

# ESPN Thematic Report on Inequalities in access to healthcare

**Austria** 







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Contact: Giulia Pagliani

E-mail: Giulia.PAGLIANI@ec.europa.eu

European Commission B-1049 Brussels

### **European Social Policy Network (ESPN)**

# ESPN Thematic Report on Inequalities in access to healthcare

**Austria** 

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Marcel Fink

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#### Summary/Highlights

The Austrian public health system is organised according to an insurance-based model. At the same time coverage by public health insurance is very high, probably amounting to more than 99% of the population. This high coverage results from the fact that the system covers not only people in gainful employment but also people receiving cash benefits from social insurance or from the means-tested minimum income scheme (MMI), as well as – under specific circumstances – dependent family members (so-called co-insured persons).

The main initial causes of non-insurance may be: a lack of insurance despite employment (e.g. people in so-called 'marginal part-time employment' or the so-called 'new self-employed' with low income); unemployment without entitlement to unemployment benefits or MMI; loss of co-insurance (e.g. after divorce or exceeding a certain age limit); the lack of a legal residence title (e.g. irregular migrants); or the lack of a certificate of registration (homeless people; rough sleepers). In many of these cases those concerned can opt in to public health insurance (e.g. in the case of marginal part-time employment) or apply for 'voluntary self-insurance'. However, some members of these groups remain uninsured, either due to a lack of knowledge of these options or due to a reluctance or inability to cover the financial costs associated.

The Austrian health insurance system covers a wide variety of different services, such as: primary healthcare services provided by contracted physicians; specialised in-patient and out-patient care; emergency care; dental services; prescription medicines; and medical devices. Nonetheless, around 19% of total health spending comes from private out-of-pocket spending. The latter – inter alia – includes: prescription fees; daily allowances for in-patient care; a proportion of doctor's fees for non-contracted physicians; and examinations and treatments not covered by public health insurance (especially in areas where health insurance funds only fully cover the costs of 'conservative' or 'basic' treatment, for example in relation to dental care). Persons with low income are exempted from prescription fees and daily allowances for in-patient care. However, an analysis using data from EU-SILC 2016 shows that households with comparatively low income often face substantial perceived financial burdens due to private payments for health examinations and treatments.

Related problems may increase in future, as the number of contracted physicians, whose costs are regulated and usually covered by public health insurance, stagnates while population numbers increase. At the same time the number of non-contracted physicians (so-called *Wahlärzte*), whose fees are not regulated and where health insurance funds only reimburse 80% of what insurance would usually pay for contracted care, is growing strongly.

Nonetheless, it appears to be fair to say that the Austrian public health system is – from an international perspective – rather socially inclusive. However, challenges exist regarding the phenomenon of uninsured people and concerning examinations and treatments not covered by public health insurance. The affordability of the latter depends on private financial resources, with the risk of developments in the direction of two-tier healthcare. Here, a more detailed assessment would be necessary regarding treatments and examinations currently subject to private (co-)payments, their actual frequency, and of the eventual need to increase the depth of coverage by public health insurance. It appears that such a structured and in-depth assessment is not available in the case of Austria at the time of writing and that related reforms instead follow the logic of ad hoc decisions.

## 1 Description of the functioning of the country's healthcare system for access

#### 1.1 General principles

In Austria public health insurance is – in principle – compulsory for people in gainful employment and for people receiving cash benefits from different systems of social protection (such as pensions or unemployment benefits). For those in gainful employment insurance usually begins automatically, but some groups such as the self-employed (and voluntarily insured people, see below) have to apply for insurance. The amount of insurance contributions to be paid is independent of the personal risk of the insured. Health insurance is currently available from 19 different public regional and occupational health insurance providers. Apart from a few exceptions it is not possible for an insured person to choose their social security institution. Social insurance providers are so-called 'self-governing bodies' (*Selbstverwaltungsträger*) in Austria, which implies that they have regulatory functions (especially in respect of out-patient health services), which is associated with some differentiation in the services and benefits offered.

But health insurance in Austria goes far beyond the scope of insurance for employed persons and people receiving cash benefits from social insurance. In addition to directly insured parties, it also covers dependent members of their families. About one third of the persons currently covered by statutory health insurance are co-insured family members who do not pay contributions of their own (e.g. children, housewives/househusbands).

#### 1.2 Financing

In 2016,<sup>1</sup> 74.1% of all current health expenditure, including on in-patient and out-patient long-term care, was covered by the public sector and 25.9% by the private sector. The private share of total current health expenditure has remained largely stable since the beginning of the 1990s, amounting to between 24.4% and 26.6%.

