

FEDERAL MINISTRY OF
HEALTH AND WOMEN



Public Health in Austria



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Foreword by the Federal Minister

„Health is not everything, but without health, everything is nothing“
Arthur Schopenhauer (1788-1860)



In the general hustle and bustle and stress to which we are subjected every day, we all too often lose sight of what is most important—our health. In industrialized societies, the dominant attitude toward health was long primarily reactive. As long as someone was healthy, he or she didn't worry, but—when illness arrived—powerful medications were called upon to restore health as quickly as possible. Recent times, on the other hand, have seen the rise of a “preventive” approach—and that is a definite step in the right direction.

The newly revised informational booklet “Public Health in Austria” is a further step in this direction—it is meant to inform readers and encourage them to do something for their own health.

With the Health Care Reform Act of 2005, the Federal Ministry of Health and Women has established guidelines for preventive medicine. One of the central points is risk-group-oriented preventive examinations. Such annual check-ups are paid for by the public insurers, making it possible to examine patients according to their individual needs. In this way, illnesses are recognized and given appropriate therapy in their early stages. Special attention is paid to the living habits of the patients (alcohol, smoking, illnesses in the family, etc.). The “new check-up”, offered free-of-charge from age 18 onward, is intended to be viewed by citizens with the same urgency as yearly inspection tags on their cars. In order that subsequent appointments not be forgotten, a recall process has been instituted to remind patients at regular intervals of the opportunity to take advantage of such an examination.

A further central point relates to the financing of the health care system. Demographic studies show that the Austrian population is growing ever older, while at the same time the working-age population is shrinking.

The high quality of the Austrian health care system makes it one of the world's best—and this should remain so in the future. With the Health Care Reform Act, appropriate steps have been taken to be as well-prepared as possible for future challenges.

As part of this foreword, I would like to refer briefly to Austria's EU presidency during the first half of 2006. One focus, from the perspective of the Federal Ministry of Health and Women, will be women's health. Efforts are underway to establish gender-neutrality in the health care system, so that women are in no way disadvantaged. This intent is the basis for the recently published Austrian Report on Women's Health of 2005.

The EU presidency is a great responsibility, for there are many important issues to be dealt with—but it is also a great honour. Europe must strive to emerge strengthened from the current crisis surrounding the Constitution and the failed budget negotiations. During its presidency, Austria will be called upon to play a significant role—it is necessary to give greater consideration to the desires and needs of citizens, for a Europe of elites cannot function in the long term. Our primary goal must be to win the confidence of the citizens, and to take seriously their worries and fears.

We will take on this responsibility, and I am confident that we will succeed in having a positive impact during our presidency.



Maria Rauch-Kallat
Federal Minister for Health and Women

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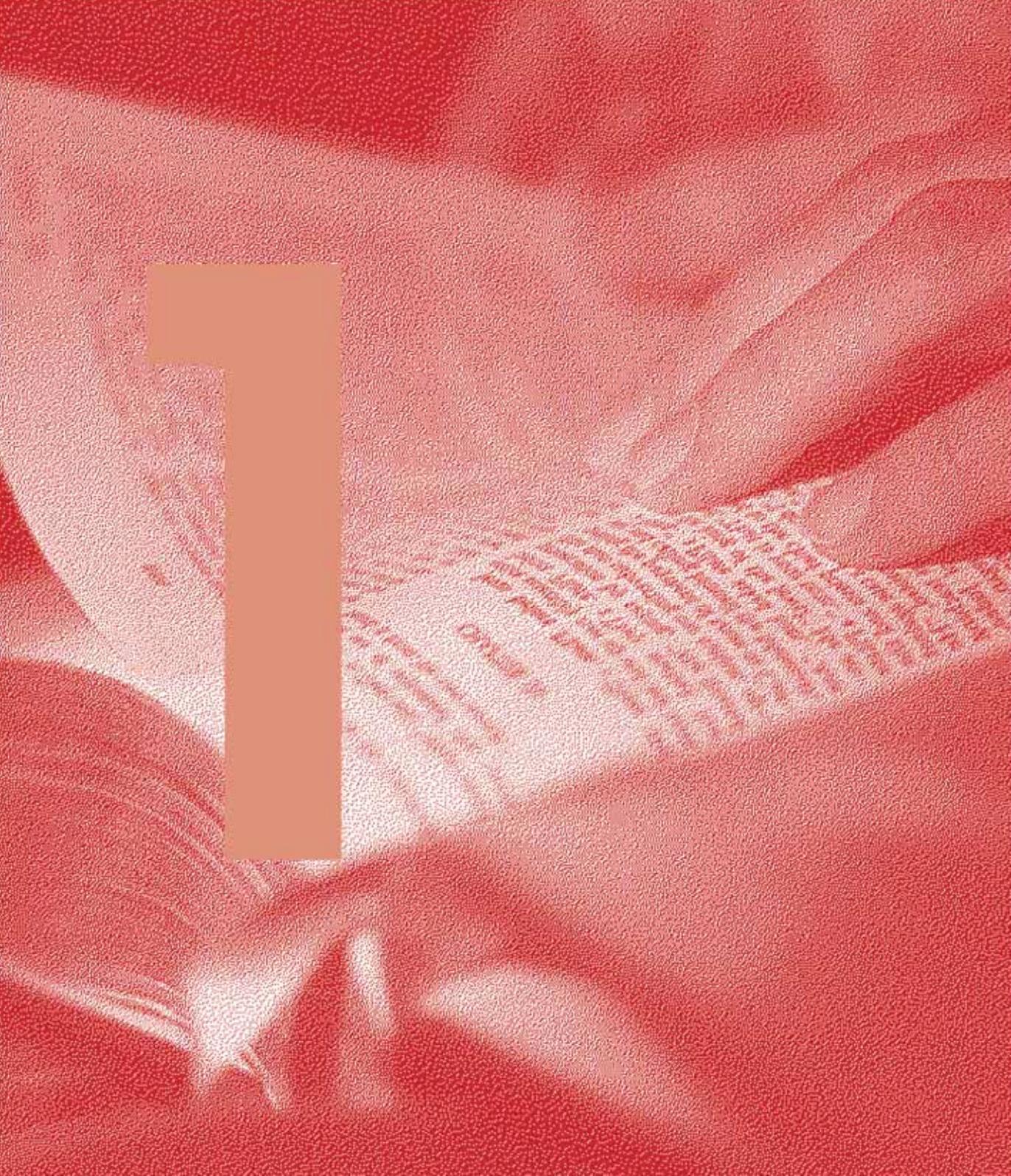
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1



1 Socio-demographic Overview and Legal Aspects

General socio-demographic data and developments

The Republic of Austria is a federation composed of nine provinces on the basis of a parliamentary democracy. A member of the United Nations and many other agencies, among these the World Health Organization, the country joined the European Union in 1995.

Austria comprises a territory of approximately 84,000 square kilometres and is thus about twice the size of Switzerland or about one quarter the size of the Federal Republic of Germany.

Life expectancy has improved considerably in Austria, as it has in all EU-countries. In the year 2004, it was 76.4 years for men and 82.1 years for women. Life expectancy is predicted to rise to 80.2 years for men and to 85.6 years for women by the year 2030.

Austria is currently in a phase of unusually rapid population growth. Since the mid-nineties, the population has grown by half a million inhabitants to the current (1 January 2005) 8.21 million. The reason for this, however, is not a high birth rate, but unexpectedly high immigration.

The population figure will continue to grow over the coming decades. Statistics Austria estimates that in the year 2030, around 8.42 million people will be living in Austria, which is 4.8 percent more than were counted in the 2001 census. Thereafter, the population figure is expected to decline due to lower net birth rates.

Since 1992 the average birth rate per woman in Austria has been less than 1.5, and the 2003 rate of 1.4 was below the EU-average of 1.5 (Source: Eurostat). On a long term scale, it would be necessary for each woman to bear 2.1 children to maintain the population at its current level.

One of the biggest challenges to social and health policy in the coming years will be the greater-than-average increase in the number of elderly and very old people. People over the age of 60 currently total about 1.8 million. In the year 2015, this figure will have already reached about 2.05 million and will grow to 2.7 million by the year 2030. The over-80 age group will increase greatly. 339,000 very old people currently live in Austria; the number will reach 461,000 by 2020 and 590,000 in 2030. At the same time, the age-group comprised of those 15 to 59 will shrink constantly. In the year 2004, there were around five million people in the workforce age group 15-60, but this number will decrease to only 4.61 million by 2030.

Table: Structure of the Austrian population according to age groups (in percent), as of 2004, with forecasts for 2015 and 2030

Year	Age groups 0 to 14	15 to 59	over 60
2004	16.2 %	61.9 %	21.9 %
2015	14.1 %	61.3 %	24.6 %
2030	13.2 %	54.7 %	32.1 %

Source: Statistics Austria

For this reason, the average age will also increase markedly. Currently at just over 40, the age of the average Austrian in the year 2030 will be 45.6.

Table: Natural population trends in Austria 1970-2030

Year	Births	Deaths	Life expectancy at birth (Men/Women)	Life expectancy at 60 (Men/Women)
1970	112,404	98,819	66.5/73.4	14.9/18.8
2004	78,968	74,292	76.4/82.1	20.7/24.6
2030	71,200	90,530	80.2/85.6	23.4/27.4

Source: Statistics Austria

General legal aspects

The safeguarding of health is a function of government in Austria. Although the public health services are a federal matter in terms of legislation and execution, the responsibilities necessary for this purpose do not lie exclusively in the hands of the Federal Ministry of Health and Women.

Important responsibilities are also assumed by

- various ministries at the federal level,
- provinces and municipalities, and the
- social security institutions as self-administrated public corporations.

Below are some examples in this respect:

- Access to the individual services of the public health care system is governed by social law. Social insurance law is of major importance in this respect. Immediate state help is virtually never necessary, because social security covers almost all needs. The reason why this works so well is the fact that the social security system is based on the model of compulsory insurance.
- The Federal Ministry of Education, Science and Culture is responsible for the university education of medical professionals.
- The hospital system—one of the largest and most important parts of the health care sector—falls within the area of competence set out in Art. 12 of the Federal Constitution Act. This means that the Federation is only responsible for legislating basic principles. Legislation of implementation laws and the execution thereof—including the assurance of hospital health care—is the responsibility of the provinces.

The distribution of competence, the variety of financers and the mixture of means of financing (social-insurance contributions and tax revenues) within the health care system require a significant amount of coordination and arrangements among the various decision-making sectors and the financers. One of the instruments for this purpose consists of the so-called agreements in accordance with Art. 15a of the Federal Constitution Act. These are national state treaties concluded, for example, between the Federation and one, several or all the provinces. The treaties also enable measures to be mutually agreed to be taken within the health care system which regard various areas of competence but which should be co-ordinated as uniformly as possible throughout the country.

Health care reform

In the year 1996, the Federation and the provinces reached an agreement on a health care system reform which, although it had been preceded by many reformatory steps, finally achieved a fundamental breakthrough in terms of a directional change in the system's development. The initial step was concluded via an agreement in accordance with Art. 15a of the Federal Constitution Act between the Federation and all nine provinces covering the years 1997 to 2000. The second stage of health care reform was initiated later on with a further agreement covering the years 2001 to 2004. The Health Care Reform Act of 2005 aims to ensure the financing of health care over the long term through cost control and improvements in efficiency. Further goals include the intensification of preventive measures and thorough assurance and improvement of quality in the Austrian health care system.

The fundamental points of the 2005 Health Care Reform

Organisational structure

The objective of this health care system reform is the closer networking of the inpatient (hospital) and outpatient sectors (hospital clinics, doctors in private practice). The newly created Federal Health Agency and the Provincial Health Platforms represent the institutionalisation of this closer co-ordination between the federal level, the provinces and social insurers.

The Federal Health Agency is the central institution for the planning, management and financing of the Austrian health care system. Its duties include health care planning, the implementation and further development of documentation and of performance-related systems of reimbursement, structured quality improvement and interface management, as well as the promotion of the implementation of modern communications technologies (health telematics).

The central organ of the Federal Health Agency is the Federal Health Commission. It includes representatives of the Federation, the social insurers, the provinces, the cities and municipalities, the religious hospitals, the patient advocacy bureaus and the Medical Chamber.

The mission of the provincial health funds is the elaboration and implementation of guidelines and planning principles outlined by the Federal Health Agency in light of both overall economic conditions and regional and province-specific needs. Its highest organ-

isational units are the health platforms on the provincial level, which also include representatives of all significant actors (service providers and financing bodies).

For example, the Federal Health Agency establishes the planning principle according to which, based on a calculation of needs, a certain region requires 20 eye doctors for outpatient eye care. Based on this principle, the health platform responsible for this region can determine how many of these doctors should perform eye care services in outpatient clinics and outside hospitals, respectively. The social insurers, on the other hand, can determine—based on their self-administration competencies or via contracts (collective, individual) with the Medical Chamber—both the staffing and scheduling of eye doctors working outside the hospitals as well as the establishment of group or individual practices.

Quality and interface management

The quality of health care must be ensured and continually improved. Over the past few years, the Federation has taken measures that effected improvements with regard to documentation requirements, the quality of medications and medicinal products, the quality of education and practice in the health care professions, patients' rights and the quality of hospital care. Furthermore, the process of defining mandatory structural quality criteria for various specialties was initiated.

With the "Act on the Quality of Health Services", the Health Care Reform of 2005 has taken the most recent and most significant step towards quality work. The fundamental principles of this act are orientation towards the patient, transparency, efficiency, effectiveness and patient safety. This creates the opportunity to develop and implement nationwide standards encompassing all areas of the health care system. The act, as well as future ordinances based thereupon, applies to all sectors, i.e. including public and private hospitals, outpatient clinics, doctors and all other health professions such as medical-technical services, midwives and nursing staff—in short all health service workers—but also addresses the management of interfaces.

Future quality reporting will regularly cover all areas and occupations in a uniform fashion throughout the Federation. This will ensure transparency towards the public, while also marking the introduction of a method for the systematic improvement of quality assurance. In order to handle all related work in the future, a Federal Institute of Quality is planned, which will work to support the Federal Ministry of Health and Women.

The themes of quality and interface management are elaborated on individually in articles of the Agreement According to Art. 15a of the Federal Constitution Act on the Organisation and Financing of the Health Care System (2005-2008). Furthermore,

these areas have been defined as explicit responsibilities of the Federal Health Agency and, on the provincial level, of the Health Platforms.

Health care structural planning

The objective of health care structural planning is to provide evenly distributed, uniformly high-quality care across the country, which is easily accessible and financed in a sustainable manner. Health care structural planning in Austria is traditionally aimed at the area of acute hospital care, since the Austrian health care structure is relatively hospital-centred compared to the systems in other countries.

The Austrian Hospitals and Major Equipment Plan (ÖKAP/GGP) went into force as part of the 1997 Health Care Reform Act, and has since been updated and expanded—and undergone further development based on new, quality-based planning methods—at regular intervals in concordance between the Federation and the provinces. Alongside the determination of hospital locations, the maximum number of beds per hospital and the maximum number of beds per speciality and province, the ÖKAP/GGP contains agreements on structural changes commensurate with demographic and medical developments (see Chapter 4).

Additionally, a new, modern approach to health care structure planning was agreed upon in 2005, an approach which forms the basis for the Austrian Health Care Structural Plan (Österreichischer Strukturplan Gesundheit, ÖSG). The ÖSG is to become the instrument of integrated planning for the whole health care field—inpatient and out-patient, acute and long-term care including rehabilitation, as well as the interfaces between the various care sectors and levels. The methodical approach employed is service provision planning, which is to replace the traditional methods of location, speciality structure and bed availability planning (see Chapter 4).

Health telematics (E-health)

The employment of modern information and communication technologies in the health care field has already been promoted and supported considerably over the past few years. The more intensive use of modern technologies is viewed as playing a key role in the current health care reform. Integrated treatment management is to be supported by the supra-institutional—and thus transmural—exchange of health information. The goal of the measures in the area of E-health is, in concordance with E-government and EU activities, to expand the legal, technical and organisational framework and to promote co-operation via the bundling of resources.

The Agreement According to Art. 15a of the Federal Constitution Act on the Organisation and Financing of the Health Care System and the Health Care Telematics Act have created the basis for new improvements in the quality of care using already-available technologies, as well as the economic means to better take advantage of these technologies. The Healthcare Telematics Act has established supplementary rules for the transfer of health data (confidentiality, integrity and transparency of communication processes), and has also provided for information management concerning matters of health telematics. The first universal applications will be implemented as “electronic health record (ELGA)” and “E-prescriptions”.

Health care financing and documentation

For the organisation and financing of the health care system, the means are to be made available for the period of 2005 until 2008 for the financing of hospitals, for the area of co-operation, for supra-regional care programmes and treatment measures, for the promotion of transplant activities and for the financing of projects and planning. The Austrian DRG System (see Chapter 6), successfully implemented for financing the inpatient care sector, will be kept and is to see comprehensive further development by 2007.

The core of the new prevention programme consists in defined prevention goals, particularly with regard to cardiovascular disease, cancer and typical geriatric complaints. The objective is not only the early recognition of common illnesses, but also education and the support of healthy lifestyle changes with regard to the central themes of physical exercise, nutrition and smoking (see Chapter 4).

Duties of the Federal Ministry of Health and Women with regard to health care

Federal health care administration is the responsibility of the Federal Ministry of Health and Women. Its duties, defined in Section E of the Amendment to the Federal Ministries Act, Fed. Law Gaz. I No. 17/2003, include:

Public health matters

These include in particular:

- general health policy
- protection against risks to general public health, including supra-regional health crisis management
- structural policy and planning, health system development

- performance-related reimbursement for health services, information and classification systems in health care, health reporting, quality in public health care, health informatics and telematics
- matters of health care, health education and health consultation
- matters connected with the Mother-Child Medical Card
- matters of preventive medical measures including preventive medical treatment for school-children
- matters of occupational medicine
- matters of sports medicine
- public hygiene and vaccination
- monitoring and combating contagious and infectious diseases
- matters of radiation hygiene, medical protection against radiation and medical radiology; medical evaluation of the use of ionising and non-ionising radiation and radio-pharmaceuticals
- matters of health resorts and natural medicinal springs, of hospitals, nursing homes and public social and welfare establishments
- medical matters concerning the handicapped
- monitoring and combating abuse of alcohol and narcotics, including federal drug co-ordination
- matters concerning pharmacies and pharmaceuticals, price controls in this field; matters concerning the Austrian Pharmaceutical Appeals Committee
- matters of health protection with respect to prostheses and utensils
- matters of dealing with narcotics
- matters concerning post-mortem formalities and funerals
- training and further education of staff in the public health administration sector

Matters of veterinary care

These include in particular:

- matters relating to the placing on the market of veterinary materials, disinfectants and animal vaccines; price regulations in this area
- matters of feed hygiene and inspection
- matters of livestock and meat inspection
- matters of animal cadaver disposal
- training and further education of personnel for public veterinary administration
- matters of veterinarians and other veterinary personnel, including matters of their professional representation
- general matters of animal protection, notwithstanding the lead competency of the Federal Chancellery and the shared competency of other federal ministries

Matters of health care and veterinary care professionals

These include in particular:

- matters relating to doctors, pharmacists, dentists, midwives, clinical psychologists, health psychologists, psychotherapists and other health care and veterinary care personnel, including their professional representation
- training and further education of medical doctors, veterinarians and pharmacists after their graduation, and of other health personnel

Matters of food inspection

These include in particular:

- matters relating to the placing on the market of foods, products for consumption, additives, cosmetic products and various consumer goods
- food hygiene
- training and further education of public food inspection personnel

General matters of gene technology

Matters of health insurance and accident insurance

These include in particular legislation and related oversight activities.

The National Health Council, consisting of 30 members, functions as a counselling and advisory body. Its recommendations are in the form of suggestions only and are not binding on health care policy decisions.

