is held by the **federal government**. The implementation of the health insurance system is, however, carried out on the basis of federal legislation by the **social insurance funds in their own sphere of activity**. This includes the provision of contract services in the extra-mural sector, the provision of medicines and medical goods, as well as inpatient and outpatient rehabilitation.

Regarding hospitals, the legislative competence of the federal government is limited to the setting of principles. Responsibility for enacting implementation laws and enforcing them is held by the **provinces (Länder)**. It is also the provinces which have to ensure sufficient availability of hospital services.

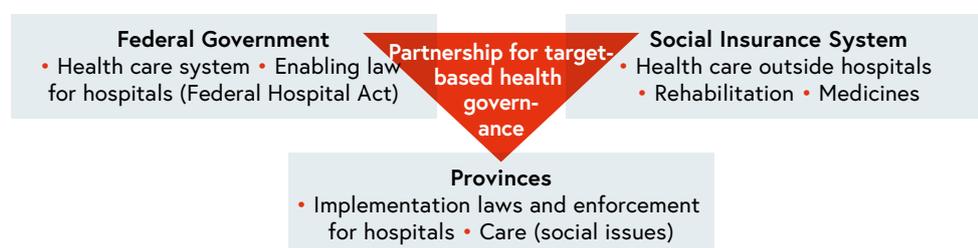
At a national level, the Federal Ministry of Labour, Social Affairs, Health and Consumer Protection (BMASGK, Link: www.sozialministerium.at, [English website](#)) is responsible for general health policy, the protection of the health of the population, the regulation of the health professions, pharmacies and medicines, as well as for legislation and the supervision of the social insurance funds. It prepares federal legislation, draws up administrative regulations, is active as a decision-maker and also as a supervisory authority, and acts as a coordinator between the most important stakeholders in the health care system.

Important areas of health care provision are the responsibility of the provinces at a **regional level**. Alongside responsibility for the operation of hospitals, the provinces are also responsible for pre-clinical emergency care (along with local authorities). In addition, the provinces enact important legislation in the social sector and are responsible for the provision of social services (including nursing care and long-term care).

However, alongside the regional administrative bodies and the social insurance funds, **other important actors** are also involved in the shaping the health care system, such as numerous health care providers and institutions and their (partially statutory) interest groups as well as patients' organisations, self-help groups, charities, and research and planning bodies.

Joint responsibility for the health care system

This complex blend of historically-grown different decision-making structures – which also contain various financing systems and mechanisms – requires a considerable degree of **coordination**, and makes **joint action** in many fields of management, planning and financing of the health care system absolutely necessary.



Source: BMASGK

Against this background, as early as the end of the 1970s cooperation between the large providers of finance – the federal government, the provinces and the social insurance funds – was laid down on a binding basis aiming at a better coordination between the different sectors of the health care system and its actors. This cooperation was gradually extended and deepened, and in 2013 it led to the establishment of a **target-based health governance system** for the joint management of the structure, organisation and financing of the Austria health care system and to the realisation of the **health reform** which has been ongoing since 2013 (→ *Info box 1*). The basis for this are domestic state treaties (agreements according to Article 15a of the Federal Constitution) which are concluded between the federal government and the provinces – with the involvement of the social insurance institutions – at regular intervals.

On the basis of these agreements, a target-based governance agreement at a federal level is used to set binding **joint strategic and operative goals** and the **measures** to be taken at federal and provincial level over a period of a number of years (usually four to five). Based on these specifications at a federal level, the binding provincial target-based governance agreements for the system partners and the respective period are concluded. The agreed catalogue of goals and measures at a federal level is accompanied by regular **monitoring** with regard to the achievement of the goals.

Info box 1:

Target-based health governance

Federal government • provinces • the social insurance system

The target-based health governance system for the realisation of the health reform which has been ongoing since 2013 has the goal of counteracting the significant fragmentation of the health care system by means of joint and cross-sectoral management of the structure, organisation and financing of health care. To this end, the partners in the system – the federal government, the provinces and the social insurance funds – conclude suitable agreements (domestic state treaties, in this case the agreement according to Article 15a of the Federal Constitution on target-based health governance and the agreement according to Article 15a on the organisation and financing of the health care system) as well as contracts based on them.

Target-Based Governance Agreement 2017-2021

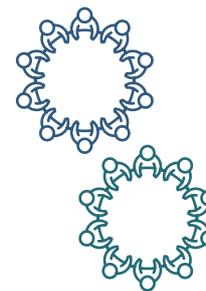
At the end of 2016, the continuation and further development of the target-based governance system established since 2013 was agreed. As an important step in its continuing operative realisation, the Target-Based Governance Agreement at Federal level was agreed for the years 2017-2021. The key focuses of this agreement are the rapid and effective realisation of the new primary care system, further activities for the strengthening of outpatient care, speeding up joint integrated health care planning and the further development of integrated models of care provision, ensuring the availability of the required health care personnel, and the comprehensive extension of the use of modern technologies (such as electronic health services). In addition, numerous measures have been agreed to improve the health of children and young people, to optimise the cross-sectoral supply of medicines, to ensure quality and to strengthen health literacy. The goal is to ensure the sustainable financing of the health care system with public funding via specifications on target-based financial governance.

Links (in German): [Health reform](#), [Target-based governance agreement](#)



The tasks which result from the Target-Based Health Governance Agreement at Federal level are carried out by the **Federal Health Agency** (BGA, Link in German: [Bundesgesundheitsagentur](#)), a public fund. It has two bodies, the Federal Target-Based Governance Commission (political level) and the Standing high-level committee (civil service level). The federal government, the provinces and the social insurance institutions are represented as equal partners and decision makers in both bodies. Alongside the administration of funding, their tasks are to monitor developments in the Austrian health

care system and to intervene in the interests of the joint strategic objectives by setting joint principles, guidelines and instruments. At a federal level, the activities of the BGA are managed by the Ministry of Health (now part of the Ministry of Labour, Social Affairs, Health and Consumer Protection). Decisions within the framework of the Federal Health Agency can only be made when all three partners agree (i.e. unanimously).



Reflecting the setup at a federal level, the tasks which result from the target-based health governance agreement at a provincial level are carried out by a Health Fund in each province. The **Provincial Health Funds** (Link in German: [Landesgesundheitsfonds](#)) also have two bodies, the Health Platform and the Provincial Target-Based Governance Commission. In both of them, the respective province, the federal government and the social insurance funds are represented, and in the health platforms there are also other members (e.g. the Medical Association, the Federation of Towns, Cities and Local Authorities, and the Patients' Ombudsman's Office, etc.). Alongside the administration of funding, their tasks are to specify the principles, guidelines and instruments of the Federal Health Agency and to initiate their implementation.

Joint principles, strategies, guidelines and instruments

Ensuring the provision of health care is an important public task. Given that the responsibility for this is divided in Austria (see above), an overall view of how the health care system should develop is required in order to be able to react in good time to future challenges. This is achieved by joint principles, strategies, guidelines and instruments which ensure health care of equally high quality throughout the country.



With the adoption of ten **national health targets** (→ *Info box 3*) and the **health reform** which has been ongoing since 2013 (→ *Info box 1*), decisive steps have been taken to ensure balanced and quality-assured care even in the case of increasing cost pressures. Numerous guidelines and instruments improve the **coordination and cooperation** of the actors within and between the different levels of care provision. For example, the joint **planning instruments** form the basis for cross-sectoral resource planning in the health care system (→ *Info box 2*).

The numerous other significant joint activities and specifications also include various **quality standards** and quality measurement (→ *Quality, transparency, patient-orientation*), the establishment of **strategies**, such as those on focuses in the use of funding in health promotion (→ *Health promotion and preventive medicine*), or the specification and regular updating of the hospital financing system (→ *Health care financing*). In addition, **concepts** and **recommendations** are drawn up, and a system for the measurement of outcomes in the health care system is being developed (Link in German: [Health reform](#)).



