European Commission

State of Health in the EU

AUSTRIA

Country Health Profile 2025

OECD
BETTER POLICIES FOR BETTER LIVES

European Observatory on Health Systems and Policies
a partnership hosted by WHO

The Country Health Profiles series

The *State of Health in the EU*'s Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policy makers and influencers with a means for mutual learning and knowledge transfer. The 2025 edition of the Country Health Profiles includes a special section dedicated to pharmaceutical policy.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Observatory's Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

Contents

Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys, the Survey of Health, Ageing and Retirement in Europe (SHARE), the European Cancer Information System (ECIS) and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was finalised in September 2025, based on data that was accessible as of the first half of September 2025.

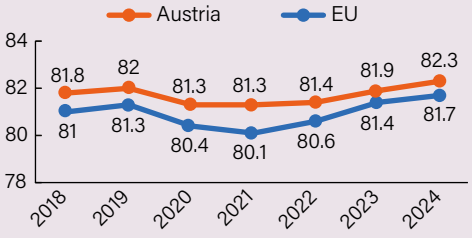
Demographic and socioeconomic context in AUSTRIA, 2024

Demographic factors	Austria	EU
Population size	9 158 750	449 306 184
Share of population over age 65	20 %	22 %
Fertility rate 2023[1]	1.3	1.4
Socioeconomic factors		
GDP per capita (EUR PPP)[2]	45 947	39 675
At risk of poverty or social exclusion rate[3]	16.9 %	20.9 %

1. Number of children born per woman aged 15-49.
2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.
3. At risk of poverty or social exclusion (AROPE) is the percentage of people who are either at risk of poverty, severely materially and socially deprived, or living in a household with very low work intensity.

Source: Eurostat Database.

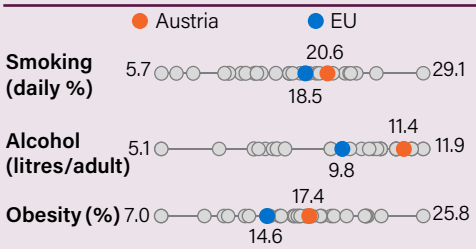
1 Highlights



Life expectancy at birth

Health Status

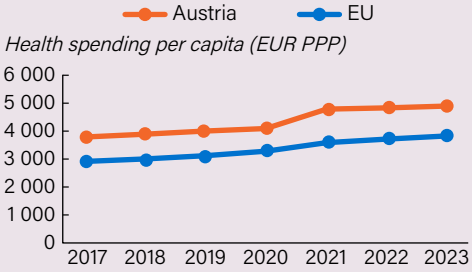
Austria's life expectancy reached 82.3 years in 2024, six months above the EU average. In 2024, for the first time since the pandemic, Austria has recovered its earlier peak; life expectancy gains over the past decade were primarily driven by reduced cardiovascular disease mortality, although cardiovascular diseases remain the leading cause of death at over one-third of fatalities.



Adults, 2022 (or nearest year)

Risk Factors

Austria's smoking prevalence exceeds EU averages, with 21 % of adults smoking daily. Alcohol consumption reached 11.3 litres per capita in 2023, which is markedly above the EU average. Adult obesity affected over 17 % of the population in 2022, exceeding the EU average and marking an 18 % increase since 2017.

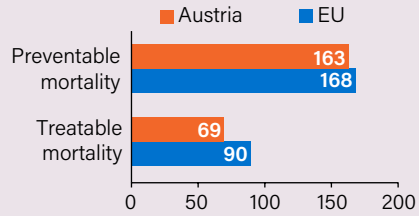


The Health System

Austria's health spending per capita reached EUR 4 901 in 2023, the second-highest in the EU. However, the country's above-average reliance on private funding raises equity concerns, particularly through out-of-pocket payments and the emerging risk of a two-tier system. Current reforms aim to strengthen cost control and shift the spending balance from hospital to ambulatory care.

Health System Performance

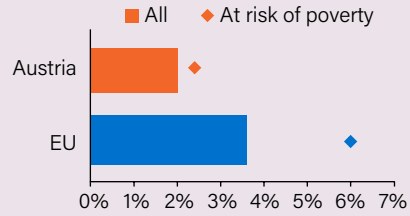
Effectiveness



Age-standardised rate per 100 000 population, 2022

Austria excels in treating illnesses, with mortality rates for treatable causes below the EU average and improving faster than the EU average. However, preventable mortality remains a challenge, with rates higher than top EU performers. Vaccination rates, particularly for influenza, are low, despite political commitment. Uptake of breast cancer screening is low, while opportunistic screenings for other cancers are strong.