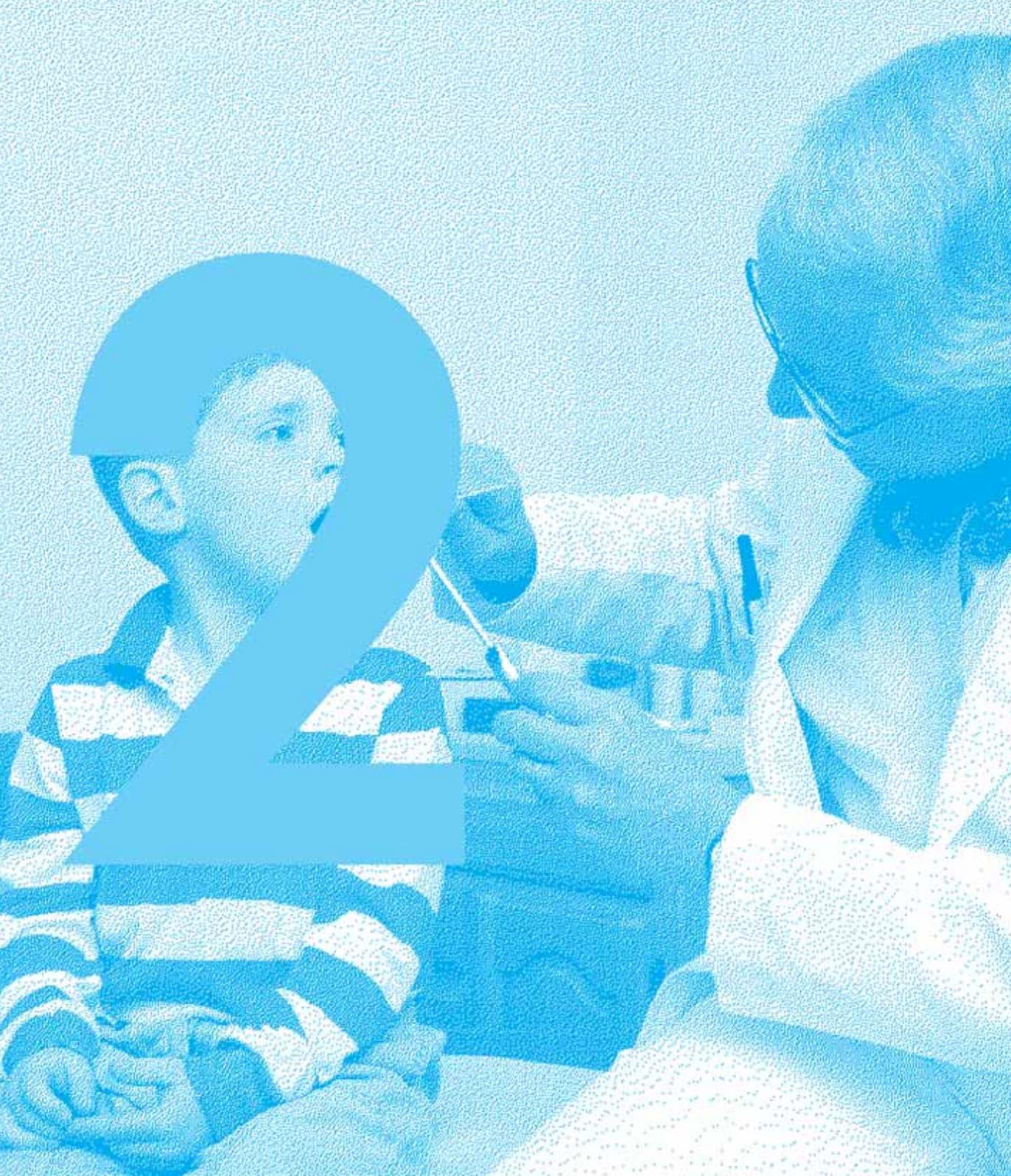
The Federal Ministry of Health and Women oversees several other special councils and commissions. Since June 2002 the ministry has also been the federal shareholder representative in the Agency of Health and Nutritional Safety (AGES), a fusion of 18 federal institutions and federal offices from the fields of food inspection, bacteriology and serology, veterinary medicine and agriculture. This means that Austria—in a way that is unique Europe-wide—has bundled the federal competencies from various special areas along the food production chain in one enterprise. The Federal Ministry's main organisation in the area of research and planning is the Austrian Health Institute (ÖBIG), a fund which is under the aegis of the Federal Ministry but exists as its own legal entity.

Decentralised health care administration bodies

The Federal Ministry of Health and Women does not have any federal sub-authorities in the public health sector. Therefore the provinces and the municipalities are principally responsible for health administration. Accordingly, there is a separate department of health in each provincial government, headed by a medical doctor with civil servant status and the Provincial Health Director ("Landessanitätsdirektor"). A Provincial Health Councillor is available to each provincial government office for purposes of consultation.

In addition, each district administrative authority has a health department (health office) which is headed by a medical health officer. Some matters such as those of the local health inspection officers are included in the municipalities' sphere of responsibility. In some cases there are also municipal associations (health districts) where municipal or district doctors (medical officers of health) serve as expert bodies. The supervisory authorities here are those of the general state administration (district administrative authorities, provincial governments).





2 The Population's Health

According to the 2003 consumer survey conducted by the Austrian Market Research Institute IMAS, four fifths of Austrians consider themselves to be in good health, with 34 percent even claiming to be in very good health. This self-perception changes, however, around age 60. At this age, only one fifth have no complaints. Altogether, 40 percent of those surveyed named headaches, nervousness and stress symptoms as their main health problems, one third reported insomnia, and every fifth respondent mentioned high blood pressure.

Morbidity

To evaluate morbidity rates in the Austrian population there are a number of statistics from hospitals and clinics, social insurers, preventive medicine programmes and legally mandated medical examinations for certain age groups. However, there is a lack of documentation from doctors' surgeries which would provide a comprehensive description of the morbidity rate situation in outpatient treatment.

Hospital morbidity

There is a very high and increasing number of hospitalisations in Austria. In 1991, there was a total of 23.9 hospital-ward patients per 100 inhabitants, increasing to 25.1 in 1995 and 31.3 in 2003. By comparison, in Great Britain there were 24.7 hospitalisations per 100 inhabitants in 2002, 15.4 in Switzerland and 9.8 in the United States.

By contrast, the length of patients' hospital stays is decreasing steadily. In 1995, the total was as high as 10.3 days, decreasing to six days in 2003. Germans spend an average of 11.6 days in hospital, the Swedes five (Source: Statistics Austria, OECD Health Data).

Austrian hospital institutions are required to provide data annually on their patients, including information on diagnosis statistics of discharge according to the ICD-10 (International Statistical Classification of Diseases and Related Health Problems, Tenth Revision),



from which information on department-specific distribution of disease, regionally-related penetration areas, diagnosis-specific and sex-specific age distribution and many other things can be derived. These statistics are a valuable source on which to base assessment of inpatient morbidity and for planning hospital locations and capacities.

A total of 2,498,929 patients were admitted to hospital wards in 2003. According to the frequency of illness, the largest portion was comprised of the 325,468 patients treated in hospital for cardiovascular illness (13.0 percent). 10.9 percent of all hospital patients were treated in wards for cancer, and 10.7 percent for illnesses of the musculoskeletal system and connective tissue. Injuries and poisonings constituted 10.5 percent of all inpatient cases (Source: Statistics Austria)

Marked changes can be perceived from hospital statistics compiled since 1990. Hospitalisations increased by 106.6 percent within 30 years, by 34.2 percent within the last ten years and, in comparison with the previous year, by 0.7 percent. Above all, cancer treatment has increased disproportionately—the number of hospitalisations involving malignant new growths in the pulmonary organs has increased by about 100.1 percent since 1993. (Source: Statistics Austria).

Table: Principal diagnoses of hospitalisation according to frequency (2003)

Principal diagnoses	Number of inpatients
Neoplasia (no. thereof which were malignant)	331,073 (273,317)
Circulatory-system illnesses	325,468
Diseases of the skeleton, muscles and connective tissue	267,524
Injuries and poisoning	261,933
Diseases of the nervous system and sensory organs	227,798
Diseases of the digestive organs	223,756
Diseases of the respiratory organs	155,461
Diseases of the urogenital organs	151,861
Psychiatric illnesses	120,043
Childbirth and pregnancy complications	119,265

Source: Statistics Austria

Since the Austrian DRG System was introduced in 1997, data on the individual medical procedures performed in hospitals has also been compiled. Procedures as of a specific cost-limit are documented (EUR 730 for surgical procedures, EUR 220 for non-surgical procedures), as are frequently performed, less expensive types of therapy such as appendix operations. It can be seen from these listings that a total of 2,905,714 such medical services were performed in the year 2003, 37.3 percent of which were surgical,

62.70 percent non-surgical. About 37 percent of the latter was made up of expensive diagnostic and therapeutic procedures, of which the largest portion, i.e. 64.8 percent, consisted of physiotherapy (Source: Statistics Austria).

New cases of cancer

Since 1970, new cases of malignant tumours have been recorded in Austria by way of statutory regulations and according to a standardised questionnaire. Since 1983, the National Cancer Registry has also included cases in which cancer was not reported in the Registry, but listed as the cause of death in the death certificate.

Statistics available for the most recent year under review (2002) indicate that 34,984 people had cancer, 1.3 percent fewer than the year before. After age standardisation, however, the rate of incidence of cancer in men increased by 2.6 and 3.5 percent over the previous year and 1992 respectively. Comparison figures for women showed minus 3.6 percent in both cases. For men, the risk of contracting cancer is almost half again as great as it is for women.

Most frequent types of cancer

For men, prostate cancer is the most frequent form of the illness, with 89.1 new cases per 100,000 inhabitants. In 2002, over twice as many cases were diagnosed as 10 years before. Prostate cancer is followed by lung cancer (44.5 cases) and cancer of the large intestine (43.9 cases).

For women, breast cancer is by far the most frequent type: in 2002, 72 women per 100,000 inhabitants became ill with the disease. Cancer of the large intestine and the lungs ranked second and third respectively, with 25.8 and 15.7 cases per 100,000 inhabitants. The age-standardised frequency rate of lung cancer is increasing markedly for women, having grown by 18.9 percent in the last 10 years, and by 5 percent in the last 5 years. However, the risk for men remains 2.8 times greater than for women.

Stomach cancer is declining among both males and females, a fact attributable to changing eating habits. The similar decline in the incidence of uterine cancer testifies to the effectiveness of the special educational programmes that have been running since the mid-1970s (Source in all cases: Statistics Austria).

Viewed across the EU, intestinal cancer has displaced lung cancer from the number-one position: 14 percent of new cancer cases in the European Union have to do with the intestines, while 13 percent each go to breast and lung cancer. Altogether, the incidence of cancer in the EU has increased by nearly 29 percent since 1990. Mortality, however, has hardly changed: in 2004, there were 255 cancer deaths per 100,000 inhabitants, compared with 243 in 1990 (Source: Eurostat).

Diabetes

Type 2 (or adult-onset) diabetes mellitus has become rampant in the industrialized world, often with fatal consequences: the disorder results in cardiovascular, eye and nerve diseases. The largest risk factor is the combination of obesity and insufficient physical activity. According to the 2004 Diabetes Report, written by social doctors and diabetes experts for the Federal Ministry of Health and Women, the incidence of diabetes mellitus in Austria is estimated to be at two percent, around the European average; no distinction was made, however, between type 1 (so-called juvenile diabetes) and type 2.

As far as type 2 is concerned, however, there are both regional and gender-related differences. Both diabetes figures and risk factors are higher in eastern Austria and in large cities, and men in these places have an approximately 25 percent higher risk than women of developing the disorder; in rural areas the reverse is true. Incidence figures display an upward tendency—also with regard to children—and the WHO projects an increase of 37 percent by the year 2025. In Austrian hospitals, for example, around 43,000 women and men were treated for diabetes mellitus in 2001, while 2,028 deaths due this diagnosis were registered in 2002—accounting for 2.7 percent of all deaths.

Communicable diseases

As in many other countries, reporting of the most important infectious diseases is required by law in Austria. The country participates in all EU networks relevant to the monitoring and control of contagious diseases. The Federal Ministry of Health and Women has been actively and fully cooperating in the European Union's early-warning and response system for five years. Within this system, not only is information exchanged upon the outbreak or increased frequency of rare diseases which could affect the health of EU citizens, but counteractive measures are also coordinated.

Tuberculosis

While the Austrian population has exhibited a continual drop in tuberculosis cases—from 10.9 per 100,000 inhabitants in 2001 to 7.2 in 2004—the foreign population, due to migration from Eastern European regions, has exhibited a constant increase from 36.7 (2001) to 63.24 (2004). Thus, foreigners' share of new cases has showed an increase—from 26 percent in 2001 to 48 percent in 2004. This trend has been similarly observable in numerous other EU countries for the past several years. The number of cases of multi-resistant TBC has likewise increased strongly over the past few years, but due to the small absolute number of cases (16 in 2004) does not represent a serious public

health threat. Despite these trends, the general TBC situation continues to hold steady or drop slightly, with rates of around 12.5 cases per 100,000 inhabitants in 2004 (compared with 13.3 in 2001).

Hepatitis B and C

Hepatitis B (serum hepatitis) is passed via blood containing the hepatitis B virus and other bodily fluids, and is contracted through sexual intercourse in particular. Newborns whose mothers became ill with hepatitis B during pregnancy or who are already carrying the disease at the time of pregnancy are at special risk. In 2000, the number of cases of the illness amounted to 264, increasing to 520 in 2003 and 576 in 2004. The vaccination concept of the Federal and provincial governments together with the Main Association of Austrian Social Insurance Institutions currently aims to provide vaccinations for all youth under age 13. The good participation in this programme has not yet begun to affect the statistics, since most victims are adults.

The number of reported cases of hepatitis C has increased markedly. In 2000, 412 cases were registered; by 2004, this figure had increased to 961. This statistical increase is due, however, to intensified surveillance.

An estimated 2.4 to 5 million people in the EU are HCV-positive. Epidemic density is greater in the Mediterranean countries than in the other EU states. According to estimates, 0.2-0.5 percent of the Austrian population (16,000-40,000 people) are infected. Transfusions of virus-containing blood reserves and the provision of contaminated blood by-products were the most frequent ways in which the disease was passed on until the introduction of serological testing. Now, intravenous drug consumption using exchangeable needles and the use of un-sterile materials constitute the greatest risk factor. Sexual transmission and perinatal infection of children by their mothers are rare occurrences.

Bacterial food poisoning

The number of cases of bacterial food poisoning is increasing slightly. 10,285 cases of illness and one of death were registered in 2000, whereas 12,504 cases of illness and six fatalities were recorded in 2004.

There is an EU-level project to monitor enteritis pathogens—salmonella in particular—as well as illnesses ("EnterNet"), which implements the fine-tuned typification as well as the identification of resistances. Austria is integrated in this project, which also contains an early-warning system. The EU-wide evaluation of epidemiological data on sal-

monella isolates made possible thereby in the past years has enabled foodstuffs contaminated with salmonella to be recalled in sufficient time. Meanwhile, a number of third-party countries have been incorporated into the system.

AIDS

Since mandatory reporting to the health authorities was introduced in 1983, 2,413 people became ill with AIDS in Austria up to April 2005, of whom 1,391 have already perished. This means that there are currently 1,022 people with AIDS living in Austria. The number of new cases reached its high point in 1993; the decrease in cases of illness and death reported since then is due to new forms of therapy which delay the outbreak of AIDS and increase the life-span of those ill with the disease. Even so, more and more carriers of HIV are dying without ever developing full-blown AIDS.

78.9 percent of the cases of AIDS reported since 1983 involve men, 21.1 percent women, and the share of women is rising: in 2004, women represented 36.9 percent. Cumulative figures since 1983 of those with known routes of infection show homosexuals and bisexuals constituting the group most severely affected (41 percent), followed by drug addicts (30 percent) and heterosexuals (21 percent). The year 2004, however, shows a definite trend in terms of new infections: 52 percent of newly infected are heterosexual, with the shares of the homosexual/bisexual and drug addict groups at 23 percent each.

Although surveys have shown that most Austrians are aware of how the disease is transmitted, each day at least one person in Austria becomes infected with HIV; in 2004 there were 470 new infections, 48 more than during the preceding year. The total number of persons infected with HIV in Austria is estimated to be in the range of 6,000-8,000. The number of patients in need of care is increasing by around 400 annually.

Compared to rates of new infections in Western Europe for the year 2003, Austria is distinctly below the overall European average (75.5) at 52.1 cases per million inhabitants. New infection rates for HIV are still especially high in Portugal (228.4), while the lowest rate was achieved by Germany (22.8) (Source: European Centre for the Epidemiological Monitoring of AIDS, 2003 annual report).

The new member-states of the EU, particularly the Baltic states, exhibited the highest growth in rates of new infection in 2003. Similar trends can be observed in several other states of the European WHO region. However, these extremely high numbers are probably attributable to the widespread introduction of HIV testing in high-risk groups.

Health of school-children

As regards the health of 11 to 15-year-olds, today's school-children feel significantly less healthy than those of the early 1990's—even though the assessment of their health is still positive by international comparison: According to the WHO studies of "Health Behaviour in School-Aged Children (HBSC)" conducted in Austria by the Ludwig Boltzmann Institute for Sociology of Health and Medicine, only 2 percent of the children surveyed gave concerning answers to the question of how healthy they felt, whereby it should be noted that children's estimates of their health grow worse the older they become: while 36 percent of the 11-year-old girls surveyed rated themselves very healthy, only 22 percent of the 15-year-old girls said the same thing; 52 percent of the 11-year-old boys felt very healthy, but only 41 percent of the 15-year-olds gave the same answer. Around a quarter to a third of school-children suffer periodically from headaches, irritability, nervousness, sleep disturbances and fatigue.

Only 38 percent of school-children regularly receive the three proper meals a day commensurate with the recommendations of nutritional science. And the composition of the meals eaten is probably not ideal. Vegetables are consumed only by a minority (16 percent) on a daily basis; on the other hand, significantly more children and youth consume sweets or drink sugary soft drinks every day. Here, as well, the 15-year-olds do worst. Since 1998, the number of school-children who eat fruit on a daily basis has plummeted, with only a quarter to half of them reaching into the fruit bowl at least once a day.

Dental health

Dental caries is still the most widespread disease of civilization, although medically effective and inexpensive preventive measures are available. For this reason, the WHO has formulated goals for the dental health of the populace. The conduct of oral health surveys is recommended in order to monitor progress toward these goals. The Dental Status Coordination Bureau was set up in 1996/97 by the Health Ministry within the Austrian Health Institute to oversee the Austria-wide conduct of oral health surveys. The data of the Coordination Bureau show that minors in Austria already fulfil all WHO recommendations with regard to their oral health.

Dental health status of children and youth

Nearly half of all six-year-olds were free of dental caries in 2001. Around 30 percent had a completely healthy set of baby teeth without any signs of decay. On average chil-

dren had two baby teeth with caries, or which had already been filled or pulled due to caries. In spite of the improvement of dental health in this age group, a relatively small group of children exhibits very poor dental condition.

The rate of dental caries among twelve-year-olds decreased significantly during the period between 1997 and 2002, hence more than fulfilling the WHO goals. Over half of twelve-year-olds are caries-free, with around one quarter exhibiting entirely healthy teeth without any signs of decay. The high repair rate of 89 percent speaks to the satisfactory level of dental care. The polarisation in the distribution of caries (with 22 percent of examined children suffering from 81 percent of the observed decay) corresponds with international observations according to which, as the prevalence of dental caries drops, the remaining damage is concentrated among fewer and fewer high-risk children. Compared internationally, Austria has now attained the same low level of caries incidence as Sweden.

Compared with the previous survey of 18-year-olds, the 2003 dental caries rate had dropped by 21 percent. A third of all caries occurrence, however, is concentrated among a quarter of those examined; the majority of these are young people from socially disadvantaged groups.

Dental health status of adults

Dental health surveys are seldom conducted in adult age groups, since it is very difficult to pull representative samples. The last such survey was conducted in 2000.

On average, the 35 to 44-year-olds exhibited 15 tooth crowns which had been affected by dental caries, of which most, however, had already been repaired. 40 percent have a complete set of teeth.

The 65 to 74-year-olds have an average of just of 23 teeth damaged by caries; 23 percent of those examined no longer had any of their own teeth and for the most part made use of removable dentures. These statistics mean that the WHO goals for 2020 have been reached for the 35 to-44-year-olds, but not for the older age group (Source: Austrian Health Institute, 2000).

Work absenteeism due to illness

Absences from work due to illness are recorded statistically for all people insured by social security institutions. These statistics allow morbidity-related evaluations for the working population from the age of 15 onwards.

The number of cases of illness-related absence from work per employed person rose from the mid-1970s to the early 1990s, but has been decreasing steadily since 1995. The average length of periods of sick leave has also fallen over the long term, rising only slightly in 2004 (12.1 days) compared to the preceding year (12.0 days).

Table: Development of work absenteeism due to illness, 1965-2004

Year	Days of absence per employee	Cases of absence per 100 employees	Average duration of absence due to illness
1965	15.6	84	18.6 days
1975	14.5	86	16.8 days
1985	15.4	104	14.8 days
1990	16.2	113	13.4 days
2000	14.1	111	12.6 days
2004	12.1	100	12.1 days

Source: Main Association of Austrian Social Security Institutions

The proportion of short-term absences (up to three days) has risen from 21.4 percent (2000) to 26.1 percent. Periods of absence exceeding four weeks' duration have remained stable at around seven percent. (Source: Main Association of Austrian Social Security Institutions).

Approximately three million Austrian employees were absent owing to illness for a total of around 35 million days in 2004, compared to 37.2 million days in the year 2000.

The breakdown of the reasons for such absenteeism has hardly changed in the past years: the majority are infections and illnesses of the respiratory organs. In 2004 they were responsible for 37.8 percent of all absenteeism due to illness. With 15 percent of the entire number of absences, disorders of the locomotive system and supporting apparatus come in second place, followed by workplace injuries (9.3 percent) and intestinal infections (8.8 percent). Absenteeism due to psychological illness has continued to increase over the past four years: from 1.5 to 1.7 percent. (Source: Main Association of Austrian Social Security Institutions).

Occupational diseases

The Austrian social security laws recognise 52 occupational diseases which can be identified as health impairments from long-term influences of occupational activities. On the one hand, the list contains substances which lead to health damage, and on the other hand it gives a number of illnesses which can arise as a result of occupational exposure. In the past two decades more and more health impairments in the workplace have been recognised as occupational diseases.

Doctors, employees and employers are obliged to report an occupational disease. Each case must be examined by the accident insurance institutions. The recognition of an occupational disease leads to support payments which are secured by law and, where necessary, to special medical treatments.

The most frequently occurring forms of impairment among the 1,434 cases reported during 2004 included hardness of hearing due to the effects of noise (36.1 percent), dermatological diseases (22.0 percent) and infections, which have greatly increased in recent years (8.2 percent) (Source: Austrian Workers' Compensation Board). The number of reported, recognised occupational diseases increased somewhat compared with 2003.

Table: Recognised occupational diseases reported (1975-2004)

Year	Recognised occupational diseases
1975	2,603
1985	2,325
1995	1,585
2000	1,517
2003	1,178
2004	1,218

Source: Austrian Workers' Compensation Board

Workplace accidents

A continuing decrease in the number of workplace accidents has been recorded in the last few years. In 2004, 122,837 accidents (1995: 181,642) were suffered by employed persons in the workplace and between work and home, of which 227 (1995: 440) were fatal (Source: Main Association of Austrian Social Security Institutions).