Regarding the public sector, in 2016 about 60% of all current health expenditure was covered by health insurance contributions and about 40% came from the tax yield.<sup>2</sup> Regarding the private sector, about 73% of related outlays takes the form of private out-of-pocket payments, 20% comes from private health insurance providers, about 6% from non-profit organisations serving households, and about 1% from enterprise-financed schemes (other than health insurance).<sup>3</sup>

Cost containment is an issue in political debates about the development of the Austrian public health sector. Nonetheless, it is fair to say that the major health reform acts (i.e. the ones of 2005 and 2012/2013) and their successive implementation were not associated with major cuts in the benefits and services available. The aim was more to strengthen nationwide planning and efficiency in the public health system (see e.g. Hofmarcher 2014; Czypionka/Hofmarcher 2015).

Overall, health expenditure has substantially increased over recent decades. Total current expenditure (i.e. excluding investment) on healthcare increased from 7.8% of GDP in 1990 to 9.2% in 2000 and then further to 10.2% in 2010 and 10.4% in 2016. Data for current expenditure excluding long-term care indicate an increase from 6.8% of GDP in 1990 to

<sup>&</sup>lt;sup>1</sup> Source: Data provided by Statistik Austria according to OECD System of Health Accounts: http://www.statistik.at/wcm/idc/idcp

lg?IdcService=GET\_NATIVE\_FILE&RevisionSelectionMethod=LatestReleased&dDocName=111479.

<sup>&</sup>lt;sup>2</sup> Source: Data provided by Statistik Austria according to OECD System of Health Accounts: http://www.statistik.at/wcm/idc/idcplg?IdcService=GET\_NATIVE\_FILE&RevisionSelectionMethod=LatestRelease d&dDocName=043878 and own calculations.

<sup>&</sup>lt;sup>3</sup> Source: Data provided by Statistik Austria according to OECD System of Health Accounts: http://www.statistik.at/wcm/idc/idcplg?IdcService=GET\_NATIVE\_FILE&RevisionSelectionMethod=LatestReleased&dDocName=043878 and own calculations.

8.9% in 2016 (8% in 2000; 8.7% in 2010).4 In addition, health expenditure per head (in EUR at constant 2010 prices) has been rising (see Figures 1 and 2). In terms of yearly average increases, there is not much differentiation between different types of health spending. Per capita spending from government schemes and compulsory contributory healthcare financing schemes has on average been rising by 1.66% per year since 2000, private household out-of-pocket payments by 1.7% per year, and 'other private spending' by 1.54% per year.

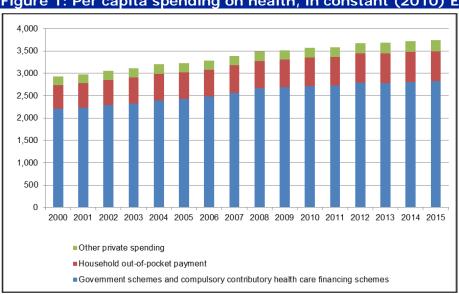


Figure 1: Per capita spending on health, in constant (2010) EUR

Source: WHO Global Health Expenditure Database & own calculations; current expenditure according to OECD System of Health Accounts.

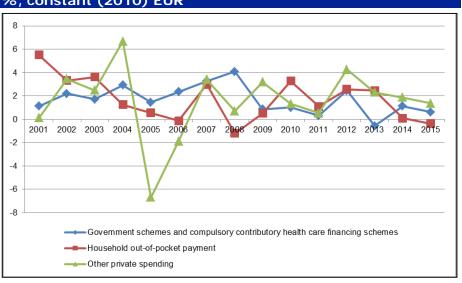


Figure 2: Yearly change in per capita spending on health, in %, constant (2010) EUR

Source: WHO Global Health Expenditure Database & own calculations; current expenditure according to OECD System of Health Accounts.

<sup>&</sup>lt;sup>4</sup> Source: Data provided by Statistik Austria according to OECD System of Health Accounts: http://www.statistik.at/wcm/idc/idcp Iq?IdcService=GET\_NATIVE\_FILE&RevisionSelectionMethod=LatestReleased&dDocName=111479.

'Other private spending' comprises spending by private health insurance providers, spending by non-profit organisations serving households, and enterprise-financed schemes (other than health insurance). In 2017 around 3,250,000 persons, which equals some 37% of the population, were covered by private health insurance (VVO 2018, 130). Around 82% of persons covered by private health insurance were covered via an individual contract, and 18% via a so-called 'group insurance', where a framework contract exists between a company (on behalf of the employer or the works council) and the insurance provider. Private health insurance offers different packages of coverage. The latter (inter alia) include: coverage for the costs of non-contracted practitioners (part of which is not covered by public health insurance; see below section 1.5) (so-called 'private practitioners insurance'); daily lump-sum sick pay during hospital stays (so-called 'per diem insurance'); private insurance for dental care (covering specific treatments normally not fully covered by public health insurance); and - in quantitative terms most importantly - insurance covering hospital costs (so-called 'first-class hospital insurance'). The latter provides not only coverage of daily allowances for in-patient care, normally to be paid by the patient (see below section 1.5), but also free choice of doctor in hospitals and treatment as a firstclass patient (i.e. lower number of beds per room, etc.).