Info box 2:



The Austrian Structural Plan for Healthcare (ÖSG)

The **ÖSG** is a joint nationwide framework which the federal government, all of the provinces and the social insurance funds adopt jointly. In this way – in spite of the different responsibilities – a joint vision of the further development of the Austrian health care system is created. The ÖSG contains planning statements for selected areas of outpatient and acute/inpatient care, for outpatient and inpatient rehabilitation, and for large items of medical-technical equipment. In addition, the ÖSG contains quality criteria for many areas of care which aim to achieve the same standards in different care-related structures throughout the country. The ÖSG ensures that health care in Austria is distributed evenly and easily reached, and that the quality is at a comparably high level in the entire country. Link (in German): [ÖSG](#)

The ÖSG is the framework for the **Regional Structural Plans for Healthcare (RSG)** which are agreed upon by the respective province and the relevant social insurance funds, and which regulate care provision at a provincial level in detail. Link (in German): [RSG](#)

Since 2018, jointly adopted parts of the ÖSG and RSG have gradually been made legally binding. Link (in German): [Regulation 1/2018 on the ÖSG 2017](#)

The health of the population

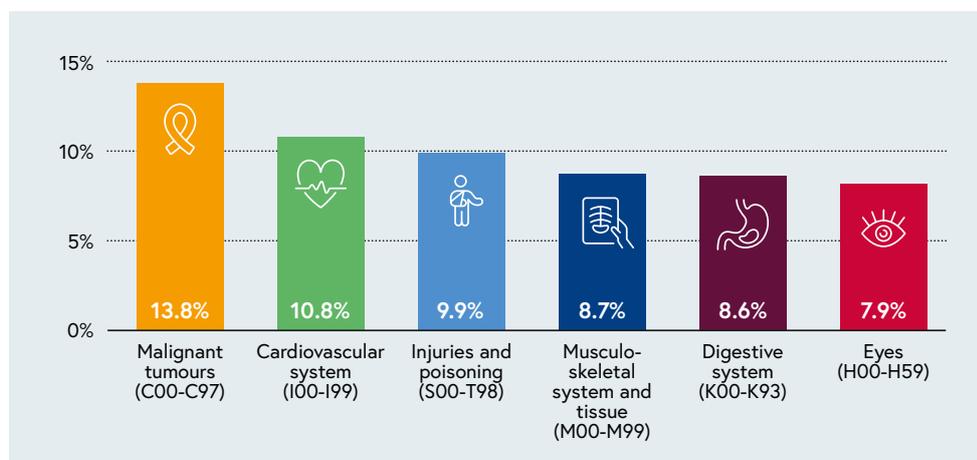
State of health

The state of health of the Austrian population is constantly improving. **Life expectancy at birth** is 79.3 years for men and 83.9 years for women. In the past ten years this signifies an increase of two years for men and 1.1 years for women. Men continue to die younger than women, but this difference has become smaller in recent years. Regional comparisons show a West-East divide, with differences between the provinces of 2.5 years for men and 2.1 years for women (Source: Statistics Austria).

The proportion of years spent in **(subjectively perceived) good health** is increasing even more rapidly than life expectancy. Men can expect (2014) around 65.9 years in good or very good health (2006: 63.2 years), which women can expect 66.6 years in good health (2006: 61.7 years). This means people are spending more than 80% of their lives in good health. Around 80% of men assess their **own state of health** as very good or good, while only around 77% of women do. Around 5% of the population feel bad or very bad (Source: Statistics Austria, health surveys 2006 and 2014). Life expectancy without chronic illness or a functional impairment is lower, however (Source: Statistics Austria, EU-SILC).

The most common serious illnesses among Austrians – on the basis of diagnoses during hospital stays (2017) – are malignant tumours (13.8 %) followed by cardiovascular diseases (10.8 %).

Morbidity – the most common illnesses (2017)
Share of inpatient stays in non-profit acute hospitals



Life expectancy at birth (years)

1997
• Men: 74.0
• Women: 80.6

2007
• Men: 77.3
• Women: 82.8

2017
• Men: 79.3
• Women: 83.9

Life expectancy without chronic illness

2017
• Men: 55.4
• Women: 55.5

Life expectancy without functional impairments

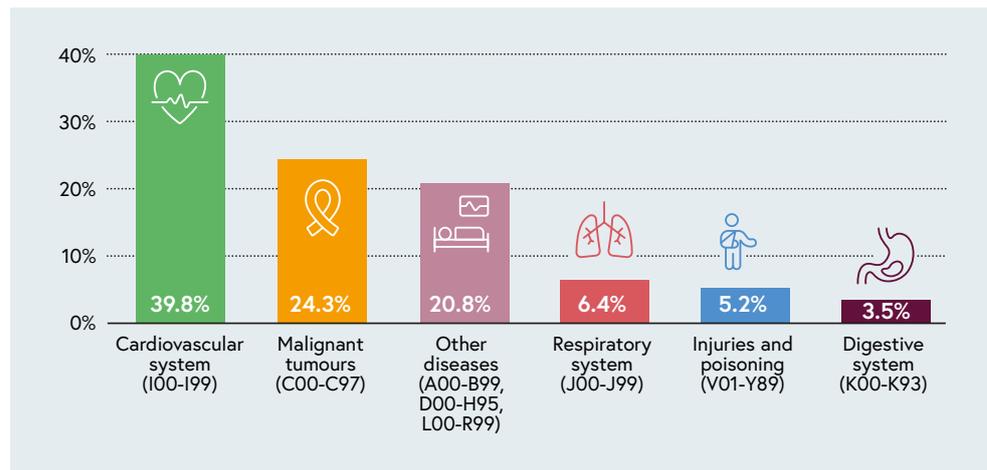
2017
• Men: 58.0
• Women: 57.6

Source: Statistics Austria, EU-SILC

Source: BMASGK

Of the total of around 83,000 deaths (2017), cardiovascular diseases are **the most common cause of death** with around 40 %, followed by malignant tumours (24 %), illnesses of the respiratory system (6 %) as well as injuries and poisoning (around 5 %). At 2.9 deaths per 1,000 live births in the first year of life, infant mortality is around the European average (Source: Statistics Austria).

Mortality – the most common causes of death (2017)



Source: Statistics Austria

Health-related behaviour



Smokers in Austria

1.8 million persons from the age of 15, i.e.

- 22 % of women
- 27% of men

In the meantime there are 24 % **ex-smokers** and the same percentage smoke on a daily basis

Source: Statistics Austria

Promoting healthy lifestyles in the population is a major task, not only for Austria. Around 1.8 million (2014) Austrians from the age of 15 **smoke on a daily basis**. Men (27 %) still smoke on a daily basis more frequently than women (22 %). Whereas the number of male smokers has fallen continuously in recent decades, the number of women smokers is rising. Among EU countries, Austria has the highest proportion of female (daily) smokers. However, according to the data of the HBSC Study (WHO) from 2013/14, the rate of 11-15 year old smokers has fallen by around a half within the past 20 years from 20.8 % to 11.3 %, so the development in Austria is following the international pattern.

Around 80 % of Austrians over 15 drink **alcohol**, whereby the majority of alcohol consumers (around two thirds of the population) do so to a moderate or average extent. Approximately 14 %, however, consume amounts which are significantly dangerous for their health over the long term. 13 % of men and 4 % of women drink alcohol on five or more days a week. Women report being abstinent or almost abstinent twice as often as men, and men state that their consumption is problematic twice as frequently as women do. The average amount of alcohol consumed has fallen by 20 % since 1970, but has remained almost the same (around 12 litres per year) in the last ten years (Source: Austrian Public Health Institute – GÖG).



Health-enhancing **physical activity (HEPA)** should, according to the WHO, consist of at least 150 minutes of sport, fitness training or physical exercise per week. In addition, the WHO recommends activities to build up or strengthen the muscles twice a week. Based on their own assessment (2014), around half of the Austrian population aged between 18 and 64 fulfils the WHO's recommendations (men: 52 %; women: 49 %). Just under a third state that they carry out exercises to build up their muscles twice a week. According to their own statements, 24.6 % of all respondents fulfil both recommendations (Source: Statistics Austria, health survey 2014).