Pensions on grounds of reduced ability to work

The Austrian social security laws grant the possibility of retirement in the case of partial or total inability, caused by illness, to pursue an occupational activity. Affected people can apply for disablement, occupational inability and general disability pensions, or for an early retirement pension as a result of reduced ability to work.

In late 2004, the pension insurance institutions paid out disablement/occupational inability/general disability pensions to 406,405 persons. Of these, around 160,000 pensions were paid to people who had not yet reached the normal retirement age limit (women up to 60, men up to 65). By comparison, that figure was 186,000 in 1994. 64,567 applications were made for disablement/occupational inability/general disability pensions in 2004; 33,694 were granted.

The most frequent reason for the award of such pensions is to be found in the group of diseases affecting the skeleton, the muscles and the connective tissue (2003: 37 percent). Psychiatric disorders take second place (22 percent), having increased by four percent since 2000, followed by cardiovascular diseases at 13 percent (Source: Main Association of Austrian Social Security Institutions).

Causes of death

In the year 2003, the number of deaths rose from the historic low (74,767) reached in 2001 to total 77,209, but before that the figure had fallen continually since 1996. Even so, the upward trend in the life-expectancy of men observable for around three decades now—following the altogether very small life-expectancy gains during the nineteen-sixties—has persisted.

Current total mortality in Austria is approximately the average rate of the EU countries (Source: Statistics Austria, Eurostat).

Table: Number of cases of death according to cause (1986-2004)

Year	Cardiovascular disease	Cancer	Injuries and poisonings	Respiratory diseases	Accidents	Total
1986	46,747	18,698	6,187	4,363	3,892	87,071
1990	42,629	19,330	5,576	4,189	3,584	82,952
1995	43,447	19,154	4,896	3,422	2,969	81,171
2004	34,914	19,231	4,261	5,111	2,577	77,209

Source: Statistics Austria

Cardiovascular disease

Cardiovascular disease remains the primary cause of death, although mortality due to this cause has been decreasing since the mid-1980s—more so among men than among women. Over the last ten years, the absolute number of cardiovascular disease-related deaths has declined by 34.1 percent when adjusted for age-structure. Above all, deaths due to cardiac arrest decreased markedly (after steadily increasing until 1984); since 1993, they have declined by 36.9 percent. These illness-group percentages correspond to the overall European average (Source: Statistics Austria).

Cancer

Mortality due to cancer has sunk by 14.2 percent during the past ten years, with the clearest drop having been in new malignancies of the stomach (minus 42.1 percent since 1993, corrected for age structure) and the throat (minus 38.9 percent). Mortality has risen from new malignancies of the ovaries (plus 27.8 percent), from melanoma (plus 21.1 percent) and from liver cancer (plus 17.4 percent)

For men, the risk of dying of cancer was 40 percent higher than that of women in 2003. Male cancer deaths were primarily due to lung, colon, prostate and stomach cancer.

Nearly half of female cancer deaths were due to breast cancer. For men, the risk of death from lung cancer has dropped, corrected for age structure, by 24.1 percent since 1993, while women's risk of the same has risen by 15 percent. The increase in female mortality due to lung cancer suggests a correlation with increased cigarette consumption. Even so, the risk of dying from lung cancer is 3.2 times higher for men than for women.

The most common cause of death from cancer in the EU is lung cancer (20 percent), followed by cancer of the intestines (12 percent) and stomach and breast cancer (each eight percent) (Source: Statistics Austria, Eurostat).

Respiratory and digestive disorders

Age-standardised mortality due to respiratory disease has risen by 9.8 percent since 1993, a phenomenon attributed for quite some time now to the increase observed in cases of chronic occlusion of the respiratory passages. Digestive-disorder mortality has decreased by 23.4 percent since 1993 (Source: Statistics Austria).

Accidents

Although the number of fatal accidents has decreased by 30.3 percent over the past 10 years, the risk of death by accident in comparison with the overall population is still considerably higher among the male population between the ages of 15 and 30. Here, as well, there is hardly any difference from the corresponding European figures (Source: Statistics Austria).

Suicides

The number of suicides is likewise decreasing, having dropped by 20.3 percent since 1993. While in 1986 2,139 people took their own lives, this figure dropped to 1,456 people in 2003. Even so, Austria continues to lead the European statistics, although the suicide count is significantly higher in Estonia, Latvia and Hungary. More than three quarters of the suicides were committed by men. The highest-risk group is that of people between the ages of 30 and 34 (Source: Statistics Austria).

Cirrhosis of the liver

In terms of mortality due to cirrhosis of the liver, Austrian men are near the top of the EU ranking; only in the new member states does cirrhosis of the liver occur more often. Women are affected significantly less often by this liver disease. (Source: Statistics Austria).

Traffic accidents

Traffic accident statistics show a fall in fatalities from 1990 to 1999, but the number of personal traffic accidents increased once again to reach a high of 57,812 injured parties in 2003. By contrast, fatalities once again have decreased slightly compared with last year (minus 2.6 percent). The number of seriously injured decreased by 0.7 percent. Youths between the ages of 15 and 24 are at particular risk; almost every fourth fatality occurs within this age group (Source: Statistics Austria).

Infant mortality

Infant mortality, i.e. the death of children within the first year of life, has been reduced dramatically by the introduction of a standardised preventive programme for pregnant women and infants within the "Mother-Child Medical Card" scheme (1974) (see Chapters 4 and 6). At the beginning of the seventies, with a rate of 26.1, Austria was still within the average European range, or above it in comparison with northern European coun-

tries (12.6). Now, the rate is 4.5 per thousand, putting Austria roughly even with Denmark (4.4), Italy and Switzerland (both 4.3), and below the OECD average of 6.1. In the USA, the infant mortality rate was 6.8 per thousand (Sources: Statistics Austria and OECD Health data).

Table: Development of infant mortality, 1951–2003 (Data in absolute figures relating to 1,000 births)

Year	Died in the first week of life	Died after the first week of life	Total
1951	26.7	34.7	61.4
1961	18.9	13.8	32.7
1971	16.4	9.7	26.1
1981	6.5	6.1	12.6
1991	3.1	4.3	7.4
2003	2.4	2.1	4.5

Source: Statistics Austria





3 Health-Relevant Behaviour and Risk Factors

Health-consciousness

Various studies and surveys provide insight as to health-consciousness and individual risk-behaviours among Austrians. In a survey conducted by the IMAS Institute during the first quarter of 2005, 68 percent named “paying attention to health, healthful living” as an important principle of child-raising. A survey conducted by the Institute for Strategic Market and Opinion Research (ISMA) during 2004 for the Healthy Austria Fund indicated that over half of Austrians give thought to their health and lifestyle—and also desire to make changes.



Table: What do Austrians want to do for their health?

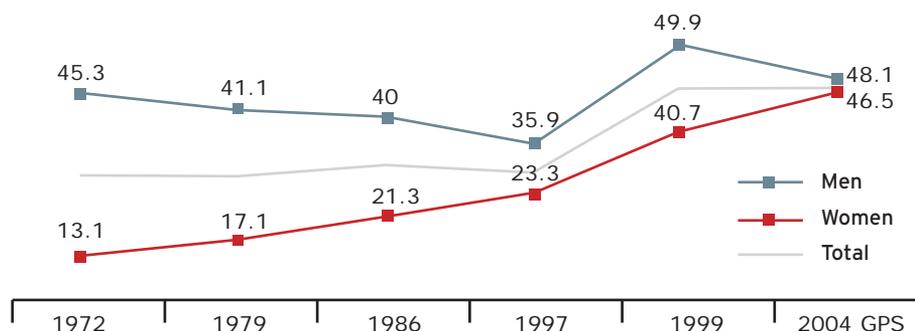
Exercise more	Eat healthier	Less stress	Regular medical checkups	Lose weight	Smoke less	Drink less alcohol
62 %	57 %	34 %	30 %	28 %	16 %	18 %

Source: Healthy Austria Fund/ISMA, 2004

Smoking

While the number of Austrian smokers remained stable between 1972 and 1997, a significant rise has taken place since 1999—despite the recent strengthening of the anti-smoking movement. In the general population survey on psychoactive substances conducted during 2004 for the Federal Ministry of Health and Women, 47 percent of Austrians indicated that they smoke. By now, women have basically caught up to men: while only 13 percent of women—but 45 percent of men—smoked in 1972, it was already 48.1 percent of men and 46.5 percent of women in 2004. The share of daily smokers is 38.3 percent. Otherwise, nine percent indicated that they smoked occasionally, 13.2 percent were ex-smokers, and 39.5 percent were non-smokers.

Table: Development of smoking behaviour (daily + regularly, not daily + occasionally) in Austria



Source: Statistics Austria (2002), Uhl et al. (2005)

As shown by a 2003 Eurobarometer survey, the increase in smoking is an EU-wide trend. In this context, Austria is close to the European average, but is in first place among 15 and 16-year-olds, according to various international school surveys. Anti-smoking campaigns and price increases have so far failed to have the desired effect, and it is becoming more and more normal for children and youth to smoke (Source: Uhl et al. 2005).

According to a survey conducted by the ISMA Institute for the Healthy Austria Fund, 16 percent of smokers would like to reduce their consumption of cigarettes. The fear of negative health consequences is justifiably widespread; 12,000 to 14,000 deaths every

year are attributed to smoking. According to an estimate of the WHO, 80 to 90 percent of all lung ailments are caused by tobacco use, and nicotine and/or the carcinogenic components of tobacco smoke are at least contributing factors in a number of other illnesses (e.g. of the cardiovascular system). In Austria, around 3,000 people die of lung cancer annually, for which cases between 90 and 96 percent are attributed to smoking.

Most shocking of all is the fact that more and more young people are taking up smoking cigarettes. Two thirds of the population begin smoking in their youth, with girls smoking more than boys since the 1990s. The results of the WHO study Health Behaviour in School-Aged Children (HBSC) shows that four percent of eleven-year-olds, 15 percent of 13-year-olds and 45 percent of 15-year-olds smoke at least occasionally, which corresponds with the results of the European School Survey Project on Alcohol and Other Drugs (ESPAD) from 2003, according to which 36 percent of 14-year-olds, 43 percent of 14-year-olds, 55 percent of 16-year-olds and 64 percent of 17-year-olds smoke. The number of youth who already smoke daily at age 15 is very high in comparison with the rest of Europe, at 20 percent of boys and 25 percent of girls. According to the 2003 ESPAD study, Austria takes first place in Europe in terms of smoking among 15 and 16-year-olds. Various steps are being taken to contain smoking habits (see Ch. 4).

Body weight

The results of the 2003 Austrian Nourishment Report confirm that fat is a critical component of nutrition among nearly all groups within the population, both with respect to quantity and quality. Thus the average fat consumption lies between 35 and 40 percent of total caloric intake, which far exceeds the recommendations of nutritional associations. Viewed internationally, the 2004 European Nutrition and Health Report showed Austria to be above the EU average in its use of red meat, particularly pork, as well as in the consumption of sugar.

Consumption of plant-based foods, on the other hand, is often neglected. Austrians do eat more fruit than the average EU national population, but far too little in the way of nutrient-dense foods—particularly vegetables, bread and grain products, legumes, low-fat milk and milk products, and fish—is consumed. Disadvantageous food selection can be observed among nearly all groups within the population, from pre-schoolers and school-children to apprentices, adults and senior citizens.

At the same time, Austrians do not engage in sufficient physical activity. In the study “Sport and Health. The Effects of Sport on Health—a Socioeconomic Analysis by the Institute of Sport Science at the University of Vienna” it was determined that 60 percent are inactive to minimally active (once or twice a month), 22 percent are moder-

ately active (once to twice a week), and 18 percent are active to highly active (three times a week or more often).

Years of deficient nutrition and simultaneously insufficient activity lead to excess weight and obesity, and are the main causes of cardiovascular diseases and diabetes mellitus. Around 37 percent of Austrians are overweight, and 9.1 percent can be said to be obese (Source: 2003 Austrian Nourishment Report).

Everyday stress

Stresses such as too much time pressure, heavy physical labour and multiple responsibilities such as a career combined with everyday obligations (household, child-raising, caring for family members) play a significant role in the condition of one's health—after all, numerous psychosomatic disorders are attributable to these stresses and others. According to an international comparative study by the WHO on subjective opinions of emotional health, twelve percent of Austrians suffer strongly or extremely from worry, depression or cares. Five percent perceive themselves to be afflicted with severe or very severe concentration and memory disorders. Around 27 percent are under stress at work, according to a study conducted by the Austrian Trade Union Federation.

Alcohol

After the average consumption of the adult population had doubled between the immediate post-war period and the mid-1970s (from ca. 7.2 litres of pure alcohol in 1995 to ca. 15.5 litres in 1974), consumption proceeded to fall steadily by 18 percent to 12.7 litres in 2003, which is equivalent to drinking over three-eighths of a litre of wine per day (30 g of pure alcohol). Over the past ten years, the number of those who misuse alcohol has decreased from ca. 18 to around 16 percent (Source: Alcohol Handbook—Austria, 2005).

A deviation from this trend is the significant increase of problematic to extreme alcohol consumption among young women (up to age 39), who today drink far more on average than women of the same age ten years ago. This confirms the so-called “emancipation effect”, according to which particularly young women are increasingly matching their substance consumption habits with those of men of the same age. Altogether, though, men still drink more than women. And daily alcohol consumption continues to grow more frequent with increasing age—alcohol represents a serious problem in Austria (sources: Alcohol Handbook—Austria 2005; representative survey for the BMGF, Uhl et al. 2005).

Only eight percent of Austrians abstain completely from consumption of alcohol, i.e. they have drunk no alcohol during the past year; only three percent have never at all consumed alcohol. Far more common than complete abstinence from alcohol is near-abstinence (in the sense of drinking a maximum of four times per year): 23 percent were near-abstinent at the time the survey was conducted. Of those who consumed alcohol, 36 percent indicated light, 18 percent moderate, twelve percent problematic and four percent extreme consumption.

Compared with the representative survey of 1993/1994, it can be seen that the share of abstainers or near-abstainers has grown significantly (2004: 31 percent; 93/94: 23 percent), while all categories of alcohol consumption have dropped slightly: light consumption by one percent (2004: 36 percent; 93/94: 37 percent), moderate consumption by three percent (2004: 18 percent; 93/94: 21 percent), and problematic plus extreme consumption by two percent (2004: 16 percent; 93/94: 18 percent).

Table: Alcohol consumption by categories

	Representative survey, 2004	Representative survey, 93/94
Always abstinent	3 %	23 %
Always near-abstinent	12 %	
Abstinent and formerly near-abstinent	5 %	
Newly abstinent	3 %	
Newly near-abstinent	8 %	
Light consumption	36 %	37 %
Moderate consumption	18 %	21 %
Problematic consumption	12 %	18 %
Extreme consumption	4 %	

Light consumption: average daily consumption below the so-called "safe level" (for women this is 16 grams, for men it is 24 grams of pure alcohol—the equivalent of 0.2 and 0.3 litres of wine, respectively).

Moderate consumption: average daily consumption between the so-called "safe level" and the "endangerment level" (for women this is over 40 grams, for men it is over 60 grams of pure alcohol—the equivalent of 0.5 and 0.75 litres of wine, respectively)

Problematic consumption: average daily consumption in excess of the endangerment level.

Extreme consumption: average daily consumption of over twice the endangerment level.

Source: Representative survey, 2004, conducted for the BMGF, Uhl et al. 2005

As far as Austrian youth are concerned, only a few begin regular consumption of alcohol—namely at least once a month—before their 13th year. However, the number of regular alcohol consumers rises with increasing age far more quickly than it used to. According to the 2003 ESPAD study, 82 percent of 14 to 17-year-olds indicated that they had consumed alcohol within the last month. This means that of the 35 countries in which the study was conducted, Austria has the highest share of such “current alcohol consumers” in this age group (in France, for example, this group amounts to 58 percent). These results must be qualified, however, with the fact that in the 2004 nationwide survey, only 67 percent of the 14 to 19-year-olds indicated having consumed alcohol during the past month. In general, youth tend to exaggerate on surveys conducted in school, and to play things down in general surveys conducted by interviewers.

48 percent of 14 to 17-year-olds questioned in the ESPAD study indicated already having consumed alcohol at least 40 times; in this, Austria is exceeded only by Denmark (50 percent). 20 percent indicated having been drunk at least ten times over the past year; in France, on the other hand, it was two percent. One must keep in mind, however, that caution must be exercised when comparing such international data, because the age at which youth are permitted to drink alcohol differs between the various countries, because different formulations significantly influence responses, and because there are also significant cultural differences concerning willingness to talk about one’s own alcohol consumption, or to exaggerate or understate.

This high alcohol consumption results in serious health problems. Around five percent of the adult population is alcoholic; every seventh man and every 17th woman will fall victim to alcoholism at some point in life. This enthusiasm for drink is also reflected in death rates: Austria leads Europe in the number of deaths among both sexes due to cirrhosis of the liver. The average life expectancy of alcoholics is shortened by around 20 years. That means a reduction of two years in the average life expectancy for Austrians as a whole. Numerous preventive measures are being taken to ameliorate this situation (see Chapter 4).

Illegal drugs

According to the annual Drug Report compiled by the Austrian Health Institute for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the Health Ministry, the trend towards broadening of the substance spectrum in experimental and problematic consumption was confirmed in 2004. Particularly youth and young adults experiment with a multitude of various substances, and a (small) number of them graduate from experimental consumption to problematic consumption in connection with psychological and social problems. The extent to which this is the case is hard to estimate based on currently available data. It does however appear to be the case that,

at least in certain regions, problematic drug consumption among young people is also on the rise.

Cannabis, ecstasy, biogenic drugs, cocaine, opiates

As in the past, the drug most commonly consumed is cannabis. Initial results of the representative study of the entire population done for the Health Ministry in 2004 confirm this. According to this study, around one quarter of Austrians questioned have consumed an illegal drug during their lifetimes (lifetime prevalence). The most common drug is cannabis (ca. 20 percent), followed by ecstasy (ca. three percent) and cocaine and amphetamines (ca. two percent each). The consumption of opiates, on the other hand, is indicated by only around one percent. It is also confirmed that, in general, consumption experience is most common among younger respondents: around 20 percent of 15 to 24-year-olds report having already consumed illegal drugs. In all age groups, the numbers are significantly lower for questions referring to current consumption (30-day-prevalence). Around four percent indicate having consumed an illegal drug within this period. Current consumption applies almost exclusively to cannabis (four percent), while all other drugs mentioned drew positive responses of under one percent.

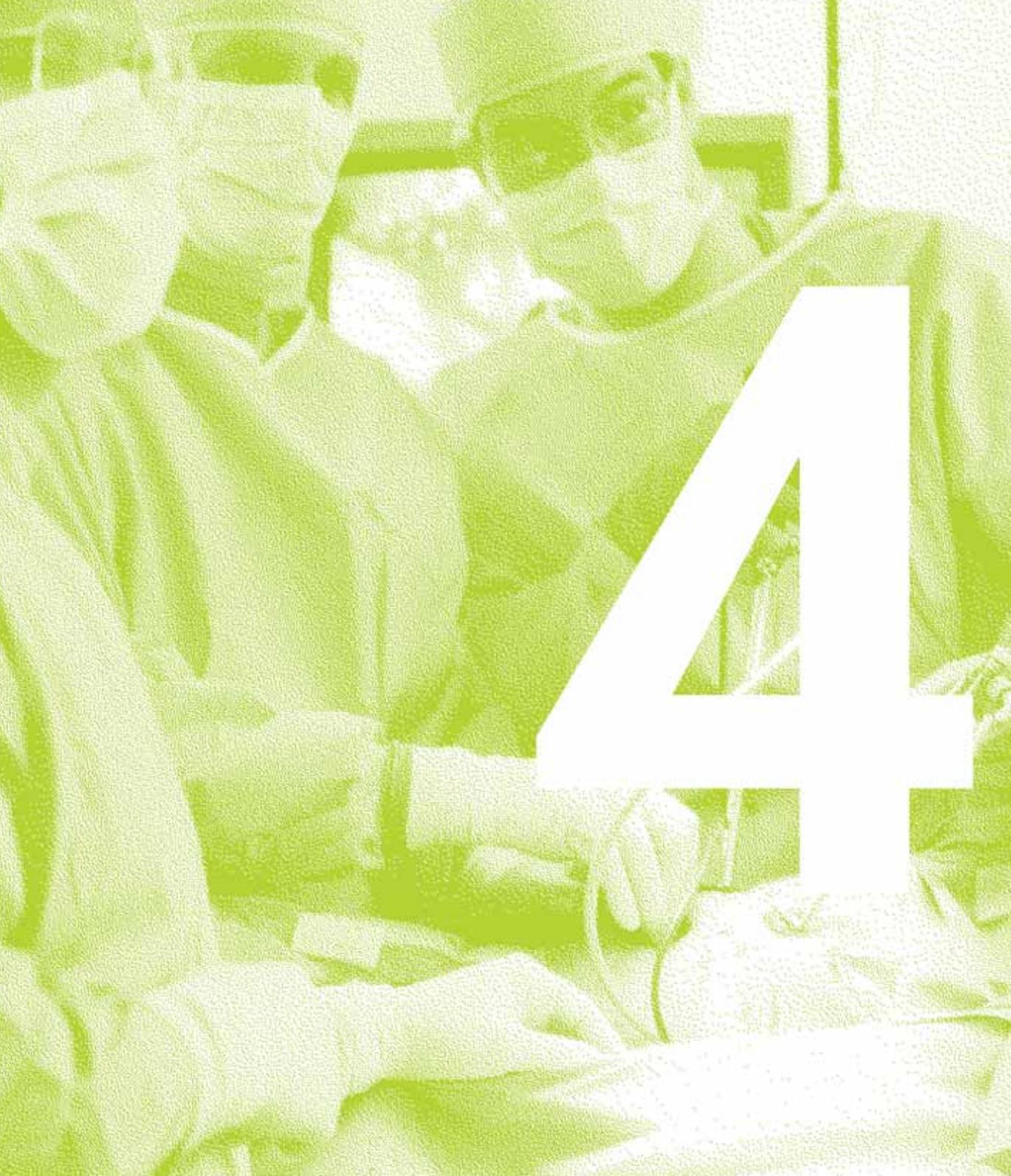
Between 20,000 and 30,000 individuals in Austria exhibit problematic opiate consumption or problematic drug consumption with the involvement of opiates, in which highly risky polytoxicomaniac and mostly intravenous use continues to dominate. Stimulating substances including cocaine are increasing in significance, while opiate consumption is shifting partly from heroine to morphine (Source: Report on the Drug Situation, ÖBIG 2004; European School Survey Project on Alcohol and other Drugs, ESPAD, 2003). A bit over half of these individuals are located in Vienna. Individuals with problematic cocaine consumption number between 10,000 and 15,000, according to expert opinions from 1999, with particularly the street scene exhibiting a growing number of individuals who consume both cocaine and opiates.