In 2017 around 57% of persons covered by private health insurance (which equals 21% of the total population) held an insurance policy covering hospital costs; and spending on such insurance amounted to around 65% of the total benefits-related spending of private health insurance providers (see VV0 2018, 129). Other important categories of benefits-related expenditure by private health insurance providers are 'special examinations, treatments and remedies/medical devices', amounting to 10% of the total outlays, and 'practitioner's services' (i.e. not related to hospital health services), amounting to 9.5%.<sup>5</sup>

#### 1.3 Coverage

As already noted above, coverage by the public health system is organised according to an insurance model. Most people in gainful employment are covered by statutory health insurance. Standard employment contracts and so-called 'independent contracts' (*Freie Dienstverträge*) with a gross monthly income below €438.05<sup>6</sup> (lower earnings limit − LEL) are – with the exception of accident insurance – in principle not subject to statutory social insurance. This is called marginal part-time employment. However, workers reaching the LEL for compulsory health or pension insurance through a combination of several marginal part-time contracts or in combination with other insured income from gainful employment are liable for the same (employee) social insurance contributions as standard employees for health and pension insurance and are fully covered by these schemes. Furthermore, people only employed in marginal part-time employment with income below the LEL can opt in to health and pension insurance for a flat-rate monthly insurance contribution – currently (2018) €61.83.

A second important channel to get coverage by statutory health insurance is the receipt of benefits from public social insurance schemes, such as invalidity/old-age pensions or

<sup>&</sup>lt;sup>5</sup> The total benefit-related spending of private health insurance amounted to €1.363 billion in 2017 (see VV0 2018, 128).

<sup>&</sup>lt;sup>6</sup> This is the lower earnings limit (LEL) (Geringfügigkeitsgrenze) in 2018, which is indexed on a yearly basis.

<sup>&</sup>lt;sup>7</sup> The number of marginal part-time contracts of people in normal dependent employment has steadily increased, from around 273,000 in 2008 to around 348,500 in 2017. The number of marginal independent contracts (*Freie Dienstverträge*) has decreased from around 44,000 in 2008 to around 27,500 in 2017 (Source: http://www.dnet.at/elis/Arbeitsmarkt.aspx; Austrian Ministry of Labour, Social Affairs, Health and Consumer Protection). At the same time it should be noted that in 2016 around 55% of all people working in marginal part-time employment as dependent employees, and around 61% of those holding one or more marginal freelance contracts at the same time, were covered by statutory insurance via other channels (due to additional employment contracts fully covered by statutory insurance or due to receiving pension benefit, unemployment benefit, childcare allowance or benefits from health insurance (for details see Korn/Schmotzer 2017, 55-56).

unemployment benefits. Since 2010 the recipients of MMI, which at that time replaced social assistance, have been covered by normal statutory health insurance.<sup>8</sup>

In addition to directly insured parties, statutory health insurance also covers dependent members of their families, if these persons are not directly insured themselves. Such coinsurance is available free of charge for children up to the age of 18 and up to the age of 27 for children in ongoing further education. For unemployed children the age limit of 18 can be raised by an additional 24 months; and for disabled children free-of-charge coinsurance may be available without age limit.

Overall, the multitude of different options for getting public health insurance cover results in a comparatively high actual coverage rate of public health insurance. According to estimations by the Federation of Austrian Social Insurance Institutions (*Hauptverband der Österreichischen Sozialversicherungsträger*) it amounted to 99.9% of the population in 2017 (Hauptverband 2018, 9). Estimations by the Federal Ministry of Labour, Social Affairs, Health and Consumer Protection indicate a coverage rate of 98%. <sup>10</sup> Fuchs (2009), doing a more detailed assessment, comes to the conclusion that around 0.8% of the population (which currently would equal about 70,000 persons) lack coverage by private or public health insurance. No more up-to-date detailed analyses are available at the time of writing.

#### 1.4 Availability of healthcare

For treatment covered by health insurance in Austria, patients can freely choose their (family) general practitioner (GP) or can directly consult a specialist. In contrast to many other countries, there is no obligation in Austria to enrol with a specific physician or to consult them prior to accessing specialised treatment, which means that GPs have no gate-keeping function. It is also possible to consult ambulatory out-patient departments of hospitals without the prior consent of the family GP or one's health insurance fund.