The share of **overweight and obese** persons has increased significantly in recent years. Around 3.4 million people affirmed (2014) that they are overweight (body mass index over 25), whereby men are more frequently affected (men: 40 %; women: 26 %). A total of 16 % of men and 13 % of women suffer from obesity (body mass index over 30). There is a tendency for higher age groups to exhibit a larger proportion of overweight and obese persons. Levels of education and employment are also connected with **obesity**: in 2014, 24 % of men and 19 % of women who had only completed compulsory schooling were obese, compared to only 7 % of men and 7 % of women who had passed the school leaving/university entrance examination or obtained a higher qualification. Unemployed men (22 %) and women (23 %) suffer considerably more often from obesity than working men (9 %) and women (10 %).



Overweight persons in Austria

- 26 % of women
- 40 % of men are overweight or obese
- 13 % of women
- 16 % of men suffer from obesity

Source: Statistics Austria

People in Austria **eat** too much fat and consume a too large amount of saturated fatty acids and salt. At the same time, the consumption of complex carbohydrates and fibre as well as some vitamins and minerals is too low. The Federal health department recommends five portions of fruit and/or vegetables daily. Only 4 % of men and 10 % of women follow this recommendation (2014). Women eat fruit and vegetables more frequently than men, who in turn eat more sausages and meat. 47.5 % of all Austrians eat vegetables and 56.2 % eat fruit on a daily basis (Source: Statistics Austria, Health Survey 2014).

The Austrian nutrition pyramid



Source: BMASGK

Health promotion and preventive medicine



Fonds Gesundes
Österreich

WHO concepts such as the **Ottawa Charter for Health Promotion** (Link: [Ottawa Charta](#)) have a decisive effect on health promotion in Austria. Since the entry into effect on the **Health Promotion Act** in 1998 and the upgrading of the **Austrian Health Promotion Fund** (FGÖ, Link: www.fgoe.org, [Information in English](#)), the status of health promotion has been increasing steadily, and awareness of it has been heightened. Since then, funding for innovations in the field of health promotion has been awarded and the capacities for health promotion have been significantly enlarged.

The fundamental principals of health promotion are also at the heart of the ten **Health Targets for Austria** (→ *Info box 3*). The Austrian Health Targets are based on the **health in all policies** approach. Their declared goal is the improvement of the health of all people living in Austria regardless of their educational background, income or the circumstances of their lives (health determinants), and particularly a sustainable increase in the number of their healthy years of life.

Info box 3:



Austrian Health Targets

Thanks to an efficient health care system, life expectancy in Austria is now one of the highest in the OECD countries. However, with regard to the number of healthy years, Austria is only around the international average. In order to promote health and quality of life, and to counteract the rising costs of health care provision, the government and stakeholders plan to lastingly raise the number of healthy years.

This is behind the idea of the ten Austrian Health Targets which were developed in 2011-2012. They show the way for a health-promoting overall policy until 2032, and consciously take into account numerous factors outside the traditional field of health care – such as education, employment and the social safety net.

The Austrian Health Targets were developed in a broadly-coordinated process with numerous representatives from politics and civil society and form the framework for an overall policy of health promotion. They thus also formed the basis for the ongoing health reform.

Link (in German): [Austrian health targets](#), [English summary](#)



Since 2010 there has also been a nationally coordinated and quality-assured **Austrian preventive medicine strategy**. This forms the basis for national health promotion and preventive medicine programmes, which are carried out jointly by the federal government, the provinces and the social insurance funds. Due to the joint and coordinated approach and the targeted deployment of funding (more than EUR 3 million per year), there are synergy effects and longer-term sustainable changes in health promotion ([Link in German](#)).



The first focuses for the use of preventive funding were measures set on the basis of the National Action **Plan for Nutrition NAP.e** ([Link in German: NAP.e](#)) from 2009, which laid down nutritional goals for Austria for the first time. Subsequently, the funding was dedicated to the improvement of equal opportunities in health for children and young people and is currently (2017-2021) being deployed in all of the provinces for the promotion of **early childhood intervention**, and in two provinces for the support of conferences on the health of young people. The other national strategies in the field of health promotion include the **National Action Plan for Physical Activity NAP.b**, which was concluded in 2012 ([Link in German: NAP.b](#)) and the **Child and Youth Health Strategy** ([Link in German](#)), which was launched for the first time in 2011 and is being continuously further developed.



Health promotion and preventive medicine are viewed as a public task and are also strongly represented in the current **health reform** (→ *Info box 1*). Numerous measures were taken in recent years to bring about improvements. The most important of these include the establishment of the **Health Promotion Funds** in every province, which, in terms of how funding is awarded (EUR 15 million per year until 2022), are orientated towards the **Health Promotion Strategy** developed as part of the health reform.

The **Health Promotion Strategy** adopted in 2014 created the framework for broadly concerted and **target as well as impact-oriented action**, and for the coordinated deployment of funding for preventive medicine, as well as the use of the resources of the Health Promotion Funds of the provinces. It provides fundamental orientation for all health promotion measures.

The main focuses of the Health Promotion Strategy

66 % of the money of the Health Promotion Funds of the provinces has to be used for:

1. Early childhood support
2. Healthy crèches and healthy nursery schools/kindergartens
3. Healthy schools
4. Healthy living environments and healthy lifestyles for young people and people of working age
5. Health literacy of young people, people of working age and older people
6. Social participation and the psychosocial health of older people

Link (in German): [Health promotion strategy](#)



Equal opportunities in health and all the other **principles of health promotion**, such as health in all policies, a coordinated approach, evidence-basing, documentation, evaluation and the simultaneous development of capacities are the starting point and pivot for the **deployment of the financing** of the Health Promotion Funds and the funding for preventive medicine. In 2016 the public sector (the federal government including the Austrian Health Promotion Fund, the provinces, local authorities and Healthy Towns and Cities and the social insurance institutions) spent around EUR 2.4 billion on health promotion and prevention (around EUR 280 per capita). Without the **expenditure** on preventing the severity and spread of diseases which were already present, it amounted to EUR 900 million (EUR 103 per capita). (Source: GÖG).



Preventive health programmes have a tradition in Austria. For example, the free **Mother-Child-Pass screening programme** has been in existence since 1974, accompanying mothers and children from pregnancy up to the 62nd month of the child's life ([Link in German](#)). The programme includes a vaccination pass for children and is currently being further developed with regard to new requirements (psychosocial aspects). Since 1998, on the basis of the **child vaccination concept**, the cost of selected vaccinations for children from 0-15 years have been assumed jointly by the federal government, the provinces and the social insurance institutions.



Since 1974, adults can take advantage of **free health check-ups** ([Link in German](#)); around 1.2 million people (2015) actually make use of this, which is around 17 % of the population (14 % in 2007). The figures also include preventive gynaecological examinations for women. **Additional preventive health activities** include the early recognition programme for breast cancer (for women between the ages of 45-69, [Link in German](#)), annual school health check-ups, examinations for Austrian Army recruits, examinations for young people in employment as well as measures to prevent tooth decay and to improve the care of the chronically ill.



In autumn 2012, the **Austrian Suicide Prevention Programme SUPRA** was presented ([Link in German: SUPRA](#)). This national prevention programme forms the basis for the development of a national suicide prevention strategy. In order to realise the prevention measures, the Suicide Prevention Coordination Office was set up in 2012 at the Austrian Public Health Institute, which supports and advises this project in close cooperation with a committee of experts. The goal is to ensure the availability of lasting and high-quality suicide support in Austria.

The **Austrian Addiction Prevention Strategy** (2015) is intended to ensure that the negative effects of addiction remain as low as possible for the individual in question and for society. The strategy forms a roof under which all activities, measures and developments on the issue can be connected ([Link in German](#)).

Health care provision

Austria has a great deal of resources in the field of health care provision. For example, the number of practising doctors and the number of hospital beds in comparison to the population is one of the highest in Europe. This generally assures good access to the health care system.