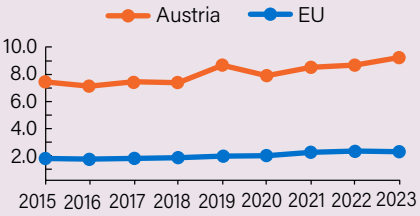
Accessibility



% reporting unmet medical care needs, 2024

Austria's near-universal SHI coverage delivers low levels of unmet medical needs, particularly among those at risk of poverty. However, the stagnation in publicly contracted doctors, combined with a growing private physician sector, has created a 'wait or pay' dilemma for patients. This dynamic forces a choice between longer waits for fully covered care or higher out-of-pocket spending for quicker access.

Resilience



Million EUR per 100 000 population (constant 2015 prices)

Austria is among the leading countries in the EU in capital investment in health ICT, particularly through its electronic health record system (ELGA). Despite this investment, adoption of digital health services remains below EU averages, revealing implementation gaps. Current reforms focus on upgrading digital services and mandating provider connections to ELGA to accelerate the digital transition.

Spotlight: pharmaceuticals

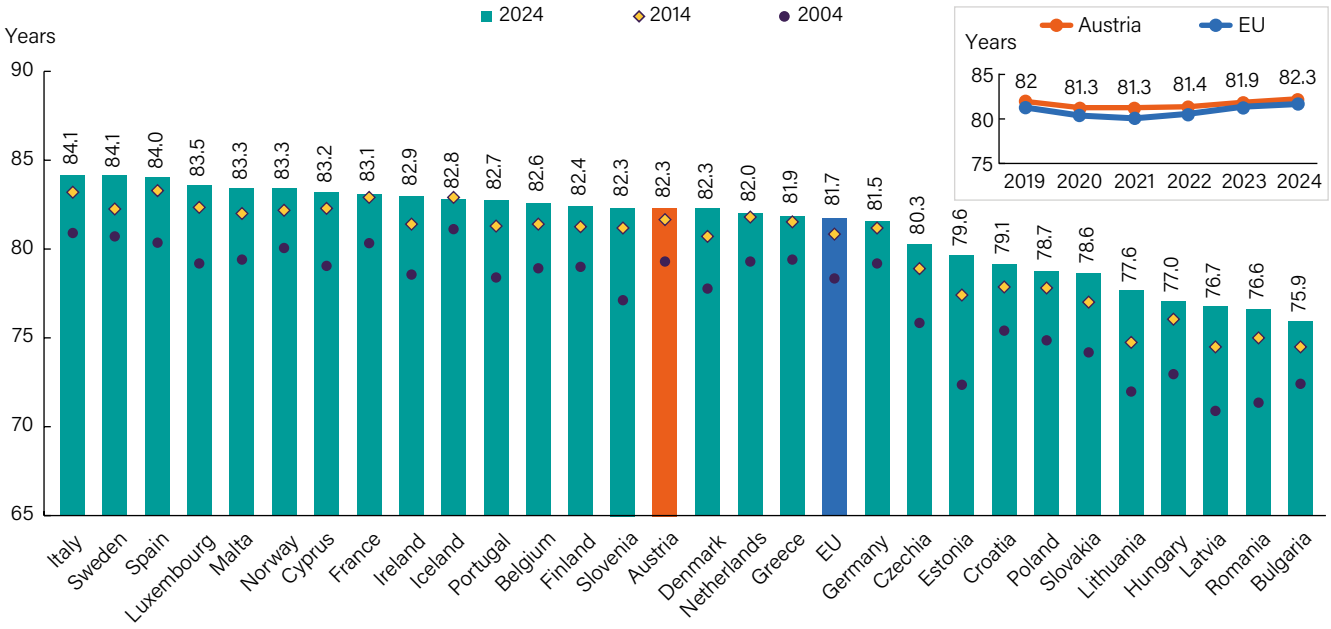
Austria's pharmaceutical spending per capita slightly exceeds the EU average, with strong public coverage for outpatient medicines. While retail pharmaceutical spending is tightly controlled through pricing regulations and strict reimbursement systems, hospital drug costs are rising due to complex, fragmented governance structures and expensive specialised treatments. Generic and biosimilar uptake remains relatively low, though robust price-linking mechanisms help reduce originator prices. The pharmaceutical industry maintains high R&D intensity, bolstered by fiscal incentives.

2 Health in Austria

Austria's life expectancy has surpassed its pre-pandemic peak in 2024

Austria's recovery in life expectancy following the COVID-19 pandemic has lagged behind that of most other EU countries, surpassing its pre-pandemic peak only in 2024, while the majority of EU member states did so earlier. In 2024, life expectancy at birth reached 82.3 years, positioning Austria six months above the EU average (Figure 1). A significant gender gap in life expectancy also persists: in 2024, women in Austria could expect to live to 84.5 years, four and a half years longer than men, a difference that is slightly below the EU average.