GPs or specialists providing out-patient care in medical practices might either be so-called 'contracted physicians' (*Vertragsärzte*) or 'non-contracted physicians' (*Wahlärzte*). 11

<sup>8</sup> This was a positive step as there is some evidence that the earlier 'special' scheme for recipients of social assistance was accompanied by social stigma and – in some cases – below-standard health treatment.

<sup>&</sup>lt;sup>9</sup> The compensatory allowance (*Ausgleichszulage*) stipulates the level of the minimum pension for persons who are, in principle, eligible for a pension. It is at the same time used as a reference in a number of other social benefits etc.

<sup>&</sup>lt;sup>10</sup> See <a href="https://www.gesundheit.gv.at/gesundheitssystem/gesundheitswesen/gesundheitssystem">https://www.gesundheit.gv.at/gesundheitssystem/gesundheitswesen/gesundheitssystem</a>, retrieved 07.05.2018.

<sup>&</sup>lt;sup>11</sup> Contracted physicians (*Vertragsärzte*) or non-contracted physicians (*Wahlärzte*) are normally self-employed. Conversely, hospital physicians are normally employees. However, they can – depending on the contract with their employer – simultaneously also run a (usually non-contracted) private medical practice.

Contracted physicians have a contract with one or more public health insurance funds and are paid by the latter using a mix of contact capitation and fee-for-service. In such cases (see below section 1.5) no co-payments by the patient usually apply for all the services covered by the respective insurance funds. In the case of non-contracted physicians, patients have to cover the doctor's fee and are usually reimbursed only for 80% of what the insurance scheme would usually pay for contracted care.

Austria, after Greece, has the second-highest physician-to-population ratio in the EU (see OECD 2017, 7). At the same time, it is fair to say that the distribution of contracted physicians across the country is largely even, with a tendency for a higher density per population of GPs in rural areas and of specialists in urban areas (for details see Hauptverband 2017). What is worth noting in this context is the fact that the number of contracted physicians has only increased slightly in recent years (from 8,203 in 2000 to 8,252 in 2015, or by 0.6%) (see OECD 2017, 13). However, during the same time the Austrian population increased by around 730,000 persons or 9%. At the same time there is a steadily increasing number of non-contracted physicians: in 2000 their number amounted to 4,768 and in 2015 to 9,566 (see OECD 2017, 13), which equals an increase of 100%. According to the evaluation by the OECD (ibid.), this development: 12

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

The stagnating number of contracted physicians is in the first instance caused by the fact that, due to resistance by health insurance providers to providing additional contracts, the related location-based staffing plans do not provide for higher numbers of contracted physicians. At the same time it is reported that in rural areas some problems exist in finding people to succeed retiring contracted physicians. Overall, it appears to be fair to say that access to contracted physicians is currently (still) guaranteed throughout the country, although the density of contracted physicians and especially specialists shows some regional variance. Still, no detailed and up-to-date assessments on local availability, waiting times etc. in out-patient medical practices are available at the time of writing.

What is evidently an issue in Austria are waiting times for specific forms of surgery (such as hip replacement surgery or cataract surgery), and for specific medical examinations such as computed tomography (CT) or magnetic resonance imaging (MRI). For some specific kinds of surgery in public hospitals <sup>14</sup> official waiting lists have existed since 2011, data on which are also accessible via the internet. Waiting times for surgeries vary to a large degree between different hospitals and no up-to-date comprehensive assessment is available at the time of writing. <sup>15</sup> At the same time it is worth noting that there is (still) some evidence that for patients who also consult surgeons as a private patient and therefore pay additional fees, which may be covered by private health insurance, waiting

<sup>14</sup> Around 70% of all beds in hospitals are provided by public hospitals in Austria (run by the Federal Republic, the Federal States, municipalities and public insurance providers). Around 15% are provided by religious orders, 1% by associations and foundations, and 14% by other private companies (see: <a href="http://www.statistik.at/wcm/idc/idcplg?IdcService=GET\_NATIVE\_FILE&RevisionSelectionMethod=LatestReleased&dDocName=033703">http://www.statistik.at/wcm/idc/idcplg?IdcService=GET\_NATIVE\_FILE&RevisionSelectionMethod=LatestReleased&dDocName=033703</a>). Health insurance providers often have contracts with private hospitals, covering the same treatments as in public hospitals. At the same time public hospitals are the main provider for standard and also specialised treatments, with the highest standards and most specialised departments concentrated in public hospitals attached to public universities.

<sup>&</sup>lt;sup>12</sup> For a more detailed assessment on the role of non-contracted physicians see also Sinabell (2016).

<sup>&</sup>lt;sup>13</sup> See e.g. <u>http://orf.at/stories/2319631/2318918/</u>.