Pre-clinical emergency care

Austria has a **nationwide network** of ground-based emergency services (with and without the involvement of emergency doctors) and air rescue services, as well as transport services for the sick. The organisation of emergency services is (with a few exceptions) the responsibility of local authorities, while the provinces are responsible for providing the necessary emergency equipment. Organisations which provide emergency services (such as the Red Cross) are usually contracted to carry out these services. Alongside professional staff, numerous voluntary employees are deployed in the emergency services and transport services for the sick. The **air rescue system** is very well developed with 38 locations (16 of which only operate in winter), and a total of nine air rescue operators carry out around 23,000 air rescue missions per year (Links in German: [air rescue](#), [Austrian Air Rescue Portal](#)).



- 144 Ambulance
 - 141 Emergency medical service
 - 140 Mountain rescue
 - 112 European emergency number
 - 1450 Health advice hotline (in development)
- Link (in German): [Emergency numbers and hotlines](#)

Outpatient services

The population of Austria is mostly provided with medical care in individual practices by **doctors in private practice**. Of the total of around 45,600 doctors in Austria in 2017 (without dentists), around 18,200 (40 %) work solely in private practices. In addition there are around 5,000 dentists, of whom the majority (78 %) also work in private practices (Source: Austrian social insurance system). Around 16 % of doctors are employed as well as working in private practice. Half of doctors in private practice have a **contract with a social health insurance fund** (Source: Austrian Public Health Institute).



Doctors in private practice are (2017)

- General practitioners 32 %
- Specialists 50 %
- Dentists 18 %

Share of doctors in private practice contracted to the social insurance system (2017):

- General practitioners 61 %
- Specialists 34 %
- Dentists 76 %

Almost a third of doctors in private practice are general practitioners, nearly two thirds of whom have a contract with a social health insurance fund. Half of the doctors in private practice are specialists, of whom somewhat more than a third are contracted to a health insurance fund. Of dentists, who account for just under a fifth of doctors, more than three quarters have a health insurance fund contract.

Source: Austrian Public Health Institute, monitoring of doctors

In addition there are doctors in private practice who **do not have a health insurance fund contract**, so-called elective doctors. Some employed doctors and doctors in private practice also work as elective doctors alongside their main work. The cost of consultations and treatment by elective doctors is partly reimbursed upon application by the social health insurance funds (80 % of the fund's tariff).



More than **900 independent outpatient clinics** which are operated either by the health insurance funds themselves or privately (usually under contract to the health insurance funds) provide specialist medical and therapeutic services (Source: BMASGK). An additional part of outpatient care is provided by **outpatient clinics in hospitals**. Alongside an emergency department, non-profit hospitals also usually have a range of specialist outpatient clinics.

Outpatient care is also provided by a range of **other health professionals** such as psycho-, ergo- and physiotherapists, logopedists, midwives, nursing and care professionals etc. These professionals can also work on a health insurance contract or without one (Link: [healthcare professions in Austria](#)).

Outpatient contacts (2017) were distributed as follows
Source:

- Individual practices 66.7%
- Group practices 8.1%
- Independent outpatient clinics 7.9%
- Hospital outpatient clinics 15.6%
- Others 1.7%

Source: BMASGK

Of the overall total of around 136.3 million **outpatient contacts** (2017) in contracted facilities or in non-profit hospitals, **two thirds** take place in **individual practices** of contracted doctors. 16 % each of outpatient contacts are divided up among group practices, independent outpatient clinics and hospital outpatient clinics. In outpatient clinics, group practices and hospital outpatient clinics, there are usually more services provided per contact than in individual practices. On average, every person in Austria contacts a contracted medical facility around 13 times a year, and a hospital outpatient clinic more than twice a year.

Number of outpatient contacts (2017) per inhabitant:

- Total outpatient contacts 15.5
- Individual practices 10.3
- Group practices 1.3
- Independent outpatient clinics 1.2
- Hospital outpatient clinics 2.4
- Others 0.3

Source: BMASGK

In 2017, within the framework of the ongoing health reform (→ *Info box 1*), the legal basis for the **new primary health care system** in Austria came into force, with which the conditions for important new care models in the private practice sector were established. In order to extend close to home, multi-professional and interdisciplinary primary care, a total of 75 new primary health care units are to be created by 2021. In the first quarter of 2018, six primary health care units were already in operation, and three additional ones were being realised. In the form of a **foundation initiative**, a wide range of support measures are being provided, such as information materials and specimen documents, a blueprint for a care concept, regional care profiles, drawing up a communications strategy, support on the ground from autumn 2018, and a financing instrument from spring 2019. In addition, in the ÖSG 2017 (→ *Info box 2*), a task profile and equipment standards for team-based primary health care were laid down as the basis for care provision contracts. Another key measure is the further development of the contracts and payment systems.

Info box 4:

New primary health care

Until now, primary care as the first point of contact for people with health problems has taken place in the surgeries of general practitioners/family doctors, and in hospitals (outpatient clinics). The transformation of the health care system, the changing needs of the population, patients and health care providers, the ageing of society and increasing specialisation in medicine entail great challenges which will now be met with new care models. In addition, by 2025 almost 60 % of the general practitioners who have a health insurance fund contract will have reached retirement age.

The promotion of the further development of primary care is an important step towards ensuring the future of health care. Via new opportunities for cooperation between general practitioners and by networking with other health professions, a broad range of treatments and longer opening hours are being facilitated. In future, patients will be accompanied throughout their entire course of treatment. In particular, comprehensive health-oriented support for the chronically ill can form an important focus. Active health promotion will also be intensified.

For doctors and other health professionals, networking and cooperation in teams is a reaction to their demands for more attractive working conditions and a better work-life balance.

The new primary health care can be designed in different ways: existing structures can be networked and further extended, or regional health centres can be built and designed in a completely new way.

Links (in German): [Primary care 1](#), [Primary care 2](#), www.pve.gv.at



In the field of outpatient care services, around 149,400 people were cared for by around 12,500 carers (full-time equivalents, FTE) at the end of 2017. Another 11,300 persons were cared for by 730 carers (FTE) in semi-inpatient day care facilities and alternative living facilities (Source: Statistics Austria).

Inpatient care

Austria has a tradition of providing an over-average number of services as inpatient services in hospitals. Austria is thus among the EU states with the largest number of hospital beds and the most inpatient hospital stays in relation to the population.

Beds and stays (2017) per 1,000 inhabitants:

Beds

- all hospitals: 7,4
- Non-profit acute hospitals: 5,2

Stays (overnight)

- all hospitals: 249
- Non-profit acute hospitals: 218

Non-overnight stays

- all hospitals: 73
- Non-profit acute hospitals: 70

Source: BMASGK

In the 271 **hospitals** with a total of 301 locations and around 64,800 beds, there are more than 2.83 million inpatient stays (including stays where the patient is discharged the same day). This results in a total of 322 hospital stays per 1,000 inhabitants. Stays where the patient remains in hospital overnight lasted 6.5 days on average (2017).

The main focus is on the 121 publicly financed **non-profit acute hospitals** (provincial funds hospitals and accident hospitals), with around 45,600 beds (70% of all beds) and almost 90% of all hospital stays 2.53 million). Around a quarter of all patients in acute hospitals are discharged again on the same day. Stays where the patient remains in hospital overnight lasted 4.9 days on average (2017).

While bed capacities in acute hospitals in the past decade have decreased slightly – in spite of increasing numbers of stays – because lengths of stay became shorter, inpatient **rehabilitation facilities** developed very dynamically with an increase in beds of almost 45 % (2017: around 11,400 beds). For **long-term care** there are around 5,100 beds in facilities which are run as hospitals (Source: BMASGK) and around 82,100 places in publicly financed care facilities run by the provinces and local authorities in the **social sector** with about 34,500 carers (2017) (Source: Statistics Austria).

Employees in hospitals (2017) per 1,000 inhabitants



- 2.8 Doctors
- 6.8 Qualified nurses
- 1.8 Auxiliary nurses
- 1.8 Medical-technical services
- 0.2 Midwives

Source: BMASGK

Austrian **hospitals employ** around 24,600 doctors and 93,300 other health professionals (2017, without administrative personnel). The largest group of health professionals are qualified nurses with 60,200 persons.