Figure 1. Austria's life expectancy peaked in 2024



Notes: The EU average is weighted. 2024 data for Ireland pertains to 2023.
Source: Eurostat (demo_mlexpec).

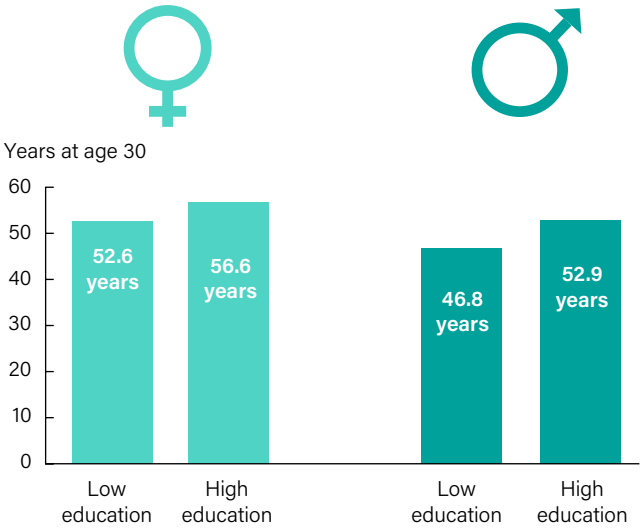
Socioeconomic disparities in life expectancy are significant, especially among men

Socioeconomic factors drive health inequities within Austria, creating life expectancy gaps that vary markedly by both gender and educational attainment. The magnitude of these disparities is most pronounced among men: in 2022, 30-year-old men with the highest level of education could expect to live over six years longer than their counterparts with the lowest educational qualifications (Figure 2). In contrast, for women, the gap stood at four years. These socioeconomic disparities reflect interconnected risks as lower education groups face higher behavioural risks, like tobacco use and inadequate nutrition (see Section 3), worsened by disadvantaged living and working conditions.

Cardiovascular disease has driven most recent longevity gains and remains Austria's leading cause of death

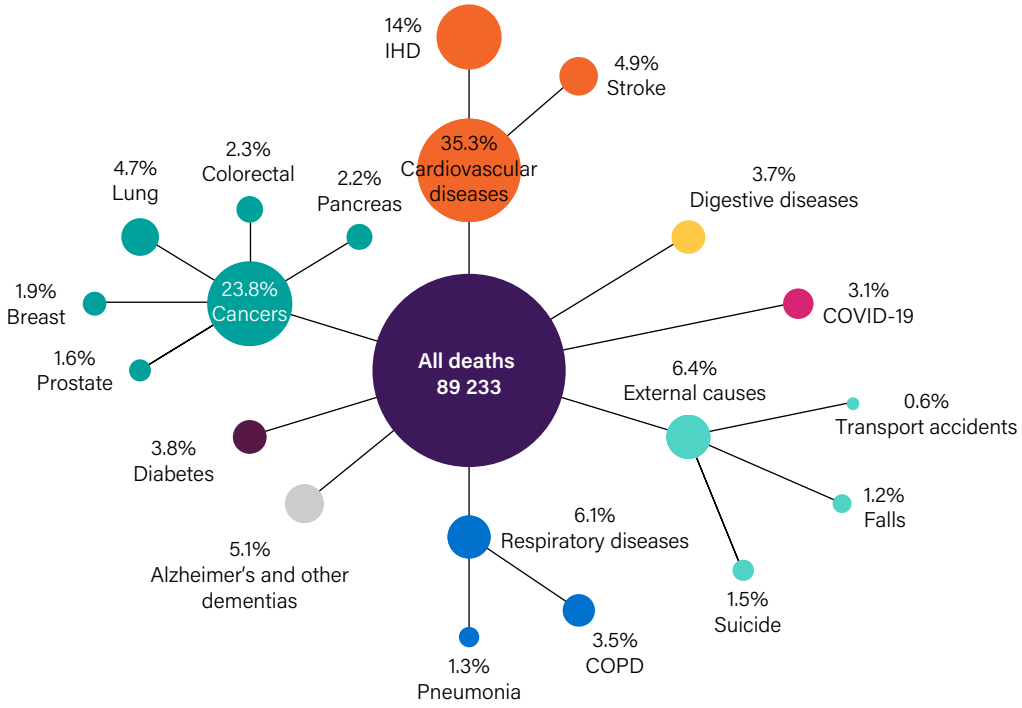
Austria's life expectancy gains over the past decade reflect significant progress in reducing deaths from major chronic conditions, with cardiovascular diseases (CVDs) driving the most substantial improvements, followed, to a lesser extent,

Figure 2. Highly-educated men in Austria outlive those with the lowest education by more than six years



Notes: High education is defined as people who have completed tertiary education (ISCED 5-8), whereas low education is defined as people who have not completed secondary education (ISCED 0-2).
Source: Statistics Austria (data refer to 2022).