Indications of highly risky drug consumption are provided especially by deaths caused directly by narcotics. In 2003, 163 individuals in Austria died as a direct consequence of drug consumption—i.e., due to an overdose or following an overdose (2000: 167; 2001 and 2002: 139 each); the share of persons under age 20 stayed about the same at twelve percent, while a slight rise took place in the 20 to 24-year-old age group to 23 percent (2000: 20 percent, 2001: 14 percent; 2002: 14 percent). The share of women in this group of drug fatalities adhered to the longstanding average of 18 percent.

As in previous years, 2003 exhibited a strong predominance of mixed intoxications with involvement of opiates (71 percent). In addition to illegal drugs, 18 percent of cases also involved alcohol, 30 percent of cases involved psychoactive medications, and in twelve percent of cases there were indications of both alcohol and psychoactive medications

(Source: BMGF Narcotics-Related Deaths in 2003; Report on the Drug Situation, ÖBIG 2004). These numbers confirm the fact, revealed in numerous studies, that first and foremost mixed consumption, particularly the combination of narcotics with alcohol and/or psychoactive medications, is particularly risky and therefore the major problem in the area of drug abuse, since the simultaneous effects of various substances are no longer controllable.

In terms of drug-related infectious diseases, the data continue to indicate a low rate of HIV infection (between two and, at most, eight percent), while the incidence of hepatitis B (0 to 34 percent maximum) and hepatitis C (39 to 51 percent maximum) is far higher. In the area of low-threshold drug assistance, a significant drop in the willingness to follow safer-use rules has been observed, a trend which can be explained first and foremost by the restlessness resulting from cocaine consumption. On the other hand, experts maintain that tuberculosis is hardly a problem in terms of drug-related infectious diseases in Austria.





4 Health Care Services

Outpatient medical care

The outpatient medical care of the Austrian population is in the hands of 18,025 (status: December 31, 2004) registered general practitioners (i.e. doctors of general medicine) and specialists (including dentists) who are mainly in private practice. In addition to conducting their individual practice, medical doctors in private practice are permitted (in accordance with an amendment to the 2001 Medical Practitioners Act) the joint use of consulting rooms or medical equipment within a group practice licensed as an independent medical care provider.

The majority of doctors in private practice have a contract with one or more social insurers. The reason these contracts are so important for doctors is because approximately 98 percent of the population is covered by social health insurance (see Chapter 6).

The basis of the contractual relationships between doctors and public health insurance funds is formed by comprehensive agreements which are concluded between the Main Association of Austrian Social Security Institutions and the provincial-level Medical Chambers. Based on these comprehensive agreements, an individual contract is concluded between the individual doctor and the respective insurance institution. Rules governing remuneration vary. In practice there is a mixed system which provides both flat rate fees as well as compensation for individual services rendered.

Primary medical care is provided by the 6,221 general practitioners (family doctors), who should be the first contact in case of illness. If specialised examinations or treatments should be necessary, the general practitioner refers the patient to a specialist in this field or to an outpatient clinic.

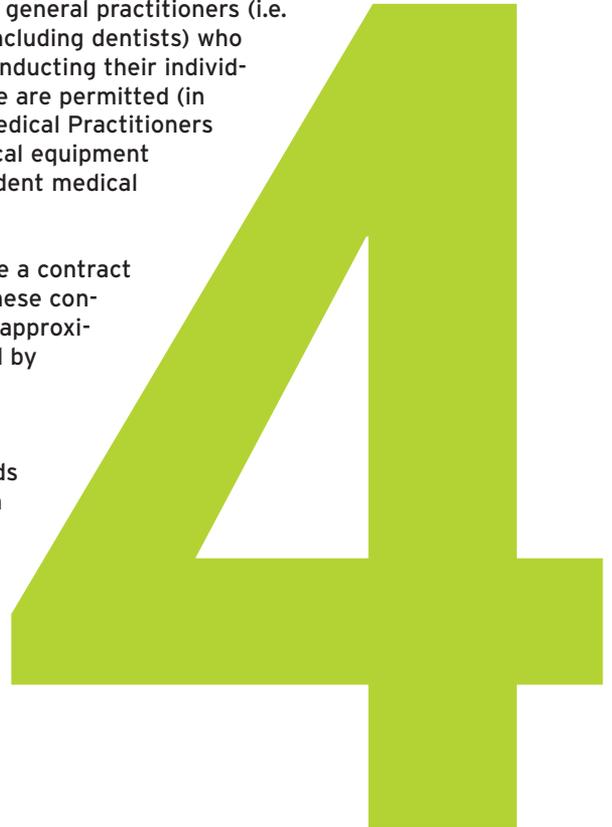


Table: Development of doctors in private practice, broken down according to general practitioners and specialists (incl. dentists), 1975-2004 (as of December 31 in each case)

Year	Specialists (incl. dentists)	General practitioners	Total
1975	4,923	4,244	9,167
1985	6,467	4,868	11,335
1995	9,200	5,877	15,077
2000	10,491	5,794	16,285
2004	11,804	6,221	18,025

Source: Austrian Medical Chamber

Doctors and outpatient clinics charge their medical services to the health boards by means of a "health card", which will replace the old system of patient certificates as of 1 January 2006. The basis for the new method is an electronic administrative system (ELSY) of the Austrian social insurers, which will support the administrative processes between the insured, employers, contract partners and social insurance institutions.

The "E-card", distributed over the course of 2005 to all those health-insured and their entitled dependents, is the key for access to health care services. This health card stores administrative data such as one's name, academic title and insurance information. The card's back side functions as one's European insurance card. This replaces the foreign patient certificate (E 111) in use up to now. Since the E-card is equipped with a digital signature function, it can simultaneously be used as a citizen's card in the sense of E-government electronic administration. Starting in 2006, a yearly fee of ten Euros will be charged for the health card.

Not all health care services are afforded complete coverage by all social health insurers. Certain insurers require co-payments from those insured (see Chapter 6), and all those insured must contribute to the costs of hospital stays, for various dental and dental-technical services, for services rendered by so-called doctors of choice (e.g. services by doctors, various therapists such as psychotherapists, physiotherapists and occupational therapists, logopedics and other providers who do not have contracts with the insurers), the annual fee for the E-card and the so-called prescription fee for medicines prescribed by a doctor.

Outpatient clinics and outpatient hospital departments

An important role in the outpatient care of the population is played by around 900 outpatient clinics (as of 2003) and a number of outpatient departments in hospitals, including general specialist clinics and health insurance fund dental clinics.

Medical laboratories, physical therapy institutes, radiological facilities, sports medical institutions and some health resorts are operated mainly by private institutions in the form of outpatient clinics. A number of these private outpatient clinics have contracts with the social health insurance institutions and therefore settle the bills not with the patients, but with the respective health insurance institution.

An important contribution to acute medical care is provided by the outpatient clinics of specialist departments in hospitals. General and/or specialised outpatient clinics are present at practically all public and non-profit hospitals. According to the law, they are to provide care in emergencies in the respective special medical area and to provide difficult diagnoses requiring a greater outlay on equipment, which cannot be provided by the surgeries of the doctors in private practice.

Hospitals

The inpatient medical care of the Austrian population is provided by 275 hospitals, of which 272—with around 67,000 beds actually set up—provided data in 2003 (as of December 31, 2003) Therefore, the following figures refer to these 272 hospitals. In terms of the population, the bed density amounted to 8.4 per 1,000 inhabitants. In the year 2003, the hospitals cared for around 2.5 million inpatients.

More than two-thirds of all Austrian hospital beds (70.3 percent) are maintained by 133 public hospitals. In addition, there are 27 private hospitals (having 7.8 percent of the beds) which similarly operate on a non-profit-making basis. Thus, the total of non-profit-making hospitals amounts to 160 (58.8 percent having 78.1 percent of the beds).

Funding bodies

The hospitals are funded by a variety of bodies, the largest of which being the provinces and/or the provincial associations with 32.7 percent of the hospitals and 52.3 percent of the beds. Others include municipalities, religious associations, statutory health insurance institutions, insurance companies and private persons.

The Austrian territory is characterised by a large number of small hospitals. In late 2003, 61.4 percent of all hospitals had fewer than 200 beds, thus providing only 26.3 percent of total beds; 40 percent of them had fewer than 100 beds (5.1 percent of the total provided). 75 hospitals comprising 31.7 percent of all beds belonged to the 200-500 bed category. 21 hospitals between 500 and just under 1,000 beds contained a further 22.7 percent of Austrian hospital beds. Including the university clinics, there were nine hospitals with 1,000 and more beds, and these amounted all together to 19.3 percent of all beds provided.

Of the 272 hospitals in Austria, around 139 (51.1 percent) are so-called "fund hospitals". These are public general and specialised hospitals, as well as private, non-profit-making general hospitals. They encompass essentially the acute-illness sector (except accident-hospitals) and are financed by public monies via provincial (health) funds (see Ch. 6). In 2003, the bed capacity of these fund hospitals amounted to 49,292 beds actually set up, or 72.8 percent of the total Austrian bed capacity.

In the year 2003, fund hospitals cared for about 2.3 million inpatients. Bed density totalled about 6.1 beds per 1,000 inhabitants. The average patient stay (midnight figures for those staying between one and 28 days) amounted to around six days in the year 2003.

Of the non-fund hospitals, 43 are private, for-profit sanatoriums (15.8 percent) with 3,726 beds (5.5 percent), which are financed by the Private Hospitals Financing Fund (PRI-KRAF) (see Ch. 6). The other 90 hospitals (33.1 percent) with 14,690 beds (21.7 percent) consist mainly of various special care facilities, particularly rehabilitation centres and facilities for the chronically ill.

It should be noted that the figures presented here cannot always be directly compared internationally, since in Austrian hospital statistics, among other things

- outpatient day clinics, as well as some outpatient procedures (e.g. outpatient operations), are attributed to and documented as part of inpatient services for billing reasons;
- one-day care for inpatient repeat and follow-up treatments (e.g. as with chemotherapy) always require re-admission and discharge, and thus must be documented as "new" cases, which raises the number of "inpatients" in the statistics;
- special rules of LKF-billing (e.g. in the areas of half-inpatient psychiatry and medical geriatrics, in changes between provincial-fund-relevant and non-relevant cost-bearers) sometimes imply separate listing of individual hospital stays, meaning a (statistical) increase in inpatient stays;
- the Austrian statistics treat as hospitals certain facilities which in other states would not necessarily have hospital status (e.g. hospital wards in nursing homes).

Table: Structure of the Austrian hospitals in 2003

	Hospitals absolute	Actual bed count	Hospitals as a % of the total	Beds in %
Total	272	67,708	100.0	100.0
Care sector				
Care sector	190	53,347	69.9	78.8
Non-acute care	82	14,361	30.1	21.2
Care area				
General care	136	44,485	50.0	65.7
Specialised care	136	23,223	50.0	34.3
Type of hospital				
General hospitals	108	41,954	39.7	62.0
Specialised hospitals ¹⁾	97	14,940	35.7	22.1
Sanatoriums	44	3,755	16.2	5.5
Nursing facilities for the chronically ill	23	7,059	8.5	10.4
Public law/Non-profit				
Public law (non-profit)	133	47,612	48.9	70.3
Private, non-profit	27	5,253	9.9	7.8
Private, for-profit	112	14,843	41.2	21.9
Size structure				
Less than 100 beds	68	3,428	25.0	5.1
100-200	99	14,352	36.4	21.2
200-500	75	21,477	27.6	31.7
500-1000	21	15,353	7.7	22.7
1000+	9	13,098	3.3	19.3
of these: university clinics	3	5,005	1.1	7.4

Health Care Services

	Hospitals absolute	Actual bed count	Hospitals as a % of the total	Beds in %
Funding bodies				
Political administrative units, of which:	133	45,814	48.9	67.7
Federal	10	566	3.7	0.8
Provincial	89	35,404	32.7	52.3
Municipa	134	9,844	12.5	14.5
Social insurance, etc., of these:	40	5,744	14.7	8.5
Social health insurers and (regional) social and welfare associations	7	1,100	2.6	1.6
Accident and pension insurance institutions	33	4,644	12.1	6.9
Private sponsors, of these:	99	16,150	36.4	23.9
Religious orders and congregations	42	10,873	15.4	16.1
Private individuals and societies	47	4,287	17.3	6.3
Associations/Foundations	10	990	3.7	1.5
Fund attribution				
Provincial (health) funds	139	49,292	51.1	72.8
Private Hospital Financing Fund (PRIKRAF)	43	3,726	15.8	5.5
Other (non-fund)	90	14,690	33.1	21.7

¹⁾ incl. two sanatoriums

Source: Federal Ministry of Health and Women, Hospital Statistics 2003

Health care structural planning

The Austrian Hospitals and Major Equipment Plan (ÖKAP/GGP)

Since 1997, an important instrument of health care structural policy has been the Austrian Hospitals and Major Equipment Plan (Österreichischer Krankenanstalten- und Großgeräteplan, ÖKAP/GGP). This legally binding plan, originally conceived with targets for the year 2005, has been updated and expanded several times since its inception.

The objectives of the ÖKAP/GGP are to maintain the high quality of health care provision, to adapt the hospital structure to meet future health care requirements and to increase economic efficiency in the hospital sector (see Ch. 1).

The hospitals plan regulates the fund hospitals' locations, specialisation structures, the upper limits of total beds in individual hospitals and provinces and the trans-regional provision of services in selected areas. More detailed determinations are established in the provincial hospital plans, which must remain within the framework of the ÖKAP/GGP stipulations.

The major equipment plan establishes the type and quantity of large-scale medical-technical devices per hospital, based primarily on the specialisation structure of the hospital as a criterion of structural quality.

The evolution of the ÖKAP/GGP since 1997 has also encompassed new levels of inpatient care, which is now no longer carried out only in fully-equipped, specialised departments, but also—with a limited range of services and under observance of binding structural quality criteria—in smaller, specialised units and separate day-clinics related to the aforementioned departments but locally administrated. This should ensure the provision of care to low-population-density regions difficult to reach.

Furthermore, the ÖKAP/GGP contains new, future-oriented care-provision areas which do not yet exist in sufficient number in Austria, such as acute geriatrics/remobilisation, palliative medical centres and psychosomatic care. Decentralisation of psychiatric care and its integration in regular care within the framework of psychiatric care reform are also covered in the ÖKAP.

The Plan's current version is the ÖKAP/GGP 2003, which entered force in May 2003. Its objectives are to be realised by 2005. The ÖKAP/GGP is to be replaced in 2006 by the Austrian Health Care Structural Plan (ÖSG).

Austrian Health Care Structural Plan (ÖSG)

While the ÖKAP/GGP represents traditional location and capacity planning (beds, specialty structure, provision of large medical-technical equipment) for publicly funded hospitals, the ÖSG follows a new sort of planning methodology—the so-called service provision planning. This means that the minimum supply or the required minimum amount of medical services (based on ca. 400 pre-defined service bundles) for the care of the population in each of the 32 established health care regions is established on the basis of comprehensive model and prognosis calculations. Sophisticated and/or rarely required services will be distributed among four care zones. In principle, the provision of services can take place irrespective of location or organisational form—inpatient or outpatient, in hospitals or in private practices, in public or in private health care institutions. The prerequisite for the provision of services is that certain structural quality criteria (especially available personnel and equipment, as well as minimum frequencies) be met.

The ÖSG is a planning framework with a target date of 2010, on the basis of which location and capacity planning must take place on the provincial or health care region level, while taking into account and/or optimising regional characteristics of the (existing) health care structure.

The ÖSG encompasses not only the hospital area, but in principle the entire health care structure (intramural and extramural areas, acute and long-term care incl. rehabilitation), and furthermore defines criteria for effective management at the interfaces between these areas of care. The ÖSG is thus an important structural policy instrument for the development of an integrated system of health care provision.

For reasons of current data availability, the ÖSG for 2006 contains service provision planning only for the area of acute inpatient care. The other areas of care are portrayed as they now are because, in the case of the outpatient area, for example, available data is as yet insufficient. In any case, even just the current situation provides an overview of the existing care situations in the various regions, and shows where there is a need for change. In connection with the planned successive introduction of a comparable documentation of diagnoses and procedures in all areas of health care, service provision planning will be continually expanded to cover all other areas.

Pharmaceuticals and pharmacies

The production, marketing, price and application of pharmaceuticals is subject to special statutory regulations in Austria which are based on motives concerning health policy and consumer protection.

The EU regards pharmaceutical laws as a matter for the Common Market and has therefore issued far-reaching European directives which are intended to bring about a uniform European pharmaceuticals market and the advantages such uniformity can entail. Austria has adapted its regulations to these EU directives.

Specific Austrian regulations and key data

- Pharmaceuticals may principally only be sold in Austria in pharmacies. Only simple pharmaceuticals such as vitamin products or teas may be sold in chemists' shops.
- The operation of a public pharmacy is regulated by a state approval procedure and strict checks on necessity. A new set of rules has governed applications for new pharmacies since the spring of 1998: a doctor must have his permanent consulting rooms in the same municipality, the distance to the nearest existing pharmacy must be at least 500 metres, and the number of customers still to be supplied by an existing pharmacy must not fall below 5,500 as a result of the new establishment. Pharmacies are obliged to adhere to detailed regulations concerning staff training, equipment of the facilities, storage, etc. and to provide night and weekend service.
- The Austrian system of pharmaceutical distribution is based on the principle of separation of the prescribing person (doctor) and the administering person (pharmacy). This principle is not adhered to in one special case in Austria: that of the "in-house pharmacies in private practices": If in a surrounding area of six kilometres from the official seat of the general practitioner there is no public pharmacy, then the doctor is given permission to operate a "subsidiary" pharmacy enterprise. This institution is intended primarily for providing a supply in thinly populated areas.

The number of pharmacies in Austria

Currently (as of May 2005) there are 1,176 public pharmacies in Austria, 19 franchise pharmacies, 942 in-house pharmacies in private practices and 44 pharmacies operated by hospitals for their own needs (hospital pharmacies) (Source: Austrian Chamber of Pharmacists).

The prevailing Austrian system of pharmaceutical distribution is acceptable under EU law and can be maintained in the future. In any case, it concerns a non-discriminatory regulation of internal channels of distribution, which the EU member states are in principle free to structure as they wish. The existence of a system of distribution of pharmacies that is geared to demand is justified to the extent that the protection from the forces of the free market allows the existing pharmacies to provide better advice, to have a better assortment of products and to avoid sales practices which conflict with the essence of a pharmaceutical product.

Prescription-only products

Pharmaceuticals with potentially dangerous effects are available only by prescription. The EU directive in question does, however, grant the national legislator wide leeway. In comparison with neighbouring EU states, the prescription rules in Austria are strict: in January 2005, 10,296 (81.8 percent) out of 12,587 approved pharmaceuticals were subject to prescription. The supporters of greater freedom for self-medication criticise the resulting high costs for the Austrian health system, because doctors have to be referred to for so-called "trivial cases". They also point out that countries pursuing a far more liberal prescription philosophy than Austria, such as Germany and the United Kingdom, are no less safe than Austria in terms of the provision of treatment.

As a justification for the prevailing Austrian system, however, it can be said that even seemingly harmless "everyday pharmaceuticals" contain substances which are not simply harmless consumer products and could lead to a masking of the clinical picture, uncontrolled use and long-term damage. That is why the strict prescription obligation can also be regarded as an awareness-enhancing measure against the abuse of pharmaceuticals.

Prescription charges

About one third of all pharmaceuticals registered in Austria can be freely prescribed by doctors. The patient receives the prescribed medicament at the pharmacy upon presentation of the prescription and payment of a deductible in the amount of EUR 4.45 (2005). For social reasons, exemptions from this prescription fee are possible.

The deductible is paid by the pharmacy to the social security institutions. In return, the pharmacy is paid the listed "fund price" of the pharmaceutical (which is negotiated regularly between the pharmaceuticals industry and the social security institutions) by social security after the presentation of the prescription slip. The social security institutions are entitled to a statutory discount from the fund price averaging 7.5 percent—depending on the turnover of the pharmacist in question. For pharmaceuticals which are particularly expensive products or whose use requires a special individual review, it

is necessary to obtain an additional "approval by the medical superintendent". This means that the social insurer will only cover the costs of this pharmaceutical when, in addition to a doctor's prescription, its use has been approved by the medical superintendent who is appointed by the social insurer as the controlling authority. In 2005, responsibility for obtaining such approval passed from the patients to the doctors.