As part of the ongoing health reform (→ *Info box 1*), a DRG financing system is being introduced for hospital outpatient clinics. This is intended to have the effect that **services** which do not require hospital stays or equipment which is only available in the inpatient sector are **increasingly provided in the hospital outpatient sector**.

Info box 5:

Hospitals in Austria

The Austrian hospital landscape is diverse and complex. Overall there are 271 hospitals with a total of 64,805 beds (2017), which can be divided into the following types:

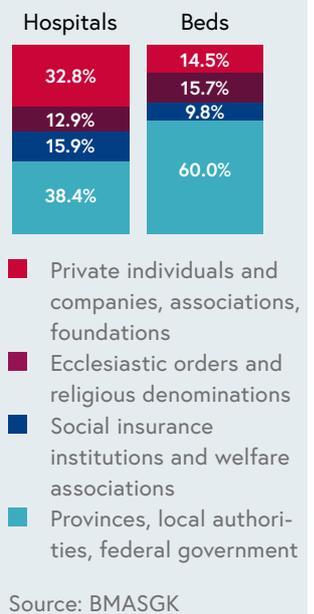
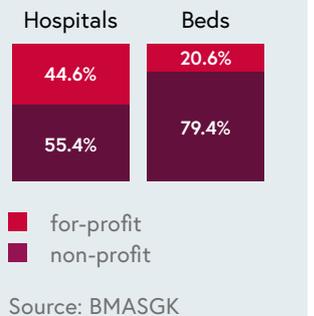
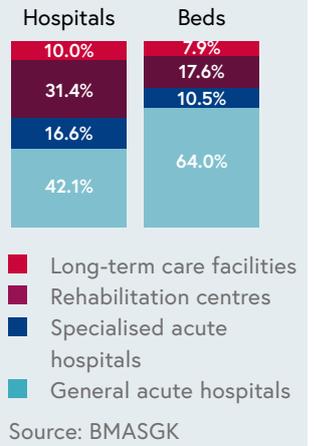
Acute hospitals are characterised by relatively short stays (an average of 4.9 days in 2017, not including day clinics). Among these, **general hospitals** usually provide a broad range of services, and at the least internal medicine and general surgery. **Specialised** hospitals provide care for people with certain conditions (e.g. orthopaedic hospitals) or of certain age groups (e.g. children's hospitals) or have been equipped for specific purposes (e.g. army hospitals). In acute hospitals, planned and unplanned services are provided.

Non-acute hospitals solely provide specialised care. They include **rehabilitation centres** (including recovery and preventive medicine) and facilities for **long-term care** (which are, however, not only provided in hospitals, but mainly in care facilities in the social sector).

Non-profit hospitals provide care to everyone regardless of their gender, age or type of medical or nursing care required. **For-profit** hospitals provide care to private patients and also to persons covered by social insurance when they obtain services which the social health insurance system is obliged to provide. Non-profit hospitals can also treat private patients to a certain extent.

These hospitals can be publicly or privately owned. **Public** hospital owners are primarily the provinces, partially also local authorities and associations of local authorities, as well as social insurance funds and welfare associations. The federal government only operates army hospitals. Provincial and local authority hospitals mainly provide acute care, while the social insurance institutions focus on rehabilitation facilities. Long-term care facilities are mostly owned by the provinces. In the **private** sector, ecclesiastic orders and churches largely run non-profit acute hospitals, whereas private individuals and companies provide (usually planned) acute care and rehabilitation centres, which usually have contracts with the social insurance institutions. Some hospitals are owned by associations and foundations.

Links (in German): [Hospitals](#), [hospitals in figures](#)



Supply of medicines

In the interests of the protection of health and the consumer, the production, market authorisation, pricing, the reimbursement of costs and the dispensation of medicines are subject to special legal regulations. In this context, Austrian legislation is oriented towards the overall framework of the EU.



The **market authorisation authority for medicines** is the Federal Office for Safety in the Health Care (BASG), supported by the specialist resources of the Austrian Medicines and Medical Devices Agency (AGES Medizinmarktaufsicht), which has been entrusted by the Federal health department with a number of tasks (authorising of medicines, clinical tests on medicines and medical devices, and the monitoring of these products (Link: www.basg.at).

Around 9,200 medicines (incl. homeopathic medicines) are authorised, of which almost two thirds are prescription medicines (as at January 2017). The average **consumption of medicines** per person in 2014 was **742 standard units** (this is the dosage per unit taken, such as a tablet, a measuring cup or ten drops). Austria was thus average for the EU states, whereby the average price (health insurance fund price) per pack of EUR 17.60 was somewhat above average (Source: Austrian Chamber of Pharmacies). In the year of 2017, around 26 packs per capita of the population were issued (Source: Pharmig). At the beginning of 2018, 5,171 medicines were included in the positive list of the social insurance funds – these are medicines which are issued on prescription in the private practice sector and paid for by the social insurance funds (Source: Austrian social insurance).



Pharmacies in Austria (2017)

- 1,362 public pharmacies
- 29 branches of existing pharmacies
- 41 hospital pharmacies
- 919 dispensing doctors

The next pharmacy can be reached within **ten minutes** for **95 % of the population**.

Source: Statistics Austria, Austrian Chamber of Pharmacies

Medicines can only be sold in pharmacies in Austria: their sale in supermarkets and drugstores as well as the operation of pharmacy chains are not permitted. Only a small number of simple medicines such as certain vitamin products or teas can also be sold in drugstores.

Pharmacies can only be opened by authorised pharmacists after a test to decide whether a new pharmacy is needed, and after an official permit procedure. **Commercial pharmacies** may only operate **one additional branch**. Around 16 % of hospitals have their own **hospital pharmacy**. A special feature in Austria are **dispensing doctors**: in rural areas without a pharmacy, doctors in private practice can dispense medicines directly to their patients. There are a total of 2,351 pharmacies in Austria (2017).

Quality, transparency and patient orientation

The core elements of high-quality and safe care

Patients' rights are legally established in Austria and enforceable. **Patients' ombudsman's offices** in all of the provinces safeguard the rights and interests of patients and mediate in the case of conflicts. In addition to offers of professional medical care, a large number of **self-help groups** support patients in coping with their illness.



Since 2005, the **Federal Act on the Quality of Health Care** has provided the legal framework for quality, transparency and patient safety. The **Quality Strategy** (Link: [Quality Strategy](#)), which has been developed in a participative and cooperative way, describes the wide range of activities with which quality is promoted in all health facilities. Health care should be safe, effective and easily accessible independent of where and in which facility or institution it is provided. In the implementation of all measures which increase patient safety, patients are informed and actively involved in the process behind the provision of health care. The **National Patient Safety Strategy** provides the framework for all health professions and for cross-sectoral activities.



National quality reporting (Link in German: [quality reporting](#)) takes up important issues which it makes accessible to the specialist and general public in a transparent and understandable way. An important tool of quality reporting are the reports about the quality system in Austrian health facilities. All hospitals, rehabilitation facilities and independent outpatient clinics are obliged to participate. The reports are generated at regular intervals via the **QBE quality platform** (Link in German: [QBE quality platform](#)) and provide an overview of quality work.

The intention is to ensure and continuously improve the **quality of care on the basis of evidence**. Nationally valid recommendations, systematic checks, evaluations and monitoring measures provide the points of reference which facilitate the optimisation of structures, processes and outcomes. Health technology assessment, quality registers or the creation of national quality standards, such as those for pre-operative diagnosis, make essential contributions here.



The **Federal Institute for Quality in the Health Care System** (Austrian Public Health Institute/BIQG, Link in German: www.goeg.at/BIQG) coordinates the **realisation of the Quality Strategy**, whereby the respective actors are frequently involved, such as the social insurance institutions, ministries and provinces, specialist societies, chambers and professional associations, patients' ombudsman's offices and self-help groups.

Transparency by measuring the quality of results

One of the most important measures of recent years to promote transparency regarding the quality of services in hospitals was the introduction in 2013 of the **A-IQI** system (**Austrian Inpatient Quality Indicators**) in all Austrian hospitals.