Figure 3. Cardiovascular diseases account for over one third of all deaths in Austria



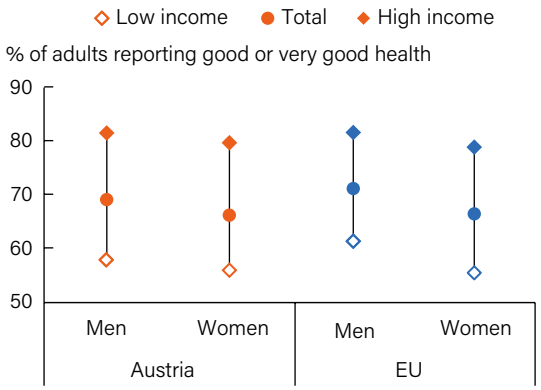
Notes: IHD = ischaemic heart diseases; COPD = chronic obstructive pulmonary disease.
Source: Eurostat (hlth_cd_aro); Data refer to 2023.

by reductions in cancer deaths. However, CVDs remained the leading cause of death in 2023, accounting for over one third of all fatalities, a share that aligns with the EU average (Figure 3).

Over two-thirds of Austrian residents report being in good health, but socio-economic disparities remain

Austria's self-reported health status remains robust, with 68 % of the population rating their health as good or very good in 2024, closely matching the EU average. However, this headline result conceals a substantial 24 percentage-point disparity between the highest and lowest income quintiles: while 81 % of individuals in the top income bracket report good health, this share falls to just 57 % among those in the lowest income quintile (Figure 4).

Figure 4. Inequalities in self-reported health by gender and income level in Austria are in line with the EU average



Note: Low income refers to adults in the bottom 20 % (lowest quintile) of the national equivalised disposable-income distribution, while high income refers to adults in the top 20 % (highest quintile).
Source: Eurostat based on EU-SILC (hlth_silc_10). Data refer to 2024.

People in Austria face a lower chronic disease burden than the EU average

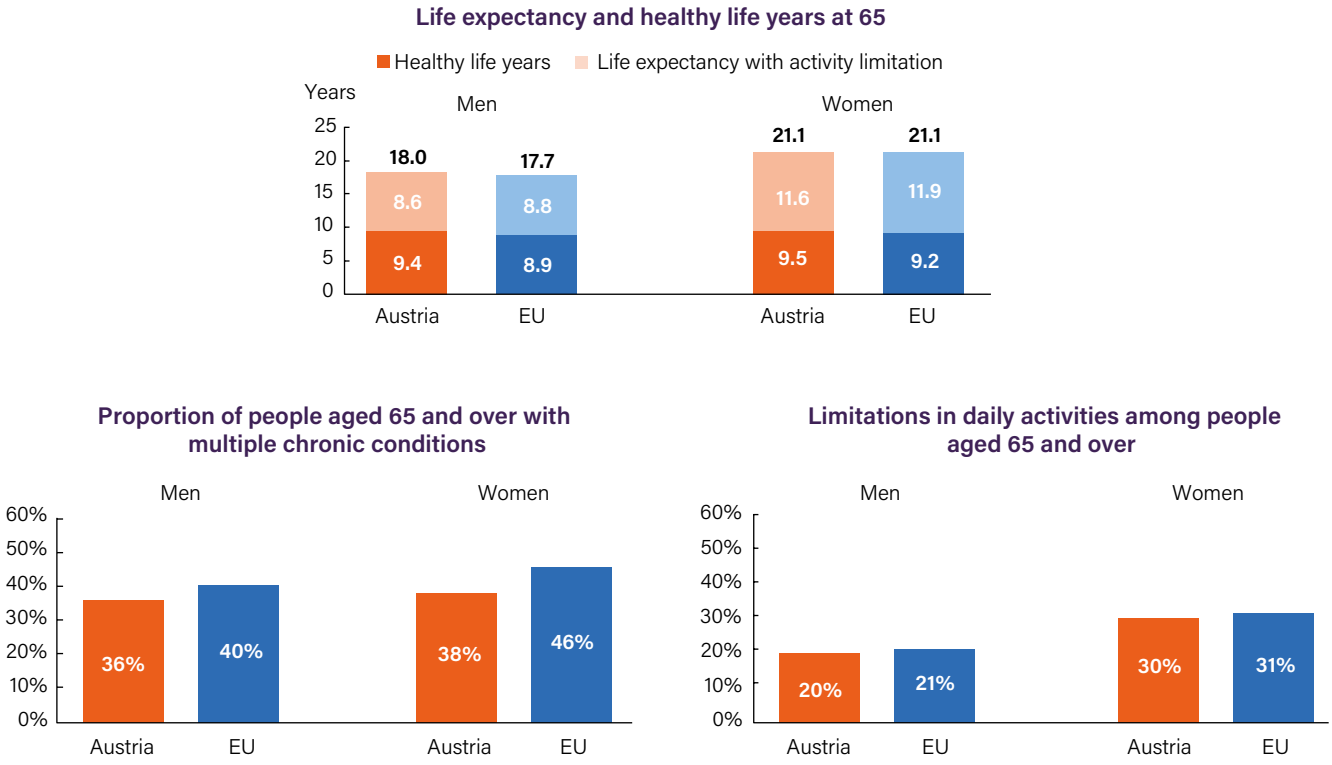
Like the rest of the EU, Austria's population is ageing: the share aged 65 and over rose from 15 % in 2000 to 20 % in 2023, slightly below the EU average of 21 %, and is projected to reach 28 % by 2050. Over the same period, the median age is set to rise from 43.6 years in 2023 to nearly 48 by 2050, moving broadly in step with the EU.