The social insurance institutions spent approximately EUR 2.4 billion in 2004 on pharmaceuticals, 3.5 percent more than in the previous year. About 14 percent of this sum is covered by the prescription fee. In summary, pharmaceutical costs (including prescription charges) amount to about 21 percent of the total expenses of health insurance. This does not include the pharmaceuticals administered in hospitals, the costs of which are included in the all-in case fees (Source: Main Association of Austrian Social Security Institutions, see Ch. 6).

In order to counter the increasing costs of the health insurers, pharmacy margins were reduced to an average of 20.7 percent effective 1 January 2004 following negotiations between insurers, pharmacies, wholesale distributors and industry (1995: 26.2 percent).

Thanks to the so-called Prescription Drugs Package passed in autumn 2003, the projected increase in the cost of medicines by about eight percent annually is expected to be somewhat less. This objective has already been reached for 2004; the increase amounted to around four percent.

In comparison with other countries, the Austrians take relatively few medicines: while in 2005 pharmacies sold 49.2 packages per capita in France and 27.6 in Italy, the figure for Austria was 21.8 packages. Germany and Great Britain consume somewhat less, at 20.2 and 20.7 respectively (Source: Austrian Chamber of Pharmacists).

People over age 80 use around 4.5 times more packages than average. School-children (ages 10 to 19) need only around four packages per year. The majority of medications were prescribed to treat cardiovascular illnesses (altogether 31.2 percent of all packages dispensed in pharmacies), stomach and intestinal ailments (8.7 percent) and for psychotherapeutic purposes (7.5 percent) (Source: Austrian Chamber of Pharmacists).

Generics

Generic drugs—preparations with the same active ingredient as the original products, which may only be brought to market following expiration of the original patent and supplementary protection certificate—are more reasonable than the originals, and thus present an opportunity for the health care system to save money. In Austria, the share of such twin products is still relatively low (2004: 12.3 percent; Source: Austrian Generic Association), in comparison to Germany, for example, where 52 percent of medicines

sold are already generics. This can be attributed both to the relatively low medicine price level in Austria, and to the fact that pharmacists are not permitted to exchange original products for generics by themselves. In 2006, the share of generics should amount to 20 percent.

Authorisation of pharmaceuticals

According to the Austrian Pharmaceuticals Act, pre-packaged pharmaceuticals ("pharmaceutical specialities") may only be marketed after a strict admission procedure. The approving authority is the Federal Ministry of Health and Women.

The EU is trying by common regulations to reduce the repetition of time- and cost-intensive national approval proceedings for each of the comparatively small national pharmaceutical markets. If a pharmaceutical product has already been approved in another EU state and is to be marketed in Austria, then it is required to admit this product on the basis of the foreign documentation at a quicker rate ("decentralised proceeding"). In cases of differences of opinion within the scope of this proceeding, the European Drug Agency in London, the European Commission and the Council act as arbitrators.

Since 1995, it has been possible to obtain EU approval for pharmaceuticals for all EU Member States. This central European procedure is mandatory for pharmaceuticals which have been produced with the help of certain biotechnological processes. Since 20 November 2005 the area for which this procedure is mandatory has been expanded to include pharmaceuticals with new drugs intended to treat HIV, cancer, degenerative neurological diseases and diabetes. Other innovative and technologically complex pharmaceuticals can be approved on either a centralised or a decentralised basis.

Price regulation

Pharmaceuticals are strictly price-controlled in Austria. Apart from the official price set by the Federal Ministry of Health and Women, the option of reporting the factory gate price to the authorities has been available since September 1999. If the authorities do not respond within a period of six weeks, this price becomes valid. Pharmaceutical prices were lowered in 1995 and again in 1997.

International comparison

Compared internationally, the Austrian pharmacy sales prices for pharmaceuticals are average for Europe, whereas the factory gate prices in Austria are below the European average. The reason for this is, among other things, the comparatively high VAT: compared to a six percent VAT charge for pharmaceuticals in Belgium and a 16 percent charge in Germany, the Austrian rate is 20 percent.

Preventive health measures and health promotion

For many years, one of the most essential aims of Austrian health policy has been to improve public health by setting up a comprehensive system of preventive health care and by promoting health-consciousness through education and information. Most recently, health promotion has, in accordance with the concept defined by the WHO in the 1986 Ottawa Charter, been pursued not only thematically (with regard to particular illnesses or risk factors) but, increasingly, in terms of the individual patient's "setting" or environment as well. The borderlines are fluid, however, and many thematic preventive care programmes such as those intended to reduce cigarette smoking or alcohol consumption are implemented in specific areas of life such as schools and workplaces. Various check-up and health promotion programmes have been added to the list of social security benefits (see Chapter 6).

In March 1998, the Federal Health Promotion Measures and Initiatives Act provided additional funding of EUR 7.27 million (ATS 100 million) per year for the implementation of the "Health Promotion Initiative". These additional funds supplement the already existing prevention measures for purposes of promoting and implementing practical action and flanking scientific studies in the health promotion sector, and, at the same time, are also intended to enable the set-up of a sustainable supporting structure. The law provides the non-profit-making Healthy Austria Fund as financier of the "Health Promotion Initiative". The main purpose of the fund is to promote innovative projects, additionally offering accompanying service and information to project operators. In order to facilitate international exchange, the Healthy Austria Fund participates in efforts including EU-wide projects designed to collect information for the purpose of health promotion.

Under the heading "Conscientious living is better living" ("Bewusst lebt besser"), the Healthy Austria Fund has conducted themed media campaigns since 1999 to promote health-consciousness in everyday life. From 2003 to 2005, the Fund emphasised physical activity, emotional health and nutrition, including the setup of a nutrition hotline, because the campaigns were meant not just to sensitize their audience or warn of unhealthy lifestyles, but also to offer practicable solutions. An initial evaluation shows that around 40 percent of the Austrian population was reached by the physical activity campaign—more women than men. The Federal Ministry of Health and Women has now initiated the nationwide campaign iSch ("innerer Schweinehund" ["the lazy dog within"]) in order to promote self-responsibility in terms of health and quality of life. The emphases here are on nutrition, physical activity, stress reduction, accident avoidance and medical prevention. The campaign has its own website (www.isch.at).

A central role in health promotion is also played by the right to self-determination (empowerment), participation and the strengthening of one's own resources. Since

1993, the Healthy Austria Fund has been home to the nationwide self-help support project known as "SIGIS". One part of this project is the regular publishing of an index of health-related self-help groups in Austria.

"Setting"-related preventive health care and promotion

Health promotion for children and youth outside of schools

From the perspective of health promotion, children and youth outside of schools are a hard-to-reach target audience with relatively poor knowledge of healthy behaviour and possible intervention strategies. For this reason, the Healthy Austria Fund conducts numerous activities in this area: two model projects—"Rural Youth Health Promotion" ("Jugendgesundheitsförderung auf dem Land") and "Pavement" ("Gehsteig") have been in progress since 2002. Furthermore, more and more networking and further education activities are taking place.

Health promotion for youth aims to strengthen young people in their self-esteem and in their abilities to perceive themselves and their needs, to formulate them and to advance their own ideas. The conduct of projects in this area is strongly linked to the question of social acceptance. The principle of participation, social involvement, is an important strategic juncture between health promotion and modern youth work (Source: Healthy Austria Fund, 2004 annual report).

In recent years, model projects and co-operative structures for health promotion have been set up at the initiative of the Health Ministry within the main relevant social systems—town, school, hospital and workplace. Some of these networks have been established in co-operation with the WHO, the EU and/or the Council of Europe, and inter-link health promotion measures at both national and international levels.

Healthy cities

The member cities of the Austrian "Healthy Cities" Network, at present numbering 31, have set themselves the objective of making urban living healthier by actively involving the citizens in their activities. Themes here range from a joint policy on drugs to health promotion for women to accident prevention. The network participates in a continuous exchange of information and experience with the WHO's international "Healthy Cities" project.

Health-promoting schools

This network aims to assist and encourage the individual tendencies of pupils to behave in a health-conscious way, and also to address teaching staff members' personal approaches to health issues. The projects are sponsored by a team involving representatives of the entire school community (teachers, parents and pupils). In order to ensure efficient handling of the networked schools, the Federal Ministry of Social Security and Generations and the Federal Ministry of Education, Science and Culture set up a secretarial network centre in the Office of Training and Professional Development. More than 120 schools have already joined the Austrian network to date. In April 1997 the Vienna network of "health-promoting schools" was officially constituted as the first regional network. Regional support structures are currently being set up in further provinces. In autumn 2005, a mutual platform entitled "Health Promotion and School" was established.

Moreover, at the initiative of both Ministries and the Austrian Juvenile Red Cross, the GIVE service office for health education was set up. GIVE stands for the working points of health education (**G**esundheitsbildung), **I**nformation, networking (**V**ernetzung) and development (**E**ntwicklung). On the basis of the Ottawa-Charta (1986) and the Declaration of Principle on Health Education (1997) the service office acts as a competent information and documentation clearinghouse to provide ongoing support for the implementation and realisation of health promotion and health establishment in schools and other educational and health institutions.

Health-promoting hospitals

The Austrian network of "health-promoting hospitals" (ÖNGK) has been in existence since 1996. It aims to promote better health among three groups:

- health promotion for patients by providing the best possible medical, nursing and therapeutic care, creating a health-promoting environment (e.g. through appropriate architecture, the food served by the kitchens, co-operation with other health service providers and enabling the patient to take as much self-responsibility as possible for their own health ["empowerment"]),
- health promotion for employees by avoiding work-related risks, via manager training programmes, participation in shaping the work ambience, creating a health-promoting environment (e.g. ergonomics) and, as necessary, providing physical back-exercise training and supervision,

- health promotion throughout the region by providing specific programmes for the population (e.g. information, consulting, training), waste and emission management and supporting local health policy through health reporting (scientific analysis of patient data in order to ascertain regional health problems).

A prerequisite for the attainment of these goals is the health-promoting development of hospital organisation; i.e., ideally, the effect on the health or illness of the target groups is to be factored into each organisational decision, and the health benefit to these groups is measured and documented as part of the quality of this hospital's outcomes.

287 health promotion projects emanating from 113 Austrian hospitals were registered in the Internet project database as of June 2005. Representatives from an average of 60 hospitals take part in the annual Network conferences, and fifteen hospitals are taking advantage of the option to actively progress toward more health promotion as ÖNGK associate hospitals.

Health promotion in the workplace

Health promotion in the workplace aims to improve well-being during working hours, to increase health potential and to prevent illness. To assist employers in these measures, an Austrian contact point within the "European Network for Workplace Health Promotion" was set up in the autumn of 1996. In order to spread the strategy of workplace health promotion regionally, as well, the "Austrian Workplace Health Promotion Network" was founded in early 2000. Furthermore, the Healthy Austria Fund has over the past few years placed emphasis on health promotion for employees in small and medium-sized businesses, which aims to improve work and process organisation and working conditions as well as promote active employee involvement and the strengthening of personal resources and competencies.

Healthy and active ageing

The comprehensive health definition of health promotion emphasises that the acquisition of new life and health competencies, the creation or preservation of life and health potentials, and the development of health-promoting settings make possible active and healthy ageing. At the centre of efforts for healthy and simultaneously active ageing are two model projects being conducted for the Healthy Austria Fund on the theme of "senior citizens in regional settings". The model project "health promotion in older people between 60 and 75 years of age in a regional setting—rural living environment" is being conducted by the Institute for Social Medicine and Epidemiology of the Karl Franzens University in Graz as a project entitled "Living Environments Worth Living in for Older People". The project "health promotion in older people between 60 and 75

years of age in a regional setting—urban living environment” is being conducted by the Research Institute of the Vienna Red Cross as a project entitled “Plan 60”.

Thematic health care measures and promotion

Medical check-ups for adults 18 and above

Since 1974 every Austrian citizen has been entitled to a free check-up once a year. This takes the form of a basic examination, which is the same for both sexes, plus a gynaecological examination for women. 786,315 Austrians took up this offer in 2003, and the trend is rising. The gynaecological test was taken by about 112,348 women. One reason for this relatively low take-up rate is probably that most women have the most important examinations carried out during visits to their own gynaecologists.

Since 2005 there has existed a new prevention programme at the core of which lie defined prevention goals, particularly in the areas of widespread illnesses such as cardiovascular disease, cancer and old-age complaints. More than ever before, the findings of modern lifestyle-medicine are being integrated in preventive check-ups, and the advising role of the doctors is also being reinforced. It is no longer just about the early recognition of common illnesses, but also about education and support for health-promoting lifestyle changes with regard to the core themes of physical activity, nutrition and smoking.

New, for example, is an emphasis on intestinal cancer prevention for people over 50. Women over forty are invited to have a mammogram done every two years. Older people can have their vision and hearing tested as part of a regular check-up. Since Austria does badly in international periodontal disease comparisons, a special screening for regular check-ups is being adopted.

Targeted informational measures are intended to motivate even more Austrians to take advantage of the opportunity afforded by free preventive check-ups. In the future, special invitations to check-ups will be sent out. By means of a call/recall-system, all people over 18 years of age are to receive regular invitations to check-ups, with persons below 40 years of age receiving them every three years and other persons every two years.

Women’s and men’s health

Societal and health-policy demands for a gender-specific, gender-sensitive and gender-fair view of health are based on a growing consciousness of differences between men and women in many health-related areas. On the one hand, there exist health risks and illnesses that occur exclusively among either women or men, and that occur more often or

progress differently or more seriously among members of one sex or the other. On the other hand, access to and actual demand for health offerings differ between men and women in several respects. So it is not primarily a question of whether women or men are healthier or sicker, but of how the health care system can do justice to gender-specific needs.

In Austria, women's health centres assume a central role in the representation of women's health issues from a holistic perspective. They promote, develop and spread strategies oriented toward women and offerings specifically for women. Of central significance for all Austrian women's health centres is the concept of women's health promotion, which rests on the basis of empowerment and the respect for the living situations of individual women and of women as a group.

The network of Austrian women's health centres is dedicated to a women-specific conception of health, for women-specific strategies and offerings in health promotion, and for women-specific health policy. The network is a competency centre and simultaneously an information clearing house. It takes critical stands on health trends and developments in women's health policy, and participates in national and international networks. Austria was one of the first European countries to have followed the WHO recommendations on this topic, and its first Report on Women's Health was compiled in 1995.

In 2001 in Austria, the International Society for Men's Health and Gender (ISMH) was founded. Its health campaigns, which are aimed exclusively at men, have most often addressed issues of sexual health, specifically the topics of erectile dysfunction and cancer prevention. A current, wide-reaching campaign was started in October 2003 by the ISMH in co-operation with the Medical Chamber, the Austrian Association Against Cancer and the City of Vienna with the motto of "Health—a men's issue" ("Männersache Gesundheit"). The objective of the campaign is to motivate men in the sense of "instructions for staying healthy" to pay better attention to their own health. The first Austrian Report on Men's Health was published in 2004.

The Mother-Child Medical Card

The Mother-Child Medical Card, introduced in 1974 to provide special care to pregnant women, new-born children and infants, is currently regarded as an achievement in preventive medicine, and it has been internationally acclaimed and emulated. The examinations provided for by the Mother-Child Medical Card represent an opportunity for the early recognition and timely treatment of illnesses, as well as to monitor a child's development.

In addition to five general and two ultrasound examinations for expectant mothers, the programme also includes nine general, one orthopaedic, one ENT, one ultrasonic hip examination and two eye examinations for the child up to the 62nd month of life. This medical service has won widespread public support and made a critical contribution to the fall in infant and maternal mortality in the past decades.

Entitlement to the Child Care Bonus (instituted in 2002) is dependent on evidencing Mother-Child Medical Card check-ups after a child has reached the age of 21 months.

Examinations for school-children and young people between 6 and 18 years of age by the school doctor

Regular checking of students' health with regard to their fitness to attend school is one of the most important tasks of the School Medical Service. School-aged children are required to have a check-up by a school doctor once every school year (apart from any admittance examination which may be necessary). These regular check-ups provide a standardised examination. They focus particularly on examination of the visual and hearing capabilities and of the locomotive and supporting apparatus. In addition, other examinations are possible with the students' consent. Should health deficiencies be discovered during a check-up, the doctor informs the student thereof.

In addition, school doctors have recently been given additional duties in the field of psycho-social consultancy, aimed particularly at the prevention of drug addiction.

In the spring semester of 2005, new health passes—and simultaneously the extensive informational brochure entitled "Feel good"—were distributed to students of the eighth form in co-operation with the Federal Ministry of Education, Science and Culture. With the health pass, an instrument has been created which provides youths with a compact summary of their health data, and which makes it easier for them to deal with the existing health care system. This is also to be seen in the context of rising self-responsibility of youth from age 14. The health pass is to be integrated in the annual school medical check-up.

Examinations of young people between 15 and 19 years of age who are already gainfully employed

About 70 percent of young people take advantage of this free and voluntary health check-up, to which they are invited by the social health insurance boards. During the first examination (during their sixteenth year of life) a detailed case history is drawn up

and a detailed basic examination is carried out. The further examinations, at intervals of one year, serve to keep track of young people's health, and there are also special programmes for eyes, ears and teeth and special examinations relating to occupation. The final such examination, at age 19, also includes a special gynaecological routine for young women.

Vaccination strategies

Prevention of disease is the health authorities' most important objective, and vaccination plays a central role in the attainment of this goal. Hence the Health Ministry developed a concept of vaccination targeted at every child, from birth until completion of compulsory school attendance. The concept includes all vaccinations recommended for children by the National Health Council, i.e. diphtheria, tetanus, whooping cough, haemophilus influenzae b, poliomyelitis, pneumococci, measles, mumps, rubella, hepatitis B and chickenpox, assuming the child has not yet had that illness.

Vaccination is voluntary in Austria and is available free (with the exception of chickenpox) to children from birth until completion of compulsory school attendance. The six-part combination vaccine for immunising newborns against diphtheria, tetanus, whooping cough, haemophilus influenzae b, hepatitis B and poliomyelitis has been available since early 2001. In order to achieve the highest possible degree of vaccination throughout the population, it is strongly recommended that the vaccination appointments entered in the Mother-Child Medical Card be kept.

The vaccination rate for poliomyelitis and diphtheria-tetanus-whooping cough presently stands at about 90 percent, and at about 85 percent for measles-mumps-rubella.

The vaccination concept is carried out by the Federal Ministry of Health and Women in cooperation with the Main Association of Austrian Social Security Institutions and with the provinces, the Ministry assuming two-thirds of the vaccines' costs, including distribution up to the district-administration authority level. The provinces are in charge of on-site vaccinations, i.e. paying the doctors' vaccinating fees and/or the provision of government doctors.

The vaccination plan for adults recommends vaccination against diphtheria and tetanus—as well as against poliomyelitis and pertussis—every ten years in order to maintain immunity. After the 60th year of life, vaccinations against tetanus, diphtheria and pertussis should take place every five years.

Special vaccinations against illnesses including early-summer encephal meningitis, hepatitis A and influenza, is especially recommended for particularly susceptible groups of people and residents of endemic areas.

Diabetes

The increase in the number of cases of diabetes associated with the risk factors of obesity and too little physical activity makes necessary comprehensive preventive measures. In order to better observe the frequency of the illness and its progress with the associated complications, a nationwide diabetes register has been called for. The outbreak of this illness and/or causally associated problems such as heart attacks, strokes and kidney disease, are to be staved off by targeted measures:

- Consciousness-raising and publicity work,
- Age and gender-specific activities and offerings for children, youth and adults,
- The creation of a prevention system and continuous monitoring of at-risk patients,
- Continuing education for doctors in the area of prevention management for risk-groups,
- Patient training, for the purpose of avoiding later negative consequences,
- Lifestyle measures such as proper nutrition and physical activity, even in cases where the illness is already present.

Addiction prevention

The theme of "addiction prevention" is given very high priority, with primary (general) prevention being particularly significant. This is not substance-specific, but integrates all psychoactive substances (tobacco, alcohol, illegal drugs, medicines, etc.) and, in the main, aims to generally strengthen the personalities particularly of children and youth, thereby making them less susceptible to problematic consumption and/or the development of addictions. Furthermore, primary prevention has to do not just with substance-related addictions, but also other forms of addiction (gambling and internet addictions and eating disorders, for example). Primary prevention is oriented toward the WHO concept of health promotion in the sense of the Ottawa Charter (WHO 1986), with the main emphasis on informational measures in various areas of everyday life, such as in day-care centres and schools, in the workplace and in youth work outside of schools, as well as in community-based addiction prevention projects. School-based addiction prevention is done with the inclusion of the entire school community as well as regionally based experts on issues of addiction. As part of the Health Ministry's "iSch" campaign, as well, addiction prevention measures are being taken in schools with the involvement of school doctors.

Smoking

Measures to reduce tobacco consumption are a major Health Ministry emphasis. A special target audience for education measures is, as always, youth. For the earlier initial contact with cigarettes occurs, the more probable it is that nicotine consumption will continue into adulthood. In 2004, the Federal Ministry of Health and Women put together a five-point package including a don't-start campaign for youth, support in quitting smoking, improvements in the legal protection of non-smokers, enforcement of existing no-smoking regulations and non-smoking areas in restaurants. Together with the Education Ministry, the "Smoke-Free Schools" project is being conducted.

On 1 January 2004, the warning messages on packages of tobacco products were made more severe, and the rules on smoke contents more stringent: the tar and carbon monoxide content of cigarette smoke was not permitted to exceed 10 milligrams, and nicotine was limited to one milligram. With a further amendment to the so-called Tobacco Act, the implementation of the corresponding EU guideline, a recommendation of the European Parliament and the Global Framework Convention on Tobacco Control of the WHO, the comprehensive ban on tobacco advertising and sponsoring, to become effective by steps starting on 31 July 2005, was initiated. Since passive smoking is also dangerous and since more and more illnesses are being found to be associated with it, the smoking ban was expanded to include various enclosed public spaces.