Info box 6



A-IQI (Austrian Inpatient Quality Indicators) and Kliniksuche.at

In **A-IQI** the quality data of hospitals is recorded on the basis of routine data. Alongside the constant further development and measurement of quality indicators, the centrepiece is the analysis via a peer review process. If there appear to be problems, a team of doctors (peers) visits the respective hospital, looks at individual cases and talks about opportunities for improvements with the doctors working there.

If necessary, the results lead to specific measures for improvements nationwide and are published annually in the A-IQI report. This covers the results of the individual indicators at a national level and also an analysis of the peer review processes which have taken place. Link (in German): Measurement of the quality of results

 **KLINIKSUCHE.at**

Via the web tool **Kliniksuche**, quality data is published which supports the public in making decisions when preparing for a hospital stay (empowerment). The point of departure for kliniksuche.at is the data from A-IQI connected with the nationally recorded routine hospital data and the quality reporting data (QBE platform). This shows medical services and subject areas which have already been analysed in the course of A-IQI. The subject areas and the individual criteria are both extended at regular intervals. This takes place after peer review processes have been carried out as a part of A-IQI. As at May 2018, 30 of the most important subject areas could be viewed, such as gall bladder removal, pacemakers, hernias, hysterectomies or hip replacements.

Link (in German): www.kliniksuche.at

The Austrian Society for Quality Assurance and Quality Management in Medicine (ÖQMED, Link in German: www.oeqmed.at) is responsible for the evaluation of doctors' practices and publishes the results in the Medical Quality Report.

Transparency through information

The complexity of the Austrian health care system demands transparency and easily understandable information. At the same time, it is also important to know which expectations the public and patients have with regard to the system. Within the framework of the health reform (→ *Info box 1*), measures are therefore being taken to make the system more understandable. For example, telephone and web-based advice is being developed whose first stage of realisation is health advice via telephone.

Info box 7:

The telephone helpline for patients: 1450

Using other European countries as a role model (the UK, Denmark or Switzerland), telephone health advice is being developed in Austria. Pilot projects are ongoing in three provinces (Vienna, Lower Austria and Vorarlberg).

Members of the public who call the helpline number 1450 (the same number from everywhere in the country) can receive round-the-clock advice on the urgency of their concerns and a medically validated recommendation for action. Can the pain be treated oneself, or should a general practitioner be consulted, or is specialist treatment required? Or is the hospital emergency outpatient clinic the right place to be addressed?

In this way, telephone health advice becomes a personal orientation aid for the health care system and leads the caller to where the most suitable support can be obtained at that moment in time ("Best Point of Service").

The telephone health helpline 1450 is a project within the ongoing health reform (→ *Info box 1*). After it has been validated it will be rolled out throughout the country.

Links (in German): [helpline for patients 1450](#), www.1450.at



Additional projects are, for example, a national strategy for the improvement of personal communication in health care ([Link in German](#)) or the integration of health competence into the occupational profiles of selected health professions.

The **public health portal** provides independent health information and services. Information about a **healthy lifestyle** which is designed to meet the needs of the population is made available on the websites of public institutions (Links: e.g. www.ages.at or www.fgoe.org).



Via a nationwide **patient survey** which took place in 2014 for the first time across all the sectors of health care (e.g. a hospital and a family doctor providing follow-up care), information was collected from the perspective of those affected which offers pointers towards a better and more intelligent way to govern the health care system. Patient satisfaction levels were well over 90% in both the inpatient and outpatient areas. In 2016 a supplementary **population survey** was published which provides insights into how people in Austria see the health care system (Links in German: [Patient survey 2015, census 2016](#)).



Health surveys can be used to analyze correlations of disease incidence (morbidity), health behavior and health-related risk factors and to identify differences by age, gender and other social and environmental factors. Furthermore, information on the utilization of health care facilities and the participation of the population in programs for the prevention or early detection of disease can be obtained. On behalf of the Ministry of Health and the Federal Health Agency, Statistics Austria has **already twice**, namely in 2006/2007 and 2014, carried out a nationwide **Health Interview Survey** (ATHIS) based on the compulsory European Health Interview Survey (EHIS). The sample was stratified according to the 32 health care regions. The questionnaire at European level (EHIS) included modules on health status, health determinants, health care and socio-demographic and socio-economic background variables. Additional national questions of **ATHIS 2014** dealt with quality of life, presenteeism (come to or stay at work while sick), as well as certain chronic diseases, outpatient health care, functional activities and the state of health of the children living in the household. In 2018/2019, the **third Austrian Health Interview Survey** will be conducted. Link in German: [Austrian Health Interview Survey 2014 ATHIS](#)

e-Health in Austria

Electronic health services (e-Health) are now a fixed element of the health care system and cover a wide range of applications, such as the electronic health insurance card, the health record and an overview of medications, plus telemedicine. A prerequisite for this is the secure transmission of medical data for preventive medicine, diagnosis, treatment and the ongoing support of patients in the form of text, sound recordings and/or images. e-Health offers not only technological opportunities, but also a chance in terms of structural policy to network the increasingly divided health services (in the sense of a division of labour) by means of information and communications technologies.

As early as 2005, the introduction of the **electronic health insurance card (e-Card)** for all persons covered by health insurance – alongside the administrative simplification of using cashless health care services – represented an important condition for the Austrian **Electronic Health Record (ELGA)**. Currently the e-Card is being further developed in a technological sense as well as with regard to safety – the latter will also be improved by the inclusion of a photo of the holder.



The legal basis for ELGA was adopted at the end of 2012. Since the beginning of 2014, the **ELGA portal** (Link in German: ELGA-Portal, [Information in English](#)), die ELGA service line and the ELGA opting-out service have been in operation. Since the end of 2015, ELGA is being introduced in stages, starting with public hospitals. In 2016, a test run was carried out with the ELGA function **e-Medication**. In the period March 2018 to September 2019, ELGA and e-Medication are being made available in stages to doctors in private practices, group practices, pharmacies and outpatient clinics. These will be followed by private hospitals, and subsequently by dentists with health insurance fund contracts. In addition, a pilot project for an **e-Vaccination pass** is being prepared.

Participation in ELGA is voluntary for patients – there is a possibility to **opt out**. **ELGA-ombudsman's offices** have by now been established in every province.

As part of the coordinated further development of **telemedicine** in Austria, the **framework guideline** for the IT infrastructure in the application of **telemonitoring** was drawn up in order to accelerate the standardisation of telemonitoring solutions (Link in German: [Framework guideline for telemonitoring](#)). The possibility to use the ELGA infrastructure is of great significance here. Telemonitoring is currently also being used successfully to care for heart failure patients and in the treatment of diabetes.



Info box 8:



ELGA – Electronic Health Record

The Electronic Health Record (ELGA) is an information system which provides patients and the doctors, hospitals, care facilities and pharmacies treating them with easy access to certain health data **from anywhere and at any time**. This improves the flow of information, supports the medical, therapeutic and nursing support of patients, and increases patient safety.

ELGA contains medical and nursing **discharge letters** from hospitals, **laboratory and radiological results** as well as information about prescribed and dispensed **medication**. The data of a person remains in the place where it originated, but ELGA networks this data and makes it available electronically via a link.

The entire population participates in ELGA, unless they have opted out of it, as do the legally established ELGA health services providers. Everyone has at any time a right to inspect and access their own ELGA health data. Health service providers have access to patients who are currently being treated or supported by them (usually for 28 days; however, patients have the right to individually determine access to and the duration of access to their ELGA health data). Pharmacies have access to the e-Medication list of a patient, but only for two hours. Patients who have not opted out of ELGA can view the e-Medication list of medicines they have been prescribed and which they have (or have not yet) picked up from a pharmacy



Via technical measures and also via legal provisions, ELGA also improves **data protection** for patients. Data transmission always takes place in encrypted form and within safe health networks which have been specially established for the health care system. Access to data in the technical area is only permitted on the basis of the dual control principle, or with comparable technical security measures. In addition, only authorised ELGA health services providers can access the data of their patients, and only as long as they are treating or supporting them. In the ELGA records, patients can at any time see who has accessed their health data, when they did so, and which data they have viewed. They also have the right to administrate their own health data, and the opportunity to wholly or partially opt out of ELGA, or to opt back in again.