In 2022, women in Austria at age 65 could expect to live another 21 years, while men could expect to live an additional 18 years - figures in line with their respective EU averages (Figure 5). However, women in Austria reported multiple chronic conditions slightly more often than men (38 % compared to 36 %). Overall, the chronic disease profile is favourable compared to the EU, but limitations in daily activities affected about 30 % of older women and 20 % of men, proportions in line with EU averages.

Cardiovascular diseases and cancer drive a major burden of illness in Austria

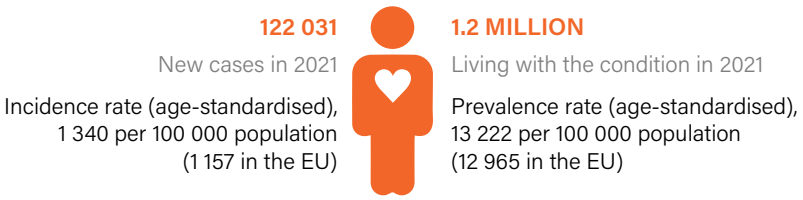
As in other EU countries, cardiovascular diseases (CVDs) and cancer in Austria are not only the leading causes of death, but also major drivers of morbidity. According to estimates from the Institute for Health Metrics and Evaluation (IHME), Austria records approximately 122 000 new CVD cases annually, with over 1.2 million people living with a CVD as

Figure 5. In Austria healthy life years are slightly longer and multimorbidity rates lower compared to the EU average



Notes: The EU average is unweighted and based on 26 EU countries.
Source: Eurostat for healthy life years (*tespm120, tespm130*) and SHARE survey (for chronic diseases and limitations in daily activities). Data refer to 2022 and 2021–22, respectively.

Figure 6. Over 13 % of Austria's population is living with a cardiovascular condition



Source: IHME, Global Health Data Exchange (estimates refer to 2021).

of 2021. This translates to an age-standardised incidence rate of 1 340 cases per 100 000 population, 16 % higher than the EU average, while Austria's CVD prevalence rate was approximately 2 % above the EU average (Figure 6).

Austria's cancer burden is lower than the EU average

Austria demonstrates an above-average performance in cancer control within the EU, with key indicators consistently stronger than European norms. In 2022, Austria's cancer incidence rate was 15 % below the EU average, and its prevalence rate was about 5 % lower in 2020, reflecting both fewer new diagnoses and a smaller share of the population living with cancer (Figure 7). This positive record is reinforced by a cancer mortality rate that fell by 12 % between 2009 and 2019. Cumulatively, these trends position Austria as a strong performer in prevention, early detection and treatment (OECD/European Commission, 2025).

However, this successful track record is tempered by significant demographic challenges and a demanding future outlook. The burden of cancer is projected to intensify significantly due to population ageing. New cases are forecast to rise by 23 % by 2040, a rate of increase that exceeds the EU's projected 18 %.

Figure 7. Nearly 5 % of Austria's population lives with a cancer diagnosis

45 525
New cases in 2022
Incidence rate (age-standardised), 489 per 100 000 population (572 in the EU)

407 953
Living with the condition in 2020
Prevalence rate (age-standardised), 4 531 per 100 000 population (4 767 in the EU)

Notes: These are estimates that may differ from national data. Cancer data includes all cancer sites except non-melanoma skin cancer.
Source: European Cancer Information System (estimates refer to 2022 for incidence and 2020 for prevalence).