Alcohol

As in other European countries, alcohol is part of social life in Austria. The efforts of Austrian health policy are therefore focused mainly on alcohol abuse. The objective is to encourage reasonable alcohol-related behaviour in a way that does not damage health. Alongside measures to prevent addiction, health policy stresses abstinence from alcohol in certain situations, in particular in the workplace, in traffic and during pregnancy. Austria takes part in the EU project "ENCARE", which deals with problems faced by children and youth living in families with alcohol-related problems. The capacity and coverage of therapy offerings is adequate.

In 2000, the Health Ministry established the Alcohol Co-ordination and Information Bureau (AKIS) in co-operation with the Special Clinic of the Anton Proksch Institute and the Ludwig Boltzmann Institute for Addiction Research. This office, which draws on a network of high-ranking experts from the fields of research, therapy and prevention, as well as from the health authorities, is the central turntable for all alcohol-related addiction prevention activities.

Illegal drugs

Austrian drug policy follows a comprehensive and balanced approach, and strives for solutions that differentiate between drug dependency and drug trafficking, in which an important role is played by the concept of “therapy over punishment” with regard to drug consumption and drug dependency. The objective is a society which is as free as possible from addiction. Current drug policy is based upon four principles (prevention, therapy, damage minimisation and repression). The objectives and principles at the federal level are expressed in particular by the rules set as laws and/or directives. The nine provinces each have their own drug and/or addiction concept, with the trend in past years having been towards an integrated and holistic approach to legal and illegal drugs. A federation-wide drug concept is currently in planning.

In the area of illegal drugs, a significant emphasis of the Federal Ministry of Health and Women has been on the improvement and expansion of monitoring. The basis for this is formed by the so-called five key epidemiological indicators defined at the EU level by the European Monitoring Centre for Drugs and Drug Addiction. In the future, the resulting improvement in the available data should make possible better and more objective analysis of the epidemiological situation and, based on this, better-targeted co-ordination of offerings.

For several years now, primary preventive measures have been increasingly complemented by secondary preventive approaches (selective prevention) and pro-active measures. They are aimed especially at risk groups, as well as at informing drug consumers and drug addicts about use strategies that help prevent serious health damage. Based on their settings, particularly endangered groups are to be integrated into the present network of treatment facilities as early as possible. The area of low-threshold and proactive offerings has been expanded, and new media (Internet) have been introduced into prevention work.

Over the past few years, regional competency centres for addiction prevention (addiction prevention units) have been created in the federal provinces. Their strategies are also strongly oriented towards the health promotion concept of the WHO, as are the prevention concepts of the Health and Education Ministries. The advisory centres deal above all with the initiation, development, advising and accompaniment of projects, as well as with professionalisation and quality assurance in addiction prevention, and they offer training for multipliers and specific training for the occupational groups involved in prevention. Just like the offices of the provincial governments and the Health and Education Ministries, they make available numerous supporting materials.

Addiction-specific advising, supervision and treatment offerings have a long tradition in Austria, and are extensive and provide full coverage in both the inpatient and outpatient areas. Furthermore, addiction-accompanying measures, such as re-integration of those affected into society, have received increasing attention in recent years. In work with addiction-endangered youth, the importance of integrative approaches, which strive to largely avoid the stigmatisation of affected youth, has been stressed. Since 1986, syringes and needles have been available without a prescription in apothecaries, at health supply shops and drugstores, and in certain facilities even free, in order to prevent the spread of infectious diseases. Addiction is recognised as an illness in the psycho-social context, and treatment expenses are borne by statutory health insurance or by the public social welfare system. Inpatient and outpatient treatment offerings are complimented by numerous self-help groups.

Due to the country's federalist structure, as well as to the interdisciplinary nature of drug issues, it is important that the activities of the diverse actors be co-ordinated. For this reason, Austria pays great attention to co-ordination on drug issues. Every federal province employs a Drug or Addiction Co-ordinator, and the federal level is home to a federal drug co-ordination office which brings together the efforts of several ministries, but is led by the Health Ministry. A co-ordination committee on the federal level (Federal Drug Forum) provides for regular co-ordination between the federal and provincial levels in all drug-relevant matters.

The REITOX Focal Point Austria of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), based in the Austrian Health Institute, collects and documents not only data which appear in the annual "Report on the Drug Situation in Austria", but also information on specifically drug-related projects and activities.

HIV infection and AIDS

For prevention of AIDS infection, general information brochures ensure the required continuity in the dissemination of basic information about this disease. Target-group-specific publications and campaigns are addressed to certain age groups (e.g. young people) or to people who indulge in certain forms of high-risk behaviour (e.g. people who frequently change sex partners, sex tourists, prostitutes and their customers).

Furthermore, a framework has been created for the epidemiological study of HIV and AIDS, the information from which is a crucial tool in the planning and implementation of measures to combat the epidemic and to care for those affected.

In the directives contained in the AIDS Act, which were last adapted to the latest scientific findings in 1999, the quality of testing and result-transmission was regulated. In

particular, consideration was given to the recommendations of the WHO, such as “informed consent” – i.e., the consent to the examination as such – as well as to extensive and comprehensive accompaniment before and after the actual HIV test.

An important contribution to HIV prevention is provided by the associations against AIDS (referred to collectively as “AIDS-Hilfen”), which receive annual support in the amount of ca. EUR 2.5 million from the Federal Ministry of Health and Women. The ongoing information and consultation activities of these anti-AIDS associations range from carrying out anonymous HIV antibody tests and the associated advisory talks right up to the psycho-social care of HIV positive people and people with full-blown AIDS. In addition to this, they also focus on special topics (e.g. the help brochure “HIV and the Law”) and target groups (e.g. special brochures for women or for homosexual and bisexual men).

Health promotion and prevention in the area of emotional health

Emotional health is one of the most important themes of the Healthy Austria Fund. The main issue contained in the emphasis on emotional health lies in the facilitation of setting-oriented health promotion and primary prevention projects with a holistic view of health. Alongside the facilitation of projects, a campaign on the theme of “emotional health” with the slogan “Look after yourself!” was conducted in co-operation with the Federal Ministry of Health and Women. As part of this campaign, Austrians were encouraged to reinforce and care for their social and individual sources of fulfilment and happiness, as well as encouraged to resort to resource-enhancing strategies in stress situations. The idea was to support people in the development of life-concepts and life-philosophies which allow the challenges and vicissitudes of life to seem resolvable and stress situations to seem changeable.

Psycho-social and psychiatric care

About 25 percent of the Austrian population has suffered at least once during their lives from a psychic disorder, which can have wide-reaching consequences not only for the sufferer but for his or her social environment. Detriment to professional life can be seen from the high number of psychic disorders which result in early pensioning due to reduced ability to work (see Ch. 2), among other things.

In Austria, psycho-social health care is provided by a mixed system of various providers in the health and social spheres. It comprises a very wide field of services, ranging from the counselling of people on the threshold of psychological illnesses through to inpatient and outpatient care for psychiatric patients.

Since the end of the seventies, psycho-social care has seen various reforms directed against the traditional institutionalised form of psychiatric treatment, with its often life-long confinement of patients in large-scale psychiatric hospitals. Efforts are made to provide care in the municipality, which is done at the patient's home and in the surrounding environment, and to maintain or quickly restore the social integration of mentally ill people into day-to-day life. The problem of restricting the freedom of movement of mentally ill people has been the subject of new legislation in recent years, with the emphasis placed on the safeguarding of personal liberty. Patients may now be confined only when they pose a danger to physical safety. An important new institution here is the "patient advocate", who represents the patients' rights in dealings with the hospital.

With the inclusion of psychiatric care in the Austrian Hospitals Plan, a binding, nationwide psychiatry concept has been adopted for the first time (see Ch. 6). Such care, which up to now has been concentrated in specialised hospitals, is to be largely decentralised. On condition that the extramural sector is expanded through semi-inpatient, outpatient and/or complementary centres, there should be 4,311 beds at 37 locations available throughout Austria by late 2005.

Psychotherapists, clinical psychologists and health psychologists

There are also other aspects of psycho-social care which have seen central reforms in recent years. In 1991 psychotherapy was regulated by the Psychotherapy Act and clinical and health psychology by the Psychologists Act. Although no overall contract has been concluded to date between the psychotherapists and the health insurers, the costs of diagnosis and treatment of disease-like disorders are to some extent refunded by social health insurance (see Ch. 6). There are major regional differences in care.

Rehabilitation

The aims of the rehabilitation of physically or mentally ill people are to restore or improve their health, re-integrate them into society and especially into the working environment, and enable them to take their place in the community without receiving medical care. Medical, vocational and social measures to achieve these aims are provided by the social insurance legislation.

Most inpatient rehabilitative treatments are provided at the 29 specialised hospitals run by the social insurance providers. According to the Handbook of Medical Rehabilitation (Main Association of Austrian Social Insurance Institutions, 2005, 2006), these currently provide a total of about 3,800 beds. In addition, there are numerous private contract institutions providing about 1,000 beds and convalescent, spa and rest homes supplying about 11,000 beds. Especially among the private-sector facilities, which have concluded

rehabilitation service contracts with the social insurance providers, the number of beds has greatly increased in recent years.

In the outpatient sector, rehabilitation programmes are provided mainly by hospital outpatient departments, registered doctors and therapists and independent clinics.

Although many new facilities have been set up recently, especially for patients recovering from strokes, there is still a shortfall in this type of care. The main emphasis, however, is on primary preventive measures.

Care of the elderly and the infirm

The responsibility for the medical, nursing and social care of the elderly and those in need of nursing care is covered by the respective health or social services, depending on the services required. The powers granted for these matters are divided among the Federation, the provinces and the municipalities, the objective being to provide these people with a self-determined lifestyle according to their needs despite their limitations. The number of those in need of nursing care is estimated at around 560,000, and this figure is expected to exceed 800,000 within the next 20 years.

Inpatient services

As of February 2005, there were 750 senior citizens' homes and nursing homes in Austria with a total of 68,461 places. Between them, they provide 15,275 residential places, 33,996 nursing places and 19,190 residential places with nursing services available.

Assistance for the elderly in hospitals and clinics

The Austrian Hospitals Plan (ÖKAP, see Ch. 4, and the Austrian Health Care Structural Plan [ÖSG]) provides for the set-up of geriatric rehabilitation departments in all larger hospitals, as well as geriatric day-centres, the latter of which are only slightly established in rural areas.

Hospice and palliative care

Hospice and palliative care aim to improve the quality of life for terminally ill and dying patients and their loved ones. In the new agreement in accordance with Art. 15a of the Federal Constitution Act on the organisation and financing of the health care system, the Federation and all federal provinces have reached agreement on the uniform planning and implementation of multi-level care in the palliative and hospice areas which offers complete geographic coverage and is equal nationwide.

Since 1 July 2002, the introduction of family hospice leave has given all employed persons in Austria the opportunity to adapt their work schedules for the care of seriously ill or dying family members. Both the reduction of working hours and complete leave (sabbatical) are legally possible. During this period, the persons providing care enjoy both complete health and pension insurance coverage and job protection. In situations of financial emergency, support is provided in the form of either family hospice leave equalisation payments ("Familienhospizkarenz-Härteausgleich") or nursing benefits ("Pfelgegeld").

Mobile services

80 percent of all those requiring nursing care are treated at home. The use of mobile nursing and social services in private households is intended to allow them to maintain their living situation.

The specific objectives of these services are:

- Preventing or delaying the need to enter an old people's or nursing home
- Avoiding unnecessary hospital stays
- Reducing the duration of hospital stays
- Relieving the burden on relatives
- Helping to reduce costs in hospital care and in homes

The provinces and municipalities are responsible for setting up the infrastructure.

The most important services are:

- Home nursing care (nursing service)
- Home help (help in the household, simple nursing services)
- Meals on wheels
- Escort or transport services

According to the 2003 Report on the Disabled, around 17 percent of nursing benefits recipients take advantage of home help, 23 percent use transport services, and 14 percent make use of meals on wheels.

Organising the mobile services is the responsibility of the provinces, for which reason there is no nationwide reporting facility for documenting the number of persons involved. According to the latest surveys, there are about 7,810 full-time (or equivalent) nursing and care personnel, as well as a great many part-time workers in outpatient services available. This means that the coverage density is at 13.4 persons per 1,000 inhabitants over age 75. Offerings are distributed fairly unevenly, however: coverage

density lies between 21 full-time persons per 1,000 inhabitants over 75 in Vienna, while it is only 6.1 in Upper Austria. By the year 2010, the coverage density in all provinces should equal a minimum of 13.6 persons per 1,000 inhabitants over age 75 (Source: Expansion of Services and Facilities for Persons Requiring Care in Austria—Progress Report, ÖBIG, 2004).

Care of the handicapped

There are 384 day-care facilities for the mentally handicapped and people with multiple disabilities, making for altogether 10,222 places—one-third more than during the nineteen-nineties. This means a service density of approximately 18.1 places per 10,000 inhabitants, which covers the demand which has been estimated for 2010. The area of assisted living encompasses around 8,400 places in 447 facilities.

Co-ordination of the transplant system

The provision of organ transplants in Austria is among the best in Europe. One important factor in this situation has been the guaranteed reimbursement of hospitals for the costs of obtaining donor organs, introduced in 1993. A co-ordination office was set up at the Austrian Health Institute (ÖBIG) as long ago as 1991 to improve the transplant system in Austria. The aim is to encourage the exchange of information and data, documentation, analysis and planning work, and to ensure that resources are distributed where they will do the most good and are regularly available, as well as to create favourable economic and organisational conditions.

In 2004 the Austrian transplant centres carried out 388 kidney, 132 liver, 62 heart, 76 lung and 41 pancreas transplants, as well as one heart-lung transplant.

The laws in Austria allow the removal of organs from deceased people in order to save the life of another person or restore a person's health. The approval of the organ donor—or his or her relatives—prior to death is not required by law. Even so, the hospital removing the organs does indeed inform and attempt to obtain the agreement of relatives. In any case, removal is not permitted when the doctors are furnished with a declaration expressly prohibiting the removal of organs. For this purpose, the ÖBIG has been keeping a central “objections registry” against organ removals since 1995. This register is consulted by the doctors prior to removing organs. Inclusion in this register is open to citizens from all countries.

The ÖBIG Poisoning Information Centre

The Poisoning Information Centre (Vergiftungsinformationszentrale–VIZ) is a telephone advising service available 24 hours a day, seven days a week, which performs various services in connection with risk evaluation, prevention, diagnosis and specialised advising concerning medical treatment of patients with both acute and chronic cases of toxicological illnesses. It was established in 1974 as a facility of the First Medical Clinic at Vienna General Hospital, to which it belonged until the end of 1991. Since 1978, the VIZ has also been part of the Austrian Health Institute (ÖBIG).

The duties consist partly of informational services by telephone, which are performed mainly by specially schooled medical personnel and/or toxicologists. The other part, the task of documentation, includes the electronic logging of consulting cases with corresponding evaluations, as well as the collection and archiving of current specialist literature.

Of the ca. 22,000 consultations provided annually, around half concern concrete incidents involving human beings. Nearly half are related to poisoning with pharmaceuticals, with a third related to chemical products (household chemicals, particularly detergents and cosmetics). The remainder concerns substances including plant matter, food-stuffs and alcohol (Source: Poisoning Information Centre, ÖBIG).

Ambulance services

Ambulance services are a provincial matter and are organised by the municipalities within their own sphere of responsibility. With the exception of the municipality of Vienna, which operates its own ambulance services, the ambulance service is provided not by the municipalities as such, but by recognised first-aid organisations under their instructions.

The most important organisations providing ambulance services in Austria are the Austrian Red Cross and the "Arbeiter-Samariterbund Österreich" (ASB–Austrian Workers Samaritan Association). In addition to these, there are other organisations distributed variously throughout the country, such as the Maltese Hospital Service (Hospitallers), the "Johanniter" (St John's Ambulance) and others. Smaller companies as well, such as the Green Cross, may enter into ambulance service contracts with the municipalities. The Austrian Red Cross is the most important organisation with respect to both the number of deployments and the number of ambulance stations.

With the exception of the ambulance service of the municipality of Vienna, which is provided exclusively by professional staff, all other organisations have a high proportion of

volunteers. In addition, most first-aid organisations in Austria also make use of conscientious objectors doing alternative service.

In addition to the more than 1,300 vehicles of the ambulance services, which are operated by non-medical staff, more and more vehicles for emergency doctors are being operated. With a total of 14 sites, the provision of emergency helicopters can be regarded as nation-wide.

The Austrian Mountain Rescue Service and the Austrian Water Rescue Service are independent organisations which are staffed almost exclusively by volunteers. Some of the duties of water rescue are also assumed by local rescue organisations.

The funding of ambulance service takes different forms in the various provinces. The cost of the service is paid both by the patients using it and by their social insurance. On the other hand, most provinces and municipalities contribute to funding by the so-called per capita charge.

Specific statutory legislation

The Narcotics Act

Austrian drug policy differentiates between drug trafficking and drug dependency, and pursues corresponding balanced and comprehensive solution strategies in harmony with international and supranational guidelines. Dependence on psychoactive drugs is viewed as an illness, and addicts have access to a diverse array of health-related measures including social integration assistance. This also applies to the area of illegal drugs. The Narcotics Act adheres to the principle of “therapy over punishment”, which means that health-related measures are given priority over punishment with regard to drug-related delinquents. Addiction prevention (see Ch. 4) is given special attention.

Over the past few years, counselling and therapy offerings have been expanded and abstinence-oriented therapy offerings have been complemented by substance-substituting and addiction-accompanying measures. Both treatment with substitutions and abstinence-oriented therapy are anchored in the new Narcotics Act. Alongside medical measures, the Narcotics Act also provides for clinical-psychological, psychotherapeutic and psycho-social assistance as “health-related measures” in cases of narcotics abuse or dependence.

Food labelling

The Austrian Food Act is from the year 1975. On the basis of this law, a multitude of directives—having to do with things such as preservatives, drinking water and fruit juices—have been issued.

The most recent significant amendments to the Food Labelling Directive, which were publicised in April 2005, have to do with:

- The labelling of allergens:
In order to protect the health of consumers who suffer from allergies (or intolerances), rules were adopted according to which certain, taxatively listed ingredients, must always be declared—e.g., even when a prepared food contains them only in trace amounts.
This includes gluten-containing grain, eggs, shellfish, fish, peanuts, soy, milk or certain fruits and their derivatives as well as the additive sulphur oxide, when it is present in concentrations exceeding ten milligrams per kilogram.
- More precise general declaration of ingredients:
Current food labelling laws contain the obligation to list all ingredients used in the production of a food, with some exceptions.
A significant simplification so far has been the opportunity to omit the declaration of components of prepared ingredients which make up less than 25 percent of the final product (e.g. the ingredients of a sausage used in making a pizza need not be declared). Due to changes in food production, which is growing ever more complex, and to consumption habits over the past few years, with the increasing demand for prepared foods, the desire of consumers for complete information has also increased.
In order to do justice to this fact, the “25-percent rule” was changed to limit the exception to those prepared ingredients which amount to no more than two percent of the final product, and which composition is defined in a European Community regulation.

The entire area of food law is currently undergoing re-formulation in accordance with EU law.

The Act on Reproductive Medicine

The Act on Reproductive Medicine (Fortpflanzungsmedizingesetz) was passed in 1992 in Austria, and has since been expanded several times.

The following are permitted:

- Artificial insemination, in vitro fertilisation (IVF) outside of the mother's body for married couples and partners living in a stable relationship for not less than three years.
- Insemination by a third party who is not permitted to charge any money for the service.

Sperm and egg cells, as well as and testicular and ovarian tissue, may only be stored subject to the consent and until the death of the person from which they were taken. Cells capable of further development may only be stored at the consent of the woman from which they were taken, or until the death of one of the husbands or life partners, but for a maximum period of ten years.

The following are prohibited:

- Donation of an ovum by an unknown woman,
- Medically supported procreation with the semen of a deceased husband or spouse in order to avoid inordinately large age-gaps between generations,
- The artificial insemination of single women or couples of the same sex,
- The (commercial) procurement of semen, ova, cells capable of development and surrogate mothers.

In order to make things easier for affected couples desiring children, a fund for the financing of in vitro fertilisation was established in 2000. The financial means come from the Family Burden Equalisation Fund ("Familienlastenausgleichsfonds"-FLAF), the social health insurers, health care institutions and private insurers. If the appropriate prerequisites (such as certain biological causes of infertility, age limits) are met, this fund will assume 70 percent of the costs for a maximum of four IVF attempts.

Statutory legislation and EU law on Genetic Engineering

Two EU directives apply to genetic engineering. These were transposed into Austrian law in 1994 by the Gene Technology Act, the Ordinance on Work with GMOs (Genetically Modified Organisms) in Contained Use, the Ordinance on Deliberate Release of GMOs into the Environment and the Ordinance on Public Hearings. In February 2001, the European Parliament adopted a new directive on the deliberate release of GMOs, containing among other things uniform criteria for assessing the risks of possible effects of genetically modified organisms on the environment; it was to be implemented by all member-states by October 2002. The strictness of the new directive's provisions is intended to restore European consumers' trust in the safe application of genetic engineering in the agriculture and food-production sectors. In Austria, this directive was implemented via the Amendment to the Gene Technology Act, BGBl. I No. 126/2004.

For genetically modified food and feed, the Regulation (EC) 1829/2003 entered force in April 2005. This regulation mandates a special approval process for all food and feed made of genetically modified organisms, and a strict labelling of all these products as “genetically modified”.