ELGA is also intended to contribute towards the avoidance of **multiple examinations** and the related stress and waiting lists, as well as the undesired effects of **polymedication**.

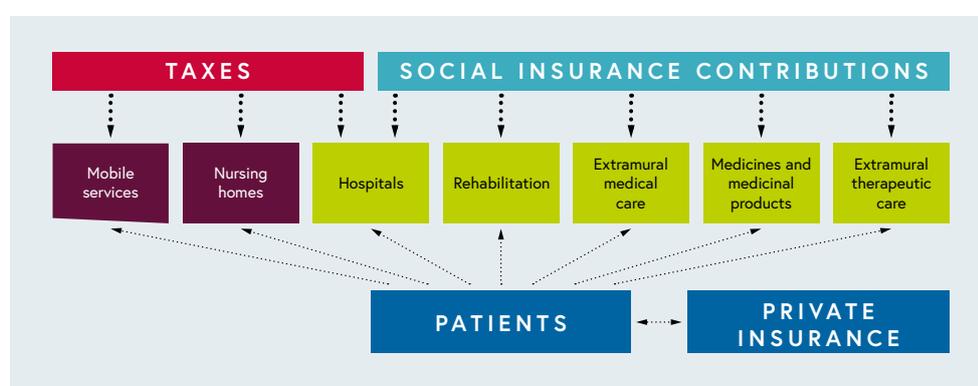
Links: [ELGA](#), [ELGA GmbH](#)

Health care financing

Financing and its origins

The health care system is financed by a combination of income-dependent social insurance contributions, taxpayers' money and private direct and indirect co-payments. This solidarity-based financing ensures fair access to health services – regardless of age, gender or origin.

Health care financing



Source: BMASGK

Individual co-payments

Using services partially involves **co-payments on the part of the patient**. Co-payments can either be fixed amounts (e.g. prescription fees for medication) or percentage co-payments, such as those for social insurance-based services provided in private practices. The cost of using services which are not included in the catalogue of services of the social insurance funds have to be borne by patients themselves. This includes the cost of prescription-free medicines, day fees for inpatient stays in hospitals, or the cost of certain dental treatment.

Socially balanced access to health services is a key concern. Persons below a certain monthly income level are therefore exempted from prescription fees for medicines and from the payment of a daily fee for inpatient stays in hospitals. In addition, exemptions for persons with notifiable communicable diseases such as tuberculosis are provided. The same applies to persons carrying out alternative civilian service and to asylum seekers supported by the federal government. In addition, those persons who have exceeded a **defined annual co-payment limit** (the upper limit for prescription fees is 2 % of annual income) are also exempted. Since 2015, the **cost of dental braces for children and young people** up to the age of 18 has also been assumed by health insurance funds in



Prescription fees in Austria (2018)

For each pack of prescribed medicines, a prescription fee of EUR 6 is charged if the price of the medication is above that of the prescription fee.

Excepted from this are persons who earn less than EUR 909 net per month, or EUR 1,046 in the case of an increased need for medication, and persons with notifiable communicable diseases and other defined groups.

the case of serious misalignment (malocclusion). In 2017, the **abolition of co-payments for hospital stays of children and young people** represented a further step in the reduction of the financial burden on families with children.

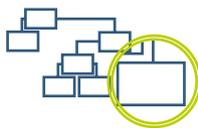
Source: Austrian Social Insurance

If the services of doctors or therapists without a health insurance fund contract who can set their fees themselves (**non-contracted doctors**) are used, the costs have to initially be paid by the patient themselves. Upon application the health insurance fund reimburses 80 % of the fee which it would have paid for the service, which, however, does not necessarily correspond to the actual costs charged.

An unmet **need for medical care** exists when people would need examining or treating (with the exception of dental care) but do not receive or take advantage of it because they cannot afford it. Only 0.2 % of the population over the age of 16 have – according to their own subjective assessment – an unmet need for medical care, so Austria is very well placed (2.6 %) in this regard compared to other EU-28 states (2016) (Source: Eurostat).

Hospital funding

Hospitals are financed from **several sources**, mainly from national and regional taxes and from lump-sum contributions of the social insurance funds. The most important providers of financing are the social insurance funds, the provinces and the federal government. In addition, patients make small co-payments (day fees of EUR 9.78 – EUR 22 per day (2018) for a maximum of 28 days a year, whereby there are exceptions).



The funding from the social insurance funds, the provinces and the federal government are paid into the Federal Health Agency and the Provincial Health Funds (→ *Health – a public task*). The Provincial Health Funds use this to finance hospital stays in public and non-profit acute hospitals (fund hospitals) according to the **Austrian DRG system** (Link in German: [DRG system](#), [Information in English](#)). The Austrian DRG system was developed by local experts for the settlement of **inpatient** hospital costs and has been in use since 1997. In private non-profit hospitals, those services which the social health insurance system is obliged to pay for are also settled according to the Austrian DRG system (via the Private Hospitals Financing Fund (Link in German: www.prikraf.info), which is funded by the social insurance system). This has attracted interest from other countries for a number of years now, and has become a financing model for other states.

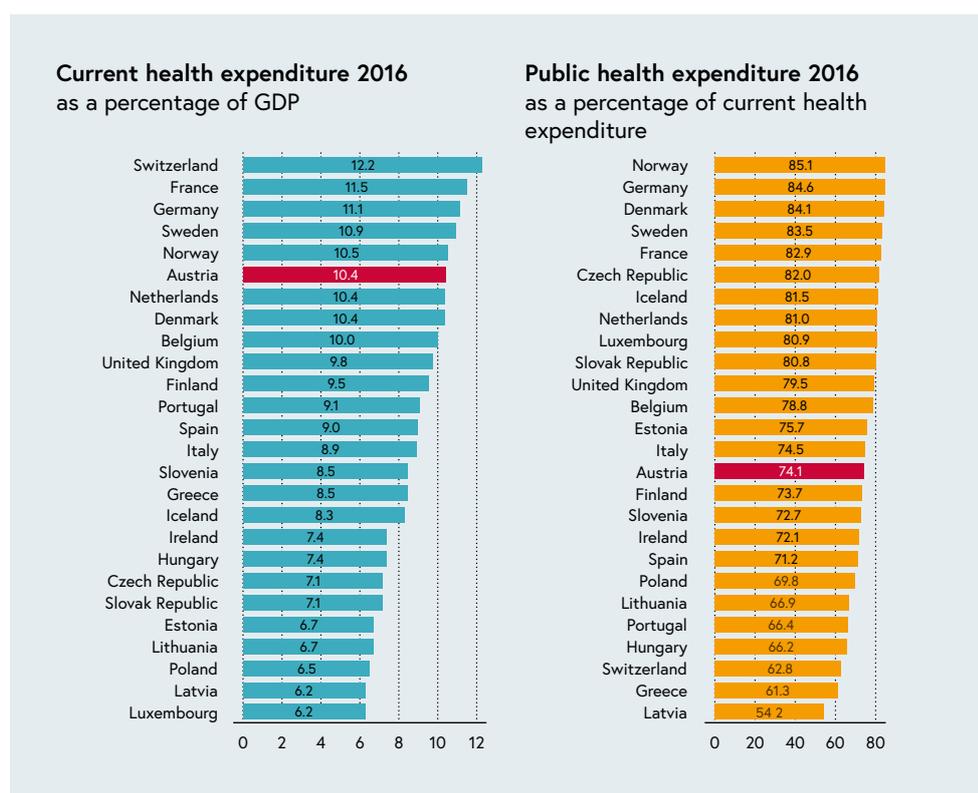
In 2017, the Austrian DRG system was extended by a model for the **hospital outpatient sector**, which will be compulsory from 2019 onwards. Via the staged introduction of procedure and diagnosis-related settlement in the hospital outpatient sector, the

transparency of services provided is improved, and the burden on the inpatient sector is reduced.