3 Risk factors

Behavioural risk factors are a large driver of morbidity and mortality in Austria

A substantial share of mortality in Austria is attributable to preventable behavioural and environmental risk factors, with the overall burden aligning closely with the EU average. In 2021, these factors combined contributed to an estimated 29 % of all deaths in the country. Behavioural risks, such as tobacco smoking, alcohol use, poor diet and lack of physical activity, are the predominant driver, linked to approximately 22 600 deaths or nearly one-quarter of the total each year. These behaviours are strongly influenced by broader social, economic, and environmental conditions, including education, income, access to healthy foods, and opportunities for physical activity. Chief among these behavioural risks are dietary risks, which were responsible for nearly half of all fatalities attributable to behavioural factors. The scale of this challenge is underscored by recent studies showing that obesity alone leads to nearly 4 000 deaths and incurs societal costs of EUR 2.4 billion (Reitzinger & Czypionka, 2024). In addition to behavioural factors, environmental risks - particularly air pollution from fine particulate matter ($PM_{2.5}$) - accounted for an estimated 3 200 deaths, representing another 4 % of the total in 2021.

Smoking is more prevalent in Austria than in most other EU countries

Smoking in Austria represents a significant public health concern, with prevalence rates exceeding those in most other EU countries. According to the latest data available from the European Health Interview Survey, 21 % of adults in Austria were daily smokers in 2019, slightly above the EU average of 19 %. More recent data from the 2024 Eurobarometer survey, though based on smaller samples with considerable uncertainty, suggest that smoking rates may have risen during the COVID-19 pandemic. This occurred despite Austria implementing an indoor smoking ban in 2019. Adolescent tobacco use in Austria is also comparatively high, with data from the 2022 Health Behaviour in School-aged Children (HBSC) study finding that 19 % of 15-year-olds had smoked tobacco in the past month (Figure 8). Overall, smoking is estimated to cause 16 % of deaths in Austria and to incur 2.3 % of current health expenditures (Pock, Czypionka, Reiss, & Röhrling, 2018).

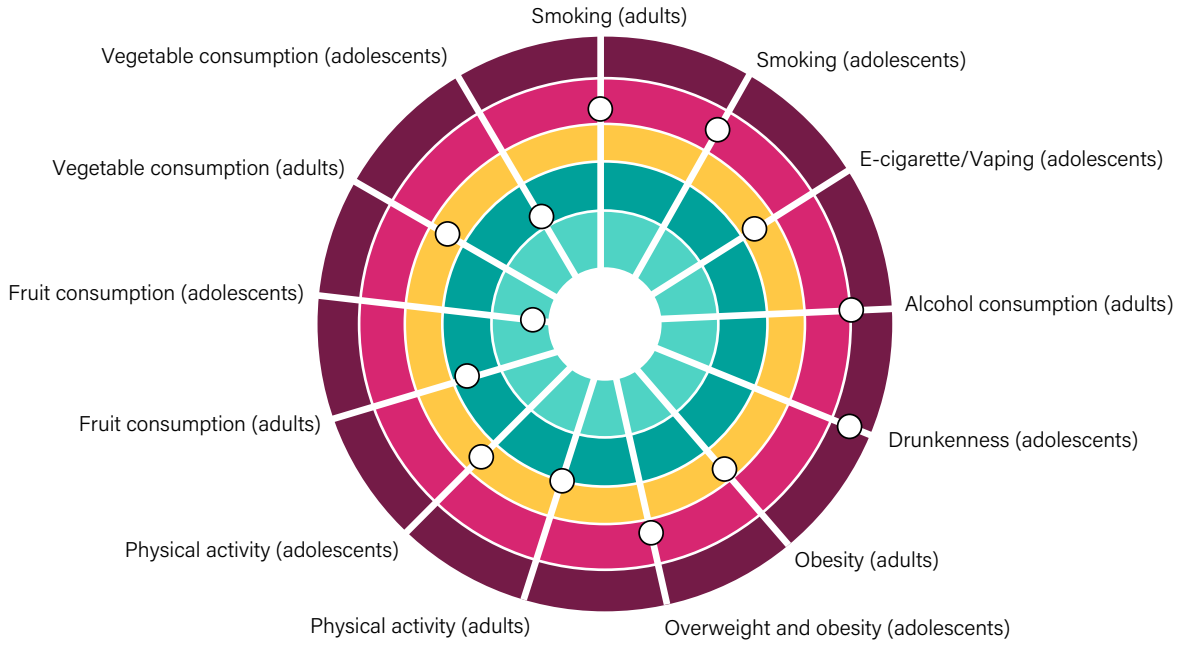
Alcohol consumption in Austria remains high

Alcohol consumption among adults in Austria reached 11.3 litres of alcohol per capita in 2023, approximately 15 % above the EU average. Among 15-year-olds, the share reporting having been drunk more than once over their lifetime decreased significantly from a peak of 43 % in 1998 to a low of 24 % in 2014, according to the HBSC survey. However, this downward trend has reversed in recent years, rising to 33 % in 2022. However, according to the ESPAD 2024 study, the frequency of alcohol consumption among adolescents has decreased. Between 2007 and 2024, the proportion of young people who have never consumed alcohol has quadrupled, while the proportion who reported not drinking alcohol in the past 30 days has doubled.