<sup>&</sup>lt;sup>15</sup> Also, the OECD Statistics on 'Health Care Utilisation' do not provide data on waiting times for Austria.

lists may get bypassed. <sup>16</sup> Private patients or first-class patients (with additional private health insurance) usually pay an additional honorarium to the surgeon (who, apart from being employed by the hospital may run a non-contracted medical practice) and/or pay additional fees to hospitals for being treated as a first-class patient (i.e. lower number of beds per room, etc.). The additional income both for surgeons and hospitals may provide an incentive to circumvent waiting lists for such patients. Overall, the issue of waiting lists and waiting-time management still appears to lack transparency, irrespective of attempts to increase the latter.

#### 1.5 Affordability of health expenditures and depth of coverage

The Austrian health insurance system covers a wide variety of different services, such as: primary healthcare services provided by contracted physicians; specialised in-patient and out-patient care; emergency care; dental services; prescription medicines; medical devices such as walking aids, wheelchairs or blood glucose strips; ambulance services; preventive and health promotion services, including vaccinations or screening examinations; and rehabilitation services.

Many services are available free of charge for insured persons of most public health insurance funds. A 20% co-payment for most services provided by physicians exists for persons insured with certain health insurance funds, namely those for the self-employed, farmers and civil servants. However, in the case of low-income patients there is an exemption from these general co-payments.

Furthermore, other specific private co-payments exist, irrespective of the health insurance fund in question. The most important ones in the area of 'basic' health services are a prescription fee for medicines in 2018 amounting to €6 per prescription, and daily allowances for in-patient care, currently – depending on the Federal Province – amounting to between around €12 and 19 per day for the first 28 days in hospital per year. Another co-payment is the annual service fee for the social insurance chip card that grants access to health services ('e-card'), currently amounting to €11.70 per year. However, vulnerable groups are exempt from these co-payments, such as: patients with notifiable infectious diseases (e.g. hepatitis, HIV/AIDS); registered asylum seekers covered by the 'federal minimum guarantee' (*Bundesbetreuung*); beneficiaries of certain social benefits (e.g. pensioners receiving 'compensatory allowances'); and people with income below a certain threshold.<sup>17</sup> Such an exemption currently applies to about a quarter of the insured population.

Out-of-pocket payments may not be covered by public health insurance in respect of a proportion of fees charged by non-contracted physicians (*Wahlärzte*) (see above section 1.4), whose fees are not regulated and where health insurance funds only reimburse 80% of what insurance would usually pay for contracted care. Also, over-the-counter (OTC) medicines bought without prescription are not covered by health insurance. In addition, in some areas health insurance funds only fully cover the costs of 'conservative' or 'basic' treatment, and only partly or not at all other more sophisticated ones. This applies inter alia to dental services, where e.g. the costs of inlays, dental crowns and fixed dental prostheses are only partly covered by public health insurance. <sup>18</sup> In such cases patients have to pay an honorarium for the related 'private services', <sup>19</sup> which may be offered by

<sup>&</sup>lt;sup>16</sup> Vgl. z.B. <a href="https://derstandard.at/1389858309759/Schneller-Operationstermine-ueber-den-Umweg-Privatordination">https://derstandard.at/1389858309759/Schneller-Operationstermine-ueber-den-Umweg-Privatordination</a>.

<sup>&</sup>lt;sup>17</sup> Thresholds for 2018 are (monthly net income): single persons, €909.42; single persons with increased need for medication, €1.045,83; couples, €1,363.52; and couples with increased need for medication, €1,568.05. The threshold is increased by €140.32 for each co-insured child.

<sup>&</sup>lt;sup>18</sup> However, since July 2015 social health insurance also covers dental braces for children and adolescents under the age of 18 in cases of severely misaligned teeth.

<sup>&</sup>lt;sup>19</sup> Fees for 'private services' to be paid by the patient are not regulated and it may be difficult for patients to identify a usual 'market price' for the related treatments. However, regarding dental treatments, for example,

both contracted and non-contracted physicians, and which will, depending on the treatment received, be only partly or not at all reimbursed by the public health insurance provider. Overall, the depth of coverage and affordability of health expenditure still appear to be rather high in the Austrian case, especially due to exemptions from co-payments for low-income groups. However, the increasing prevalence of non-contracted physicians and in some areas (such as dental care) rather narrow definitions of the services and treatments that are fully covered are likely to contribute to social inequalities in the actual quality of medical treatment (see below section 2 for more details).

## 2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

It is fair to say that currently no up-to-date and detailed assessment exists for Austria regarding inequalities in access to healthcare and actual medical treatment. Analyses of the Austrian health system more often adopt a rather general perspective, not differentiating between different income groups or according to other socio-demographic factors. For example, the 'population survey' [Bevölkerungsbefragung] on health issues published by the Ministry of Health in July 2016, covering a wide variety of topics, does not present results according to different socio-demographic groups (see Gesundheitsministerium 2016). A similar situation applies to the Austrian Health Interview Survey (ATHIS) of 2014, where the results did not get presented according to income groups (see Statistik Austria 2015; Statistik Austria 2016).