The Gene Technology Act

The Gene Technology Act is primarily a piece of safety legislation and is intended to guarantee a high level of safety for human and health and the environment where genetic engineering is used. It regulates, among other things:

- Contained use of genetically modified organisms (GMOs)
- The releasing of GMOs and the marketing of products containing GMOs
- The establishment of the Advisory Board on Biotechnology and Genetic Engineering (together with its scientific committees), which advises authorities and reports on such matters as applications for approval

Initiated by the plebiscite on genetic engineering and the discussion of release of GMOs in Austria, the 1998 gene technology amendment extended parties' rights in release proceedings and introduced specific liability provisions. With the 2004 amendment to the Gene Technology Act, further liability provisions were concluded for the protection of gene-technology-free and organic farming.

The most important legal regulations concerning the application of genetic engineering in medicine are:

- Interference with the human genome is strictly prohibited (see also the Act on Reproductive Medicine).
- Molecular genetic testing (MGT) may only be carried out on humans by order of a doctor to determine a disease risk or the danger of transmission of a hereditary disease. Furthermore, it is permitted to diagnose a disease and to prepare a therapy and monitor the progress of the therapy. Molecular genetic testing requires the written approval of the affected person and may—in the case of predictive MGT—be carried out only by institutions that are authorised to do so. Furthermore, special consulting and informational service and stricter data protection are provided for.
- Absolute anonymity must be ensured for MGT for scientific purposes. Moreover, the use of MGT data for employment and insurance contracts is expressly prohibited.
- Somatic gene therapy, i.e. the correction of defective genes in individual patients, is permitted. However, it must be carried out by a doctor in a hospital approved for this purpose.

The Medical Products Act

The Medical Products Act, which came into force on January 1, 1997, transposes three EU Directives into national law, thus regulating not only the licensing and marketing but also the professional use, maintenance and clinical testing of medical products in Austria. The concept of medical products is a broad one, covering medical equipment, such as nuclear resonance scanning and X-ray equipment, medical implants (both active ones such as heart pacemakers and inactive ones such as hip prostheses), medical requisites such as syringes and infusion equipment, medical aids for the handicapped (such as wheelchairs and prostheses), in vitro diagnostic agents and medical laboratory equipment, as well as a multitude of medically important products such as contact lenses, spectacles, blood-pressure gauges, hearing aids, bandages, pregnancy test kits and condoms.

The Federal Ministry of Health and Women monitors the safety and effectiveness of medical products and steps in to protect patients if there is an indication that products are deficient or dangerous.

The Employee Protection Act

The protection of employees in Austria is statutorily governed by the Federal Act on Safety and Health Protection in the Workplace (Employee Protection Act [Arbeitnehmer/innenschutzgesetz–AschG]), which has been in force since January 1, 1995. The starting point for the renewal of this legislation was Austria's accession to the EU and the resulting need to adjust to EU employee protection regulations. Up to this time the medical care of employees at work was mandatory in Austria only for companies with upwards of 250 employees; since January 1, 2000, every workplace with even only one worker has been required to assure preventive services which help to minimise both workplace accidents and occupation-related physical and mental stress.

For the work of preventive services in larger workplaces (over 50 employees), time contingents have been established that must be dedicated to workplace medical and safety-related prevention efforts. The amendment to the Act, which entered into force on January 1, 2002, introduced a workplace-related gradation system which established various prevention time contingents according to the given risk and stress situation for the workers concerned: the factor 1.2 hours per worker and per year applies to office workplaces and those with similar levels of strain (slight physical exertion), while the factor 1.5 hours per worker and per year applies to all other workplaces. An additional prevention time contingent of 0.5 hours per worker and per year is added for those who regularly work night shifts (but not heavy night work in the sense of the Heavy Night Work Act). In smaller workplaces, prevention specialists must make regular inspections.

The obligation to appoint safety specialists and occupational doctors can be filled by employing in-house or external specialists and doctors, or by using a safety centre or (in the case of smaller workplaces) the prevention centres of the Austrian Workers' Compensation Board (AUVA). According to the degree of danger or stress, the employers must also make use of other suitable specialists such as chemists, toxicologists, ergonomists and occupational psychologists.





5 Professions in the Public Health Services

Medical doctors

According to the Austrian Medical Practitioners Act the practice of medicine, i.e. any activity based on medical and scientific findings which is carried out directly on a person or for a person (examination, diagnosis, treatment, prevention, etc.), is restricted to doctors.

Accordingly, no provision is made in Austria for professions such as non-medical practitioners, acupuncturists or the like. This has also not changed since Austria's membership in the EU.

In 2004 there were 38,422 doctors in Austria. 11,716 of these were general practitioners (specialists in general medicine), 16,426 specialists, 4,106 dentists and 6,174 "Turnusärzte", i.e. doctors completing postgraduate hospital residencies (Source: Austrian Medical Chamber).

The number of doctors authorised to practice has more than doubled since 1975. The trend is clearly towards specialisation. Whereas the number of medical specialists has almost trebled in the last 25 years, the number of general practitioners has risen considerably more slowly.

Table: Change in the number of medical doctors in Austria, 1975-2004 (each figure as of 31 Dec.)

Year	Doctors completing residencies	General practitioners	Medical specialists (incl. dentists)	Total
1975	3,145	5,506	7,202	15,853
1985	5,269	6,781	9,671	21,721
2000	5,585	10,939	18,069	34,593
2004	6,174	11,716	20,532	38,422

Source: Austrian Medical Chamber

Coverage density of medical doctors

The coverage density of doctors showed a clear upward trend until 1998, after which this growth began to recede slightly. Even so, figures published by the OECD show Austria ranking above average, with 2.9 doctors per 1,000 inhabitants (as of 2004). Countries with more doctors available included Italy (4.4/1,000, as of 2002) and Belgium (3.9/1,000), while there were fewer doctors available in Great Britain (2.1/1,000).

Table: Change in coverage density of medical doctors in Austria, 1960-2004

Year	Inhabitants per doctor
1960	714
1980	625
1990	455
1998	333
2002	330
2004	289

Source: OECD Health Data, Austrian Medical Chamber

In 2004 there were a total of 18,670 employed medical doctors, which included 6,174 "Turnusärzte" in hospitals or in teaching practices and outpatient teaching clinics to complete their training as general practitioners and medical specialists.

Austrian doctors have their own representative body in the form of the "Österreichische Ärztekammer" (Austrian Medical Chamber) which is subdivided into nine provincial chambers. Every doctor is required to be a member. The main duties of the Medical Chamber include, among others, statements of opinions on proposed legislation which affects doctors, the representation of doctors in negotiations (e.g. with the social health insurance board) and the administration of an internal pension fund.

Training of doctors

The training of medical doctors is divided into two parts—university studies and practical training. With the University Act of 2002, the medical faculties of the Universities of Vienna, Graz and Innsbruck were spun off and re-established as separate, legally independent Medical Universities. At the same time, new curricula were introduced which are, altogether, more practically oriented than in the past.

The first part of training entails the completion of a Human Medicine or Dental Medicine degree at one of the three Medical Universities (minimum duration: 12 semesters; average duration: 15.5 semesters), at which end a diploma thesis must be written.

In the 2004/2005 academic year, 2,416 individuals began studying medicine, and 2004 saw 1,581 receive the title of doctor of human medicine and 167 that of dental medicine. The attainment of the doctor title is a prerequisite for beginning the second part, a three-year general medical internship or a six-year internship in the desired specialisation (44 areas of specialisation). As part of the practical training ("Turnus") for general medicine, the requirement since the beginning of 1995 has been for at least six months in institutions of primary medical care (teaching practices, outpatient teaching clinics, outpatient departments), with the rest of the time served in hospital departments. In order to attain the right to practice independently ("ius practicandi"), doctor's examinations are required. For all doctors who began their post-promotional training before 1 January 1997 and will finish before 31 December 2006, such examinations are not required. This exception does not apply, however, to persons who attained the right to practice independently in a foreign country and thus have a maximum of three years' permission to practice the medical profession as a general practitioner, specialist or dentist, employed in hospitals or correctional facilities.

Medical doctors from the EU are also admitted to post-graduate practical training in Austria. However, there are long waiting lists for Austrians as well as for EU citizens.

Health care and nursing professions

Health care and nursing occupations are regulated by the Health Care and Nursing Act with regard to vocational patterns, areas of activity, vocational obligations and education. Health care and nursing careers are comprised of the professional health care and nursing service and the assistant nursing service.

Professional health care and nursing service

The professional health care and nursing service is the care aspect of the health-promoting, preventive, diagnostic, therapeutic and rehabilitative measures to preserve or restore health and prevent illness. The service encompasses the care and supervision of people of all ages suffering from physical and psychological diseases, people with handicaps, and the seriously and terminally ill, as well as care-giving participation in rehabilitation, primary medical care, health-promotion and the prevention of illnesses in the intramural and extramural fields, including participation in diagnostic and therapeutic treatments ordered by a doctor. Depending on the area of activity it may be practised

on a basis of independent or shared responsibility or take an interdisciplinary form, and it includes qualified health carers and nurses, qualified paediatric nurses/child carers and qualified psychiatric health carers and nurses.

For what is known as the extended area of activity (for example, as a teacher of health care and nursing, intensive care or hospital hygiene), additional special training is required. Nurses can practise on a self-employed basis or may be employed, for example, by hospitals, doctors or home nursing services.

Training in general health care and nursing is provided at nursing schools, lasts three years (at least 4,600 hours) and is intended to provide the necessary theoretical and practical knowledge and skills. Applicants must have completed the tenth grade in school, must demonstrate the necessary physical and mental aptitude, and must be trustworthy. Training ends with a diploma examination.

Courses in paediatric health care and in psychiatric health care and nursing are provided either as specialised basic courses or as advanced courses following basic training in general health care and nursing. The specialised basic courses are given at specialist schools for the care of young people and children and for psychiatric health care and nursing, last three years and comprise at least 4,600 hours of theoretical and practical training. The advanced training courses in these disciplines take at least one year and include 1,600 hours of theory and practice.

Other subjects in which this choice exists between advanced courses following basic training in general health care and nursing and specialised basic courses include intensive care (and paediatric intensive care), anaesthesia nursing, care of kidney replacement therapy patients, post-operative care, hospital hygiene, and for teaching and management duties. In every case the training ends with a board examination, for which diplomas are awarded.

Assistant nursing service

The assistant nursing service provides assistance to the professional health care and nursing service in caring for patients in need of nursing, and assistance to doctors. The care may be provided only at the instructions and under the supervision of members of the professional health care and nursing service and/or doctors. The theoretical and practical training lasts one year and a total of 1,600 hours. It takes the form of an assistant nursing course at a hospital or a facility run by a district authority that provides home nursing services, and can be followed within an employed relationship. Candidates must have reached the age of at least 17, have successfully completed their general compulsory schooling and be mentally and physically suitable. After completion of the training course a board examination is taken, for which a certificate is awarded.

Medical-technical services

The medical-technical services comprise the higher medical-technical professions and the medical-technical service.

Higher medical-technical professions

The higher medical-technical professions, which are regulated in the Federal Act on Medical-Technical Services (MTD Act), include:

- Physiotherapists (application of all physiotherapeutic measures taking into consideration functional connections with the areas of health education, prevention, therapy and rehabilitation)
- Biomedical scientists (execution of all laboratory methods within the areas of medical examination, treatment and research)
- Radiology technologists (execution of all radiological-technical measures involved in the use of ionising rays)
- Dietitians (selection, composition and calculation as well as instruction and monitoring in certain types of diet for the feeding of ill or possibly ill persons, including counselling),
- Occupational therapists (treatment of the ill and the disabled via crafts and other creative activities, self-help training and the creation/implementation of and instruction in the use of auxiliary devices for the purposes of prevention, therapy and rehabilitation),
- Logopedics (logopedic examination and treatment of speaking, language, voice and hearing difficulties, as well as audiometric examinations),
- Orthoptists (implementation of prophylactic measures as well as the examination, analysis and treatment of sight problems, myopia, otherwise poor sight and problems with ocular motion).

Training for these occupations takes place at medical-technical academies, or as part of medical-technical college baccalaureate courses of study. Completion of the Austrian "Matura" school-leaving examination or foreign equivalent is a prerequisite for training at medical-technical academies. This training takes three years and concludes with a diploma or baccalaureate degree awarded upon successful completion of a board examination.

The activities must be carried out self-responsibly at a doctor's instructions, although practitioners of some occupations may consult with and advise healthy patients without a doctor's instructions. The occupation may be practiced on a freelance or employed basis.

Medical-technical service

The medical-technical service, peculiar to Austria, is a three-pronged group of medical-technical occupations regulated in the MTF-SHD Act. It encompasses the execution of simple medical-technical laboratory methods, simple physical treatments and the provision of assistance in the use of X-rays, only at a doctor's instructions and under his or her supervision. Training is provided at medical-technical schools, lasts 30 months and again ends with a diploma.

Auxiliary health professions

Alongside the professional medical-technical service, altogether six auxiliary health professions are regulated by the MTF-SHD Act. The auxiliary health professions encompass the occupations of operating theatre assistant, laboratory assistant, mortuary assistant, doctor's assistant, occupational therapy assistant and disinfection assistant, which may only work according to specific instructions and under supervision. Training takes place in courses with 130 to 135 hours of teaching, which are completed with examinations before a commission.

Cardiotechnical service

The increase in technology in the heart-surgery sector, especially as regards extracorporeal circulation, has led to the development of a highly-specialised professional group of cardiotechnicians. The profession and corresponding training were regulated in 1998 via the Federal Act on Cardiotechnical Services. Training lasts 18 months and takes place in conjunction with employment at a hospital. Prerequisites include a diploma in radiological-technical services and/or medical-technical laboratory services, or a trade license in professional health and nursing services, as well as graduation from training in either intensive nursing or anaesthetic care.

Medical masseurs and therapeutic masseurs

The occupations of medical masseur and therapeutic masseur have been regulated by their own law since 2002. It encompasses classical massage, the use of packs, thermal and ultrasound therapy and special massages such as lymph drainage, for the purpose of treating illness. The applications may only be performed according to a doctor's instructions. Training to become a medical masseur lasts 1,690 hours; aspirants must be at least aged 17, have successfully completed their ninth year of schooling, and be trustworthy and physically and mentally suited to the job. Training to become a therapeutic masseur lasts

an additional 800 hours, with occupational training as a medical masseur as a prerequisite. Blindness is not a reason for exclusion from training, but blind masseurs are limited to the practice of classical and special massages. Furthermore, there exists the opportunity to train for special qualifications in electrotherapy and hydro- and balneotherapy. Therapeutic masseurs are permitted to practice independently.

Midwives

The occupation of midwife is regulated in the Federal Act on Midwifery. Activities include supervising, advising and caring for pregnant women before, during and immediately after delivery, attendance at the birth and participation in the care of mother and baby. Midwives can practise on a self-employed basis or be employed by, for example, a hospital or a doctor.

Training takes place at midwifery academies or as part of a college baccalaureate degree. Completion of the Austrian "Matura" school-leaving examination or foreign equivalent is a prerequisite for training at midwifery academies. This training takes three years and ends with a board exam and diploma or a board baccalaureate exam and baccalaureate degree.

Emergency medical service

Since 2002, the occupation of emergency medical technician has been regulated by its own law. Emergency medical technicians may do their jobs voluntarily, professionally or as soldiers in the Federal Army, as part of their alternative public service or as civil servants. The duties of rescue emergency medical technicians (first level) encompass the independent and self-responsible treatment and supervision of individuals who are ill, injured or otherwise in need of assistance before and during transport, as well as the qualified use of primary lifesaving techniques. Emergency medical technicians (second level) also support doctors in all emergency and catastrophe-related medical activities, and administer the required medications.

Training as an emergency medical technician takes place in two modules and lasts 260 hours for rescue emergency medical technicians (first level), and an additional 480 hours for emergency medical technicians (second level). In order to be a professional emergency medical technician, further training in general and specialised emergency skills and an additional professional module must also be completed. Aspirants must be at least 17 years old, have successfully completed their compulsory schooling, and be both trustworthy and physically and mentally suited to the job.

Total number of people in non-medical occupations

The number of people exercising a non-medical profession in the health field can only be estimated, since there is no registry of those involved in these professions in Austria. One exception is that of midwives, who are represented by a mandatory representative body (the Austrian Midwives' Association). Only the number of those in training and/or those persons employed in hospitals is contained in the documentation. At the close of 2003, over 75,000 people were employed by hospitals in the occupational areas of professional health and nursing services, auxiliary health and nursing services, professional medical-technical service, auxiliary medical-technical service and paramedical service as well as 1,134 midwives (Source: Statistics Austria).

Table: Development of the non-medical staff in hospitals, 1970-2003

Year	Professional health care and nursing service	Medical-technical services	Emergency medical service	Assistant nurses ¹	Midwives
1970	14,682	2,014	7,467		641
1980	22,186	3,445	13,114		826
1990	30,842	5,896	17,003		801
1999	45,071	8,636	5,248	11,140	1,553
2003	47,687	9,534	5,143	10,824	1,134

Source: Statistics Austria

EU-recognition of qualifications

Diplomas, examination-grade certificates and other evidence of professional capability on successfully completed courses in general nursing or midwifery taken within a contractual country in the Treaty on the European Economic Area are recognised in Austria on the basis of individual EU sectoral guidelines. The European Union's general recognition guidelines apply to all other professions.

¹ Replacing ward-assistants since 1998, previously included in paramedical health services

Psychotherapists, clinical psychologists and health psychologists

At present (status: June 2005) 5,861 psychotherapists, 4,413 clinical psychologists and 4,395 health psychologists are practising in Austria. Training as a psychotherapist is provided for under the Psychotherapy Act and covers two areas: general training ("preliminary psychotherapeutic instruction") consisting of a minimum 765 hours of theory and 550 hours of practice, and training in scientific-therapeutic method, covering a minimum 300 hours of theory and 1600 hours of practice. Only a portion of all psychotherapists practise their profession exclusively on a freelance basis; most are salaried employees.

Training for the professions of clinical psychologist and health psychologist is founded in the Psychologists Act; graduation from a senior (college-level) school in psychology is a prerequisite. The course requires a minimum 160 hours of theory and 1480 hours of practice in subject-relevant facilities. 88.5 percent of all clinical and health psychologists practising in Austria have completed both types of training, and 51 percent of these are also psychotherapists. The professions can be practised both on a freelance basis and under a work relationship with an employer.

The majority of clinical and health psychologists have set up their practices in urban areas; coverage density in the individual provinces varies greatly.

Pharmacists

In the whole of Austria there are about 12,831 people working in pharmacies, and some 4,623 of these are trained pharmacists (as of 2003, source: Austrian Chamber of Pharmacists). The proportion of women is about 76 percent. Training is regulated in the University Studies Act, the Pharmaceutical Personnel Regulations and the Pharmacists Act, and is divided into several sections. The first stage is the study of pharmacy at one of the three science faculties (Graz, Innsbruck and Vienna). The minimum course length is nine terms, and the average is about 14.5 semesters. After obtaining a scientific degree, the final examination results in the title "Master of Pharmacy". Having passed a board examination at the end of the aspirant year, candidates become associate pharmacists. After another five years' full-time employment, a pharmacist becomes qualified to run his own pharmacy.





6 Social Security Services, Costs and Financing

The social security system

The system of social security in Austria is a public welfare system including legal measures to ensure a basic standard of living and provide health services in the following cases:

- Illness
- Invalidity
- Maternity
- Unemployment
- Old age
- Death of a person obligated to pay financial support

Furthermore, the Austrian social security system provides support for the permanently handicapped, and since 1993 it has paid money to people requiring permanent care and in need of help (nursing benefits—"Pflegegeld"). The amount of these payments depends on the degree of the handicap or the extent of the nursing needs.

The Austrian social insurance comprises the branches of health insurance, accident insurance and pension insurance. The implementation of social insurance is ensured by separate corporate bodies—the so-called social insurance institutions. Currently there are 17 health boards and seven insurance institutions, of which some cover two or all three fields of social insurance. The structure, both by region and by professional groups, has evolved historically. All insurance carriers are combined in the Main Association of Austrian Social Security Institutions, their umbrella organisation.

Social insurance is financed by the contributions of the insured people and, in the case of employees, by their employers. The insured people's income is used as a basis for calculating the insurance contribution, which only applies up to an annually determined top threshold. It is currently (2005) at EUR 3,630 gross per month for employed workers and at EUR 4,235 for freelancers and farmers.



The individual parts of the social security system comprise:

Social insurance

This is a compulsory form of insurance based on the solidarity principle. It is linked in particular to gainful employment, but there are also regulations for old-age pensioners and unemployed people. Self-insurance for those who do not work is possible. An income-oriented contribution system enables benefits to be provided for people who are economically at a lower level. The insured people have a legal entitlement to social insurance benefits. They are financed predominantly by the income-dependent contributions. The individual social insurance providers administer themselves and are coordinated by a central institution, the Main Association of Austrian Social Security Institutions. The individual subgroups or providers are formed by the provinces, professional groups and individual enterprises. Supervision of health and accident insurance institutions is the responsibility of the Federal Ministry of Health and Women.

Unemployment insurance

This insurance is a compulsory form of insurance which provides money, support and advisory services in case of unemployment. Unemployed people are also insured in case of illness.

Social care

This is funded exclusively from tax funds and provides support for people who have suffered from damage by war, political persecution or as a victim of crime.

Social assistance

This forms the safety net of the welfare state and protects people who cannot be helped by other social security systems. It falls within the competence of the provinces.

Health risks and their coverage by services of the social security system

Social health insurance

The coverage provided by statutory health insurance extends not only to the insured himself but to members of his family such as children and spouses or partners, provided they do not pay health insurance contributions in their own names. About two thirds of

those with health insurance pay contributions, while the remainder receive free coverage as family members (e.g. children) and/or, since 2001, if they are co-insured by an additional contribution in cases regulated by law. As a result, 98 percent of the population is covered by statutory health insurance.

Statutory health insurance is organised according to vocational groups and regional aspects, with some very wide variations in arrangements.