Overweight and obesity rates among adolescents in Austria are relatively high

In 2022, 17.4 % of adults in Austria were classified as obese based on self-reported data, three percentage points above the EU average and marking an 18 % increase since 2017 – one of the largest relative rises among EU countries over this period, when Austria's rate previously matched the EU average. Physical activity levels in Austria are similar to the EU average with 31 % of adults performing physical activity outside of work more than three times per week. However, daily fruit and vegetable consumption is below the EU average by about five percentage points, with 56 % of the population consuming fruit and 55 % of the population consuming vegetables daily.

Figure 8. Austria sees higher smoking rates in adults and adolescents compared to the EU average



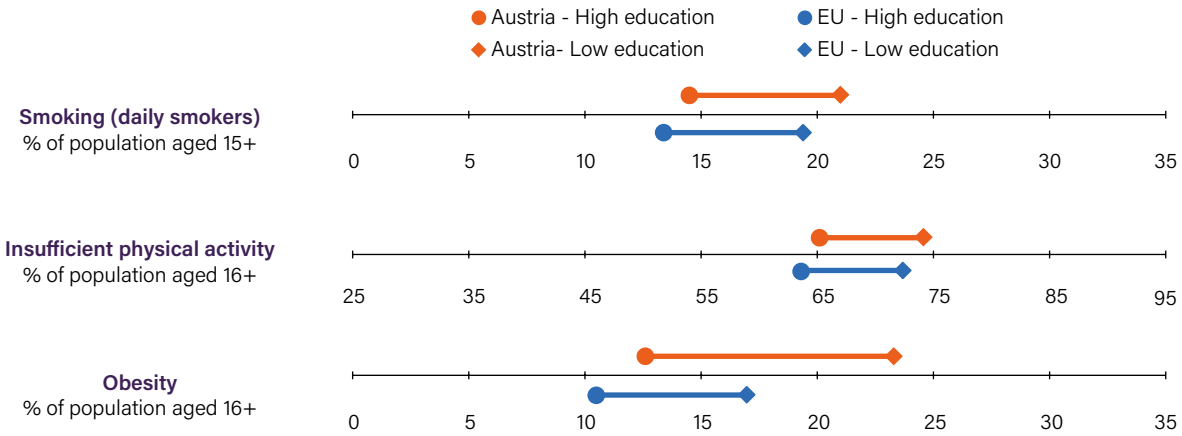
Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country reaches the white target area, indicating that all countries have room for improvement in all areas.
Sources: OECD calculations based on HBSC survey 2022 for adolescents' indicators; Eurostat based on EU-SILC and OECD Data Explorer for adults' indicators (2022 or nearest year), except for smoking (EHIS 2019).

A similar trend of rising obesity is evident among adolescents: according to data from the HBSC study, overweight and obesity rates among 15-year-olds in Austria surged by over 50 % between 2010 and 2022 reaching 23 % in 2022, slightly above the EU average of 21 %. While Austria has implemented comprehensive policies (such as the programme "*Frühe Hilfen*") aimed at fostering healthy behaviours from childhood in recent years, the continued rise in paediatric overweight and obesity underscores a need to reevaluate and intensify these measures.

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

As in other EU countries, behavioural health risks in Austria disproportionately burden the most socioeconomically disadvantaged groups. In 2019, 21 % of adults with the lowest education levels smoked regularly compared to 15 % of those with the highest education levels, a gap consistent with the EU average. Insufficient physical activity affected 74 % of people living in Austria with lower education and 65 % of those with the highest education. The steepest education-based disparity lies in obesity, with data from 2022 showing that over 23 % of low-education residents were classified as obese – nearly double the rate of highly educated peers (Figure 9).

Figure 9. In Austria, people with low education experience disproportionately high obesity rates



Note: Low education is defined as the population with no more than lower secondary education (levels 0-2), whereas high education is the population with tertiary education (levels 5-8). Low physical activity is defined as people doing physical activity 3 times or less per week.
Source: Eurostat based on EHIS 2019 for smoking (hlth_ehis_sk1e) and EU-SILC 2022 for physical activity and obesity (ilc_hch07b, ilc_hch10).