One important starting point for assessing inequalities in access to health services is the above-mentioned issue of **coverage by public health insurance**. Although detailed upto-date data on this issue are not available, it is – according to estimations – likely that at least 0.5% of the population living in Austria are not covered by public health insurance, due to different reasons. The main initial causes of non-insurance may be: a lack of insurance despite employment (e.g. people in so-called 'marginal part-time employment' or the so-called 'new self-employed' with low income; see Fink 2017); unemployment without entitlement to unemployment benefits or MMI; loss of co-insurance (e.g. after divorce or exceeding a certain age limit); the lack of a legal residence title (e.g. irregular migrants); or the lack of a certificate of registration (homeless people; rough sleepers) (LBI-HTA 2012). In many of these cases the people affected could opt in to public health insurance (e.g. in case of marginal part-time employment) or apply for 'voluntary self-insurance' (see above section 1.3). However, some members of these groups remain uninsured due to a lack of knowledge of these options or due to a reluctance or inability to cover the associated financial costs.

According to data from **EU-SILC**, the **share of the population reporting 'unmet needs for a medical examination or treatment'** due to financial reasons, waiting times or long travel distances to access services is (together with the Netherlands) the lowest in the EU, with very little variation across gender, age group, activity status and income quintile.<sup>21</sup> In 2016 only 0.2% of the total population in Austria (aged 16 or over) reported unmet needs for a medical examination or treatment due to the three reasons above (EU-28 average: 2.5%). And from a medium-term perspective, the share of people with self-reported unmet needs for medical examination or treatment has fallen in Austria (number for 2008: 0.7%). Unemployed persons in Austria show only a slightly higher incidence (1.2%) of such problems (EU-28: 5.3%). The same holds for people in the lowest income quintile, with 0.4% (EU-28 average: 5%).

there is a non-binding 'autonomous fee guideline' by the Chamber of Dentists, providing some guidance – see: <a href="http://wr.zahnaerztekammer.at/fileadmin/content/shared/infocenter/amtliche\_mitteilungen/VO\_OEZAEK/AHR\_2017\_2018.pdf">http://wr.zahnaerztekammer.at/fileadmin/content/shared/infocenter/amtliche\_mitteilungen/VO\_OEZAEK/AHR\_2017\_2018.pdf</a>.

<sup>&</sup>lt;sup>20</sup> See above section 1.3, last paragraph.

<sup>&</sup>lt;sup>21</sup> See Eurostat database indicator [hlth\_silc\_08]; see also OECD (2017).

A similar situation holds for the **share of the population reporting unmet needs for dental examination or treatment** due to financial reasons, waiting times or long travel distances. In 2016, only 0.5% of the Austrian population (age 16 or over) (EU-28 average: 4%) reported unmet needs due to these three reasons and here again there has been a downward trend (in 2008 it was 1.6%). Again, the figure for unemployed people (2%, compared with 10.1% in the EU-28) and for people in the lowest income quintile (1.1% compared with 7.9% in the EU-28) are only slightly higher than the Austrian average.

One point in this context is that people in Austria, even if not covered by health insurance, might get *urgent* examination and treatment free of charge under specific conditions. According to the Act on Hospitals and Sanatoriums (*Krankenanstalten- und Kuranstaltengesetz; KAKuG*<sup>22</sup>) public hospitals in Austria have to provide treatment in very urgent cases ('emergency treatment') irrespective of financial aspects or insurance status. If the patient does not have the financial resources to pay for the treatment, or if their identity cannot be determined, the hospital has to cover the costs itself or try to get partial reimbursement from other funds within the health system. Reportedly, physicians in hospitals repeatedly follow a so-called 'paradoxical management strategy', which involves applying a broad definition of emergency treatment in order to be able to help uninsured people (see with further literature references LBI-HTA 2012, 50f).

Other qualitative evidence also suggests that problems of access to healthcare due to missing insurance are an issue in Austria. As a result, health services for uninsured people are provided by, in particular, social NGOs or hospitals following charitable principles.