Health insurance provides the following benefits:

Medical aid

In case of illness, the insured person can visit any contracting doctor of his insurance carrier. In this case the fee is paid by the insurance provider; an annual co-payment of EUR 10 is charged to cover the costs of the E-card (see also chapter 4). The patient also has the option of consulting a doctor who is not in possession of a contract ("aid by doctors of choice"). In such cases, the health insurance fund will reimburse 80 percent of the amount which would have been paid by the insurance provider to a contracting doctor if he had been visited. The individual providers of health insurance may, however, lay down in their conditions that—unless total geographic coverage with doctors is provided—100 percent of the usual contracting doctor's fee will be repaid.

The health insurance scheme for civil service employees, self-employed people and farmers generally requires a co-payment.

The treating doctor is free to choose the therapy (within certain economic constraints) and can refer the patient to a specialist, an outpatient clinic or a hospital.

Medications

Medications prescribed by the doctor in observance of the Guidelines on Economic Prescribing of Medications and Medical Equipment, as well as the Code of Reimbursement, can be obtained at every pharmacy at the expense of the health board. The patient must pay a deductible of EUR 4.45 per packet. Medications for notifiable infections are exempt, as are people in need.

Hospital care

In case of need, every insured person has the right to hospital care without any time limitations as long as the illness requires it. There are two classes of fees in Austrian hospitals, a general and a special one. The insured person must pay a small contribution

towards the general fee class per day, which differs for each insurance carrier and in each province and currently (2005) amounts to between EUR 8 and EUR 15. This cost contribution only has to be paid for a maximum of 28 days per year, and it need not be paid at all in special cases, such as childbirth. In the special class the health board will pay a nursing fee compensation, which amount differs for each hospital. All other services must be paid for by the patient himself or by his private supplementary insurance, if he has one.

Home nursing services and midwives

Since 1992 certain medical and nursing services in the household sphere of the insured person which are ordered by a doctor have been covered by health insurance. The services are provided by trained nursing staff and relate in most cases to administering injections, dressing of wounds and special diets.

Since 1997 the services of self-employed midwives have also been re-included in a general contract and are therefore paid for by the health insurance funds.

Psychotherapy and clinical-psychological diagnosis

Since 1992 psychotherapy and clinical psychological diagnosis have been obligatory benefits provided by social health insurance. Whereas a general contract with the social health insurance fund covering clinical-psychological diagnosis has existed since 1995, so that this benefit can also be provided by fund psychologists at fund cost, only contributions are paid at present towards the cost of psychotherapy services provided. Evidence that a doctor has been consulted must be produced at the second psychotherapy session or before. The amount of the financial contribution is currently EUR 21.80 plus VAT per psychotherapeutic session.

Furthermore, the individual provinces have variously designed, additional forms of financing through the public health insurers: direct financing on the basis of contracts with the providers, in the form of currently seven collective "association solutions" through psychotherapeutic provider associations in the provinces of Burgenland, Lower Austria (two associations), Upper Austria, Tyrol and Vienna (two associations). In certain cases, psychotherapy by independently practicing psychotherapists who have contracts with social health insurers is also financed. Additionally, there exist psychotherapeutic care offerings in the health insurers' own facilities, as well as indirect financing via public-sector contributions to (co-)providers. (Source: Psychotherapy with Patient Certificates. Description and Evaluation of Implementation to Date, ÖBIG 2004).

Altogether, social insurance spent EUR 42.7 million for psychotherapy in 2003 (1999: EUR 27.3 million).

Services of the medical-technical professions

Since treatments performed by the medical-technical professions are equal to those performed by medical doctors, physiotherapeutic, logopedic and occupational therapy services are also covered by health insurance as long as they are performed according to a doctor's prescription. If the provider performing the service does not have a contractual relationship with a social insurer, 80 percent of the sum that would have been required for the services of a contract partner of the social insurer are reimbursed by the health insurer—the same arrangement as with “doctors of choice”. The addition of these services to health insurance coverage is meant to ensure outpatient treatment following hospital stays (as, for example, in the case of stroke patients)

Health insurance is increasingly taking on responsibilities that fall under the field of preventive health measures and illness prevention:

Mother-Child Medical Card examinations

Since 1974 the examination programmes for pregnant women and infants have been among the services provided by health insurance (see Chapter 4). The standardised programme provides examinations of pregnant women and children up to the 62nd month of life. The service is offered free of charge.

Health examinations and preventive medical check-ups

The contracting doctors of the health insurance providers and contracting institutions such as hospitals, medical-diagnostic laboratories and OPDs owned by the health insurance providers are available for the medical check-ups paid for by social health insurance. Every insured person can take advantage of various sorts of health examinations and consulting (see Chapter 4).

In addition to the services provided in kind, health insurance also pays cash benefits in certain cases:

Travel and transport costs

Health insurance will reimburse costs for travel and transport to the nearest contracting doctor if the distance involved is very long or if, owing to the patient's health condition, the use of public transport would be inadvisable or unreasonable. The same applies for transport to and from hospitals.

Grants for prosthetic materials and auxiliaries

Ten percent of the costs of such items (in the case of some insurers, it is 20 percent), but a minimum of EUR 24.20 must be paid by the insured parties. The co-payment for glasses and contact lenses is at least EUR 72.60, for orthopaedic shoes EUR 72.67. Exempt from such co-payments are children under the age of 15 and the financially needy.

Sickness benefits payments in cases of occupational disability through illness

A claim to sickness benefits payments exists for employed people in cases of temporary occupational disability which is caused by an illness. The claim exists after the fourth day of illness up to not more than 52 weeks of illness. The amount of the sickness benefits is based on one's most recent income up to the top contribution threshold and is 50 percent of the same up to the 43rd day, after which it is 60 percent. However, sickness benefits are suspended for as long as the sick person continues to receive his salary/wages. These timeframes differ in each collective bargaining agreement.

Maternity benefits

Expecting mothers may not be employed eight weeks before and after giving birth for the protection of their health (protection during pregnancy and maternity). As a compensation for loss of income during the protective period, women are granted maternity benefits which are paid by health insurance. The amount is calculated by daily rates and is based on the average net income of the last thirteen weeks or three months. Holiday and Christmas bonuses are taken into account on a pro rata basis.

Social accident insurance

In case of a work accident or an occupational disease the accident insurance will pay for the medical treatment and the costs of any rehabilitation. It provides financial support through daily benefits, nursing benefits or a pension. The accident insurance also deals with measures for preventing accidents in companies and occupational diseases (see Chapter 4).

The nursing care scheme

The nursing care scheme was introduced in 1993 with the objective of granting people in need of care a statutory claim to nursing benefits, irregardless of how this need came

to be. The nursing benefits are provided so as to enable the affected people to obtain the required care and help and to carry on a life based on their personal requirements.

The prerequisites for a claim to nursing benefits are:

- Permanent need of nursing and assistance owing to a bodily, mental, psychological or sensory handicap expected to last at least six months
- Constant nursing need of more than 50 hours per month
- Permanent residence in Austria; the granting of nursing benefits within the European Economic Area is also possible in certain situations.

The nursing benefits must be applied for by the insurance providers or the authorities. The amount of the nursing benefits is commensurate with the amount of nursing required. Nursing benefits are graded into seven stages and range from EUR 148.30 for more than 50 hours of nursing per month to up to EUR 1,562.10 for nursing amounting to more than 180 hours per month (with additional virtual immobility or a comparable condition).

In total, about 270,163 Austrians were receiving nursing benefits at the end of 2004. Nearly 73 percent were allocated to stages 1 through 3, most of them (35 percent) in stage 2. Nursing benefits of stage 7 were received by about 1.5 percent (Source: Main Association of Austrian Social Security Institutions).

Private health insurance

About one-third of the Austrian population pays premiums into a private supplementary insurance policy in addition to their social security contributions. Such insurance products may afford the insured person better accommodation (single rooms, for example) in the hospital, coverage of the costs of treatment by a doctor of choice, payment of daily benefits in cases of illness, or the assumption of costs for complementary medical treatment procedures.

The private health insurance premiums are calculated according to actuarial principles and are partly tax-deductible. The number of persons privately health-insured has decreased over the past ten years.

Health expenditures

In 2003, the calculation method used by Statistics Austria (ESA 95—"European System of Accounts") indicated total spending of ca. EUR 17 billion for the Austrian health care system. The proportion of the gross domestic product was thus 7.5 percent, of which 67.1

percent is attributable to public health expenditures (Source: Statistics Austria). In comparison with other countries, Austria occupies an average position. The average percentage in the OECD countries amounts to 8.4 percent, and to 7.5 percent in the EU. The first place is taken by the USA with 14.6 percent of GDP, followed by Switzerland (11.2 percent). At the bottom end of the scale comes Korea (5.1) (Source: OECD Health Data and Eurostat, 2002 figures). Since the beginning of 2005, step-by-step implementation of the "System of Health Accounts" for the calculation of health expenditures has been taking place in Austria. Initial results from these calculations, which complement those of the ESGV 95, have been available since the end of 2005.

Health insurance is the most important financing entity of the health system. In the year 2004, it spent EUR 11.50 billion on services for insured people. The largest portion of this sum, namely EUR 3.2 billion, flowed into the hospitals. EUR 2.9 billion were spent on treatment by doctors and EUR 2.4 million on pharmaceuticals and other drugs. Dental treatments and prostheses amounted to about EUR 707 million. EUR 454 million were paid for maternity benefits and about EUR 373 million for sickness benefits. About EUR 58 million were spent on health establishment and illness prevention. At EUR 351 million, the administrative costs of all health insurance providers amounted to three percent of the total receipts.

Table: Breakdown of health insurance expenses for 2004 (in millions of Euros)

Type of expense	Amount
Hospital nursing	3,239
Medical assistance	2,851
Medications	2,423
Dental treatment	707
Motherhood benefits	454
Sick-leave benefits	373
Therapeutic accessories	236
Medical rehabilitation	211
Travel and transport costs	156
Early diagnosis and health promotion	87
Health establishment and prevention of illness	58
Other services	57
Home medical care	9
Administration	351
Other expenses	304
Total	11,516

Source: Main Association of Austrian Social Security Institutions

Social health insurance income and expenses

Over the past 20 years, a significant shift of the financing load to private households can be observed; the most important forms of private health-related spending are deductibles, additional fees and co-payments, which currently amount to 28 percent of health-related spending. The total income of the social health insurers was EUR 11.2 billion in 2004. The rise in income as a percentage of the previous year's figure was 2.8 percent, that of spending 3.9 percent. In order to raise cost-consciousness, the social health insurers have been required since 2003 to inform insured parties once a year about the costs of the services provided for them and their dependents.

As is shown in the table below, health insurance is primarily funded by contributions, which are raised half by employees and half by employers in the case of those persons who are not self-employed. At present (2005) the rates of contribution to health insurance, which vary depending on the type of employment, are 7.5 percent for white-collar and blue-collar workers and 7.3 percent for civil servants. The monthly top threshold in the health insurance is currently at EUR 3,630 per month. The rate for self-employed persons stands at 9.1 percent, and 7.5 percent applies to farmers, with the highest contribution base being EUR 4,235 in each case.

Table: Breakdown of income in health insurance, 2004 (in millions of Euros)

Type of income	Income	Breakdown in %
Contributions for insured persons	9,438	83.79
Other income	1,410	12.51
Prescription fees	336	2.98
Asset revenues	79	0.70
Total income	11,263	100.00

Source: Main Association of Austrian Social Security Institutions

Hospital costs and financing

At the end of 2003 there were 272 hospitals with a total of 67,700 hospital beds in Austria. 139 of these hospitals are financed by public funds (the so-called "fund hospitals"). These so-called fund hospitals contain about 73 percent of the total hospital beds in Austria. For the most part, they provide care in the Austrian acute inpatient sector. Cost data are available for these hospitals.

The operating costs of these hospitals rose between 1999 and 2003 from nearly EUR 7 billion to around EUR 8 billion. The cost increase consistently runs a bit faster than the consumer price index, but the rate of ca. ten percent during the early 1990s has since been reduced to around 3.7 percent. In 2003, the average costs per nursing day were EUR 439. The predominant part of the hospital costs were the staff costs (about 57 percent), with nearly six percent going to medications.

The federal provinces are responsible for assuring hospital care. Financing is provided by the provinces and municipalities, social insurers, private insurers and the patients themselves. Federal funds are also provided—currently 1.416 percent of the VAT collected annually—as well as a fixed annual amount (EUR 242 million as of 2005).

The Austrian DRG System

Since 1978, hospital financing has been regulated within the framework of time-limited contracts based on the Constitution between the Federation and all the provinces. With the Agreement in Accordance with Art. 15a of the Federal Constitution Act on the Organisation and Financing of Health Care, which has been in effect since 2005, the Federal Health Agency was established, which is also charged with performing the duties defined in the above agreement. These duties include the further development of the hospital financing system for publicly financed hospitals.

Since 1 January 1997, inpatient stays in the public and non-profit general hospitals and public specialised hospitals have been billed on the basis of the “Leistungsorientierte Krankenanstaltenfinanzierung (LKF)”, the Austrian DRG (Diagnoses Related Groups) System.

In contrast to the hospital financing practises in use up to 1996 (in the form of undifferentiated daily flat-rates), the Austrian DRG System is a per-case flat-rate system which makes possible hospital financing on the basis of services actually rendered to the patients. Each patient constitutes one case. Illness and therapy, as well as the age of the patient in the case of certain illnesses, are the main factors determining the cost weights and thus the fees to be paid.

The constant maintenance and further development of the portion uniform throughout the country, namely the per-case flat-rate system, is a project of the Federal Health Agency, which also decides upon the model of the DRG System to be applicable for a calendar year. Furthermore, certain province-specific base rates within the DRG System are possible, in which certain provider-functions of specific hospitals (major hospitals, certain specialised hospitals, hospitals with special medical or regional provider functions) can be given consideration.

Together with the nationally co-ordinated health care structural planning instruments, the Austrian DRG system forms the prerequisite for necessary structural changes. In combination with significant complementary measures, especially quality management, lasting improvements for patients have already been effected. In spite of an increasing number of stays (partially attributable to the fact that, in Austria, services classed as “outpatient operations” are counted as inpatient stays), both the number of hospital days and the average length of stay have been reduced. The number of acute care beds has also been reduced. Via the documentation associated with the DRG System, greater transparency has been achieved with regard to diagnoses and procedures in hospitals, thus providing an important store of data for public health planning and decisions. And finally, success was achieved in terms of reducing the yearly increase in the already-high cost of hospitals.

Since 2002, private for-profit hospitals and sanatoriums have also been financed according to the Austrian DRG System, from monies of the Private Hospitals Financing Fund (“Privatkrankenanstaltenfonds”–PRIKRAF). The PRIKRAF is fed by social health insurance means and reimburses private for-profit hospitals’ services to socially insured patients which must be covered by social health insurance.

The coming years will see further development of the Austrian DRG System, with updating of the DRG weights and the introduction of diagnosis and procedure documentation—as well as the development of a DRG-based reimbursement system—for the area of outpatient care.

Documentation in Hospitals

The hospital documentation activities necessary for the steering, planning and financing of the hospital sector and the health care system as a whole are regulated on the federal level and lie within the competence of the Federal Ministry of Health and Women. The further development of public health care documentation is based on a good foundation, since extensive data has been collected in hospitals since 1978 (personnel, resources, utilisation, costs, as well as diagnoses and procedures from the 1990s onward). Over the past few years, the system of documentation has been streamlined and updated, and the various individual areas have been fine-tuned relative to one another. Beginning with the reporting year of 2004, hospital data have been collected with new tools including extensive plausibility checking routines, which additionally assures this data’s quality.

The introduction of outpatient diagnosis and procedure documentation planned for the next few years (for hospital outpatient clinics, private practices and independent outpatient clinics) will constitute a further milestone on the way to creating a store of data

and information with which the various sectors of the health care system will become easier to compare. This will provide a still better basis for the steering, planning and financing of the health care system.

Annex A: Research

The medical research and education at universities is carried out at the three Medical Universities in Vienna, Graz and Innsbruck. In addition there are a number of extra-university research funds and research institutions performing special work in the field of medical research. The most important of these are:

Fonds zur Förderung der wissenschaftlichen Forschung (The Fund for the Promotion of Scientific Research)

This science fund is Austria's central funding body for basic research. It supports, among others, projects in the field of human medicine. In 2004, EUR 18.5 million were approved, i.e. 17.4 percent of the financial contributions for this sector.

Österreichische Akademie der Wissenschaften (Austrian Academy of Science)

The Austrian Academy of Science (ÖAW) is the leading institution of academic research in Austria outside of the university system, with numerous locations in various cities.

Ludwig-Boltzmann-Gesellschaft (Ludwig Boltzmann Society)

Founded in 1961 for the promotion of applied and basic research, the Society was newly constituted in 2004. It is one of the biggest private funding bodies of research facilities, currently supporting 129 institutes and research institutions, 73 of which conduct research in the field of human medicine.

Österreichisches Bundesinstitut für Gesundheitswesen (Austrian Health Institute)

The ÖBIG is a research, planning and training institution intended to provide support for the health care system in Austria. Moreover, it offers information services in the field of health care (literature service for medicine, hospital system/health system and poisons). The ÖBIG also runs things such as a co-ordination office for the Austrian transplantation system, a co-ordination centre for dental status surveys and the Austrian REITOX Focal Point of the European Information Network for Drugs and Drug Addiction.

In total, the Federation spends about 22 % of its funds dedicated to research and the promotion of research on medicine and the health system. In 2005 the amount was EUR 328.8 million (Source: Austrian Research and Technology Report, 2005).

Annex B: Reforms in the Austrian health care system (overview)

- 1972** Founding of the Federal Ministry of Health and Environmental Protection
First Austrian health and environment plan
Principal reform of hospital laws
- 1973** Founding of the "Österreichisches Bundesinstitut für Gesundheitswesen (ÖBIG)" (Austrian Health Institute)
Start of systematic hospital planning
- 1974** Start of the reform of nursing education and the education of auxiliary professions in medicine
Laws on preventive medicine
Introduction of the Mother-Child Medical Card
Introduction of municipal nurses
- 1977** Establishment of a poisoning information centre
Hospital Cost Accounting Ordinance leads to first uniform hospital cost and statistics data throughout Austria
- 1978** Founding of the Hospitals' Co-operation Fund ("Krankenanstaltenzusammenarbeitsfonds"–KRAZAF) for financing and financially reforming hospitals and forming an Austria-wide platform for planning and control measures in the health sector
- 1979** Founding of the Academy for Occupational Medicine
- 1985** First (non-binding) Austrian hospitals plan, Federal and Provincial resolution to reduce quantity of beds in acute medical care
- 1986** AIDS laws
- 1988** Reform of hospital statistics
Reform of the funding of home care
First (non-binding) plan for major medical-technical equipment
- 1989** Compulsory introduction of diagnosis documentation in hospitals (according to ICD-9)

- 1990** Reform of the laws on handicapped people
Reform of the laws on coercive measures for mentally ill people
Declaration and introduction of integrated health and social districts
- 1991** Recognition of psychotherapy as a service provided by health insurance
Recognition of home care as a service of social insurance
Establishment of a co-ordination office for the transplantation system
- 1992** Fundamental reform of social legislation: Financing of preventive medicine and health promotion becomes mandatory for the social insurances
Law on reproductive medicine
- 1993** Introduction of nursing benefits for handicapped people
Compulsory introduction of documentation on medical procedures in publicly-funded hospitals
- 1994** Laws on gene technology
- 1995** Reform of laws on tobacco
- 1997** Introduction of health care reform
Abolition of the "KRAZAF", establishment of the Structural Fund (on the federal level) and the nine Provincial Funds for hospital financing and as an all-Austrian platform for planning and control measures in the health sector
Introduction of the DRG-based hospital reimbursement system ("Leistungsorientierte Krankenanstaltenfinanzierung (LKF)", the Austrian DRG System) in the fund hospitals
Health Care Documentation Act
First compulsory Austrian Hospitals and Major Equipment Plan (ÖKAP/GGP)
Deductible for health insurance certificates, contributions to costs of convalescence and rehabilitation stays
Health Care and Nursing Act
Medical Products Act
Novel Food Ordinance
- 1998** Reform of the Narcotics Act
Nation-wide vaccination strategy
Health Promotion Act
Gene technology amendment
Expansion of insurance system to cover persons in negligible occupational situations
Cardiotechnicians Act

- 1999** Revision of the Austrian Hospitals and Major Equipment Plan, including agreements within the framework of psychiatry reform
- 2001** Second stage of health care reform introduced
Revision of the Austrian Hospitals and Major Equipment Plan, introduction of service provision planning to various service areas including new inpatient-care levels and binding criteria on structural quality
Shift of diagnosis documentation in all hospitals from ICD-9 to ICD-10
Amendment to the Medical Practitioners Act
New EU deliberate release directive (gene technology)
Amendment to the Employee Protection Act
Cardiotechnicians Training Ordinance
- 2002** Austrian DRG System with refined cost weights
- 2003** Establishment of the Federal Ministry of Health and Women
- 2005** Reform of public health care (Health Care Reform Act)
Co-ordination of federation, provinces and social insurers via the Federal Health Agency and the Provincial Health Funds
Anchoring of universal quality assurance via the Act on the Quality of Health Services
Healthcare Telematics Act
Austrian Health Care Structural Plan (draft)



The present brochure provides an overview of the Austrian public health system and imparts information on its structure and purpose in a clearly arranged and distinct manner. At the same time it shows the development of the system on the basis of facts and figures from various sources. The most recent available data were considered in this publication.



The brochure's content is broken down into the sections of socio-demographic overview and legal aspects, the Austrian population's health, health-relevant behaviour and risk factors, health care services, professions in the public health services, and social security services, costs and financing of the public health system.



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