The legally binding **documentation** in hospitals as the basis for settlement in the DRG system is regulated at a national level. The nationwide uniform documentation of diagnoses in the inpatient sector, and the documentation of services in the inpatient and outpatient sectors also provide important information and a basis for decisions on planning and governance measures in health policy and for the measurement of outcome quality (→ *Quality, transparency, patient orientation*).

Health expenditure

Total health expenditure (including long-term care and investments) amounts to around EUR 41.3 billion or 11.2 % of gross domestic product (2017). **Current health expenditure** (including long-term care, excluding investments) amounts to around EUR 38.5 billion or 10.4 % of GDP. Austria thus is in the top third of EU states (2016). Current health expenditure excluding long-term care and investments amounted to EUR 32.8 billion or 8.9 % of GDP (2017).

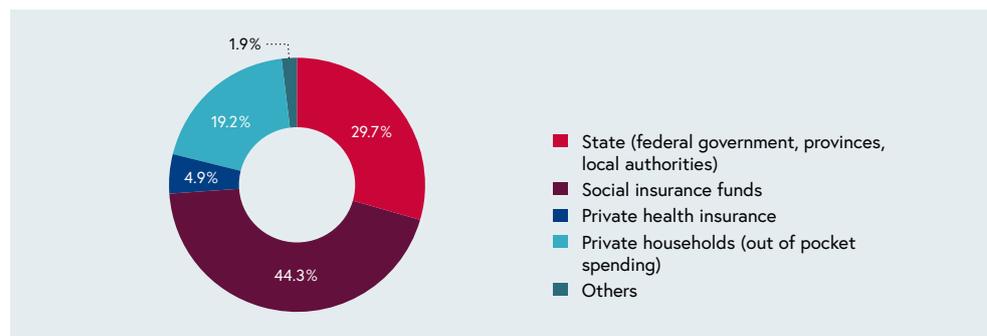


Source: OECD

Around three quarters (74.0 %) of current health expenditure (2017) is covered by **public funding**; this contains expenditure of the social insurance funds, the federal government, the provinces and local authorities. The remainder (26.0 %) is private health expenditure and consists – alongside the expenditure of private households – also of spending by private insurance companies and private non-profit organisations, as well as the services of occupational physicians (Link: [Health expenditure](#)). With regard to public health expenditure as a proportion of total health expenditure, Austria is around the European average (2016).

At around EUR 17 billion, **the social health insurance system** finances around 44.3 % (2017) of all ongoing health expenditure (including long-term care). Whereas the extra-mural sector is almost exclusively financed by the social health insurance system, in the intramural sectors the costs are shared by the public purse and the social insurance funds. Nursing and care services are predominantly financed from tax revenue.

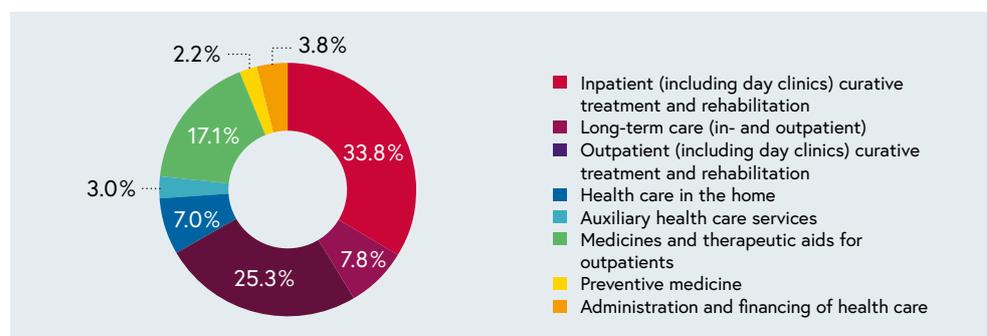
Current health expenditure - the sources of funding (2017)



Source: Statistics Austria

The greater part of current health expenditure (around 34 %) is used for **inpatient care**, while around 25 % is spent on the outpatient sector (2017). Medicines and medicinal goods (around 17 %) as well as nursing and care services (inpatient, outpatient and home care together account for 15 %) are also relatively large items of expenditure.

Current health expenditure – the use of funds (2017)



Source: Statistics Austria

Like most industrialised countries, Austria faces rising health expenditure bills. Between 2004 and 2017, overall health expenditure (including spending on long-term care and investments) increased by an average of 3.9 % per year. As part of the ongoing health reform, since 2013 public health expenditure (without long-term care) has been gradually adjusted (→ *Info box 1*) to the medium-term forecast for GDP (**Target-Based financial governance**). Agreed sectoral (social health insurance and the provinces) and regional budget caps soften the increase in health expenditure and thus secure the financing of the health care system over the long term.

Health as an economic factor

Health is not only a “cost factor”, but also a significant component of the national economy. The health economy overall, including the core element (the health care system) plus the extended health economy (other health-relevant goods which are dependent on subjective purchase decisions), achieved – according to the input-output table for the year 2013 – **production figures** of almost EUR 54 billion (of which EUR 35 billion was in the core area) or 8.9 % of the total economy, or 15.1 % of the total economy and **gross value added** of EUR 31 billion (of which just under EUR 22 billion was in the core area), or 10.9 % of the total economy.



This has a significant effect on employment. The entire health economy had around 624,000 **employees** in 2013 (of whom around 434,000 were in the core area), which represents a proportion of 14 % of the total economy. In **full-time equivalents** this corresponded to around 489,000 jobs (of which around 340,000 were in the core area) (Source: IHS)



Sources and notes

The list of sources only contains those sources which are not already indicated in the text with a link. Please note that many of the links lead to websites in German language. As at February 2019

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- Dokumentation im Gesundheitswesen – Ambulante Dokumentation (not published)
- Österreichischer Pflegevorsorgebericht 2015 [Link](#)

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- Unmet health care needs statistics, Eurostat Statistics Explained, January 2018 [Link](#)

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Austrian Chamber of Pharmacies, Link: www.apotheker.or.at

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- Beitragsrechtliche Werte in der Sozialversicherung 2018 [Link](#)
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- Obergrenze für Rezeptgebühren [Link](#)
- Statistische Daten aus der Sozialversicherung, Monatsbericht Mai 2018 [Link](#)
- Statistisches Handbuch der österreichischen Sozialversicherung 2017 [Link](#)

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Statistics Austria, Links: www.statistik.at, www.stat.at/web_en/

- Österreichische Gesundheitsbefragung 2014, main results of the Austrian Health Interview Survey (ATHIS) and methodical documentation. A: Jeannette Klimont, Erika Baldaszi; on behalf of the Federal Ministry of Health and the Federal Health Agency, Vienna 2015 [Link](#)
- Statistics (as at end of 2018); most of the statistics are available in English (see English website above):
 - Economy – National Accounts (Wirtschaft – Volkswirtschaftliche Gesamtrechnungen, Hauptgrößen [Link](#), Bruttoinlandsprodukt nach Wirtschaftsbereichen, real [Link](#))
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 - Population (Bevölkerung – Bevölkerungsstruktur – Bevölkerung nach Alter und Geschlecht [Link](#), Demographische Indikatoren [Link](#), Gestorbene [Link](#))
 - Health – Health Status (Gesundheit – Gesundheitszustand – Lebenserwartung in Gesundheit 2014 [Link](#), Subjektiver Gesundheitszustand 2014 [Link](#))
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Notes

- **Non-profit acute hospitals** are hospitals which are financed via the provincial health funds (fund hospitals) and hospitals with an accident and emergency department (Source: BMASGK).
- The number of **contacts with doctors** (2017) was taken from compulsory documentation in the outpatient sector and covers – apart from hospitals (out-patient clinics) – contacts in individual doctor’s practices, group practices and independent outpatient clinics (those which have health insurance fund contracts) (Source: BMASGK).
- The number of **pharmacies** (2017) covers commercial pharmacies, hospital pharmacies, pharmacies in doctors’ surgeries as well as branches of commercial pharmacies (Source: Statistics Austria).