One well known example of the latter is the Hospital of the Brothers of Mercy (*Barmherzige Brüder*) in Vienna, which reportedly every year provides ambulatory health services to around 20,000 to 30,000 uninsured patients, and in-patient treatment to around 1,000 to 1,500 uninsured patients (see LBI-HTA 2012, 50). Examples of health services organised by social NGOs for persons without health insurance are AMBER-MED<sup>23</sup> and the Neunerhaus Health Centre<sup>24</sup> in Vienna or the Marienambulanz<sup>25</sup> in Graz. All of them offer medical and also some dental treatment to persons without health insurance, as well as – to some extent – to insured persons who for different reasons (social anxiety, fear of additional costs that cannot be financed, etc.) do not want to consult a physician or specialist within the normal health system. Many – but by no means all – of the patients are homeless people or people without Austrian citizenship. AMBER-MED treated more than 3,500 patients in 2017; Neunerhaus medical services reported 3,699 patients in 2016 and provided 27,206 cases of treatment (of which 4,874 were dental treatments); and the Marienambulanz had 2,393 patients in 2016. One evident problem is that such services are only available in some of the biggest urban centres, but not in other geographic areas.

One other issue worth analysing in more detail is that of **private co-payments** – for consultations with **non-contracted physicians** (*Wahlärzte*) and/or for **treatments and examinations not covered by public health insurance**. Unfortunately, detailed published assessments on these topics are not available at the time of writing. What is, however, evident is that private household out-of-pocket payments for health services are substantial in Austria (see above section 1.2). And according to results of the population survey [*Bevölkerungsbefragung*] on health issues published by the Ministry of Health in July 2016, the fear that personal health spending will rise is the number one apprehension of Austrians regarding future developments of the health system (71% indicate that they have this fear or strongly have this fear) (Gesundheitsministerium 2016).

<sup>24</sup> See <a href="http://www.neunerhaus.at/organisation/jahresberichte/">http://www.neunerhaus.at/organisation/jahresberichte/</a>.

 $<sup>{}^{22} \ \</sup>textbf{See} \ \underline{\text{https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen\&Gesetzesnummer=10010285}}.$ 

<sup>&</sup>lt;sup>23</sup> See <a href="http://www.amber-med.at/">http://www.amber-med.at/</a>.

<sup>&</sup>lt;sup>25</sup> See <a href="https://www.caritas-steiermark.at/hilfe-angebote/menschen-in-not/gesundheit/marienambulanz-medizinische-erst-und-grundversorgung/">https://www.caritas-steiermark.at/hilfe-angebote/menschen-in-not/gesundheit/marienambulanz-medizinische-erst-und-grundversorgung/</a>.

Some empirical evidence on related questions can be provided by **analysing** data from **special-module questions** on **health services** and **private health spending** in **EU-SILC 2016**. The latter asks whether the respondent or members of the household have made use of health services in the preceding year. Health services are: doctor visits; medical examinations and treatments (including dental); prescription medicines; physician-directed spa and rehabilitation stays; physician-directed vision and hearing aids; and physician-directed orthopaedic or other medical devices (e.g. shoe inserts, prostheses, wheelchairs). Health services do not include: home care or everyday help with permanent physical, mental or age-related restrictions; non-prescription (OTC) drugs; and treatments that are taken without a doctor prescribing them (for example, non-physician-directed oral hygiene, acupuncture, etc.). Other questions in the survey ask whether: the household had to cover financial costs for such services (even after eventual reimbursement by health insurance funds); if they had no such costs because private payments were fully reimbursed by the health insurance fund; and how difficult it was for the household to cover the private payments eventually made.

The results of an analysis of these questions according to income quintile are presented in Table 1.

Table 1: Households obtaining health services in previous year: private payments, cost reimbursement and difficulties in covering private payments, according to income quintile, in %

		Income Quintiles					Total
		1	2	3	4	5	
Members of households obtaining health services in previous year	yes	91%	94%	96%	96%	97%	94%
	no	9%	6%	4%	4%	3%	6%
Of households obtaining h	nealth services:						
Private payments	no answer	12%	11%	12%	10%	9%	11%
	yes	58%	68%	72%	75%	79%	70%
	no	31%	21%	16%	15%	12%	19%
In case of no private payments:							
no private payments due to full reimbursement by health insurance funds	yes	18%	16%	27%	27%	33%	22%
In case of private payments:							
Private payments could be covered:	With big difficulties	10%	5%	4%	2%	1%	4%
	With difficulties	11%	10%	7%	6%	4%	7%
	With some difficulties	24%	21%	18%	17%	11%	18%
	Rather easily	26%	29%	32%	31%	28%	29%
	Easily	21%	23%	23%	28%	30%	25%
	Very easily	9%	13%	16%	17%	26%	17%

Source: Statistics Austria EU-SILC 2016, own calculations.

First, it is evident that a higher share of households in the lowest two income quintiles did not obtain any health services in the previous year, compared with those in the highest income deciles.

Second, in total more than two thirds (70%) of households obtaining health services also faced private out-of-pocket health payments (which were not fully reimbursed by the

health insurance funds). Such private payments were somewhat more common in the high income quintiles (with 79% of all households reporting such payments in the  $5^{th}$  quintile), but the two bottom quintiles also showed a rather high frequency of private payments (58% of the  $1^{st}$  quintile and 68% of the  $2^{nd}$  quintile).

Among households with no private payments, in 22% of cases this was due to the fact that such payments were fully reimbursed by health insurance funds. The breakdown according to income quintile shows that households in the higher income quintiles with no private payments more often reported a full reimbursement of earlier private payments.

For the **two bottom income quintiles**, and especially for households in the 1<sup>st</sup> income quintile, **private health payments** more frequently **imply financial difficulties** or big financial difficulties than for households of the higher income quintiles. Of the households with private payments, 45% of the bottom income quintile reported difficulties covering their costs, whereas this only applied to 16% of the top income quintile.

These results suggest that: a) households with lower income might show a greater tendency to avoid private out-of-pocket payments; and that b) such payments, if they apply (which is the case for most households with lower income), entail substantial financial strain for a significant minority of households with low income.

Analyses based on the **Austrian Health Interview Survey (ATHIS 2014)** (see Statistik Austria 2016) indicate that **health status**, **health behaviour** (smoking, doing sports, obesity, etc.) and also the frequency of **preventive** cancer *examinations* (mammography, pap smear, colonoscopy) and of **vaccinations** show a substantial **social bias** in Austria. Low-income groups tend to have less favourable health outcomes and health behaviour and at the same time are less frequently covered by preventive cancer examinations and show lower rates of vaccination. Causal relationships between these findings and the design of the Austrian health system have not been examined in detail at the time of writing, whereas such an analysis would be necessary for a full understanding of the social impact and the social selectivity of the Austrian health system.

The **health reforms of 2005 and 2012/2013** and their successive implementation were not accompanied by major cuts in benefits and services available. Cost containment has been one of the goals, but the aim is to achieve these by strengthening nationwide planning and efficiency in the public health system and by fostering health prevention. Measures that explicitly increased the accessibility of health services for low-income groups have included:

- normal public health insurance coverage for recipients of MMI (2010);
- capping user charges for prescription drugs at 2% of annual net income per calendar year for people with low incomes and high drug consumption (intended to benefit around 300,000 people) (2008);
- expanded ambulatory dental care benefits for the whole population by allowing dental clinics owned by sickness funds to offer a full range of dental services, including dentures (2012);
- health insurance coverage for dental braces for children and adolescents under the age of 18 in cases of severely misaligned teeth (July 2015).

In order to **increase the social inclusiveness** of the Austrian health system, a more detailed and up-to-date **assessment** of the **problem of non-coverage by health insurance** would first be necessary. This is largely a 'black box', with no valid data and no analysis of the main causes of this phenomenon (lack of financial resources for voluntary insurance; information gaps; requirement of a certificate of registration, etc.).

A second issue is that of the **catalogue of treatments and examinations** covered by public health insurance. Here, a more detailed assessment would be necessary regarding treatments and examinations currently subject to private (co-)payments, their actual frequency, and the eventual need to increase the depth of coverage by public health insurance. It appears that such a structured and in-depth assessment is not available in

the case of Austria at the time of writing and that related reforms (such as those covering dental braces – see above) instead follow the logic of ad hoc decisions.

#### 3 Discussion of the measurement of inequalities in access to healthcare in the country

It is fair to say that Austria does not show a strong national research tradition of analysing inequalities in access to healthcare. Data used in this context often derive from surveys etc. that are part of international programmes by the OECD, the WHO and Eurostat (see Habimana et al. 2015).

These data provide valuable insights, but also have their limitations.

The frequently used EU-SILC indicator on 'self-reported unmet needs for medical examination and treatment' only provides a rough picture on the accessibility of health services, concentrating on examinations and treatments 'really needed' (in the wording of the Austrian questionnaire, 'unbedingt benötigt'). What would be interesting from an Austrian perspective is an additional international comparison of the frequency of private out-of-pocket payments according to income group, and the perceived financial burden of such payments (see for Austria above Table 1).

EU-SILC 2017 includes a special module on health, inter alia covering questions on the frequency of attending GPs, specialist physicians and dentists, and the subjective perceived financial burden of medical and dental examinations and treatment. Unfortunately, the related data for Austria are not expected to be available until August 2018 at the earliest. An analysis of these data will provide a more comprehensive picture of inequalities in access to healthcare in Austria and from an international comparative perspective, rather than the narrow indicator on self-reported unmet needs for medical examination (and treatment) (see above).

Furthermore, it should be stressed that surveys such as the EU-SILC are not likely to cover people with especially high risks of non-coverage by health insurance, such as homeless people or people with unclear residential status. To assess their problems, other (more qualitative) research methods appear to be more appropriate.

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