4 The health system

Governance of the health system is split between federal, regional and corporatist stakeholders

Austria's healthcare system is defined by a complex, multi-level governance structure that strategically balances centralised federal oversight with decentralised service delivery by the nine federal states (*Länder*). This system is underpinned by comprehensive social health insurance (SHI), which provides coverage to 99.9 % of the population. This complex arrangement involves the federal government, the *Länder* and corporatist stakeholders. At the federal level, the government establishes the overarching legal framework, regulates healthcare providers and shapes most areas of service provision.

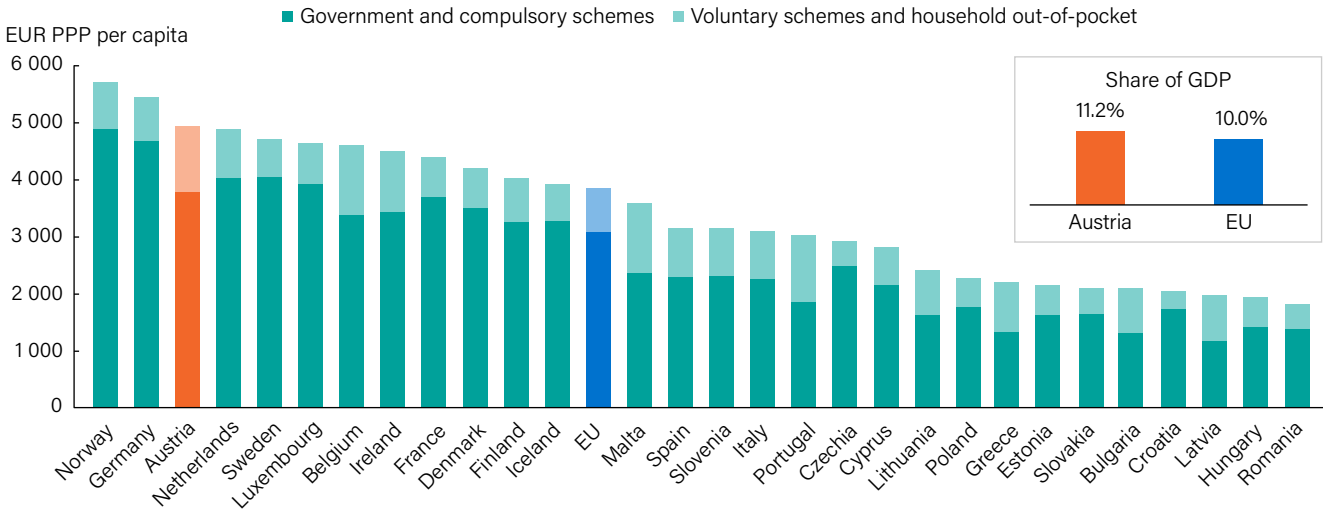
At the same time, the *Länder* are responsible for planning and regulating hospital care, funding capital investments and operating about 75 % of the country's acute care hospital capacity. Operational costs for these hospitals are financed separately through regional health funds (*Landesgesundheitsfonds*), which pool SHI contributions and taxes and disburse them via Austria's DRG model. In contrast to the publicly-managed hospital sector, outpatient care is mostly delivered by private, office-based physicians who work under collective contracts with SHI funds. A distinctive feature of Austria's system is the virtual absence of formal gatekeeping, allowing patients access to specialists and outpatient departments with no referral.

This intricate arrangement is further shaped by robust corporatist self-governance, which is even set by constitutional legislation. Following a 2020 reform, the SHI system is now organised into three main bodies - for employees (*ÖGK*), the self-employed and farmers (*SVS*), and public sector, mining and railway employees (*BVAEB*) - coordinated by an umbrella association, the *Dachverband*. This association, along with state medical chambers, negotiates the binding collective contracts that define fees and obligations for physicians.

Austria's healthcare spending per capita is the EU's second-highest

In 2023, Austria's current health spending represented 11.2 % of GDP, 1.2 percentage points above the EU average. After adjusting for purchasing power, per capita health spending reached EUR 4 901, about 28 % above the EU average of EUR 3 832 (Figure 10). This gap with the EU average stems from public spending per capita that is 22.6 % above the EU average, and private expenditure per capita over 49.2 % above the EU average.

Figure 10. Austria spends more on health per capita than most EU countries



Note: The EU average is weighted (calculated by OECD).
Sources: OECD Data Explorer (DF_SHA); Eurostat Database (demo_gind). Data refer to 2023.

Austria has cost control mechanisms in place, though their impact has been limited

Since 2013, the core payers - the federal government, the Länder and SHI funds - convene in the target-based governance commission to establish common binding financial and health objectives over multi-year periods (*Zielsteuerungsvertrag*) designed to align resource allocation and service delivery across governmental levels. Central to these agreements is an explicit objective to keep publicly funded health expenditure growth sustainable while preserving service quality.

Despite high public coverage, out-of-pocket payments remain substantial

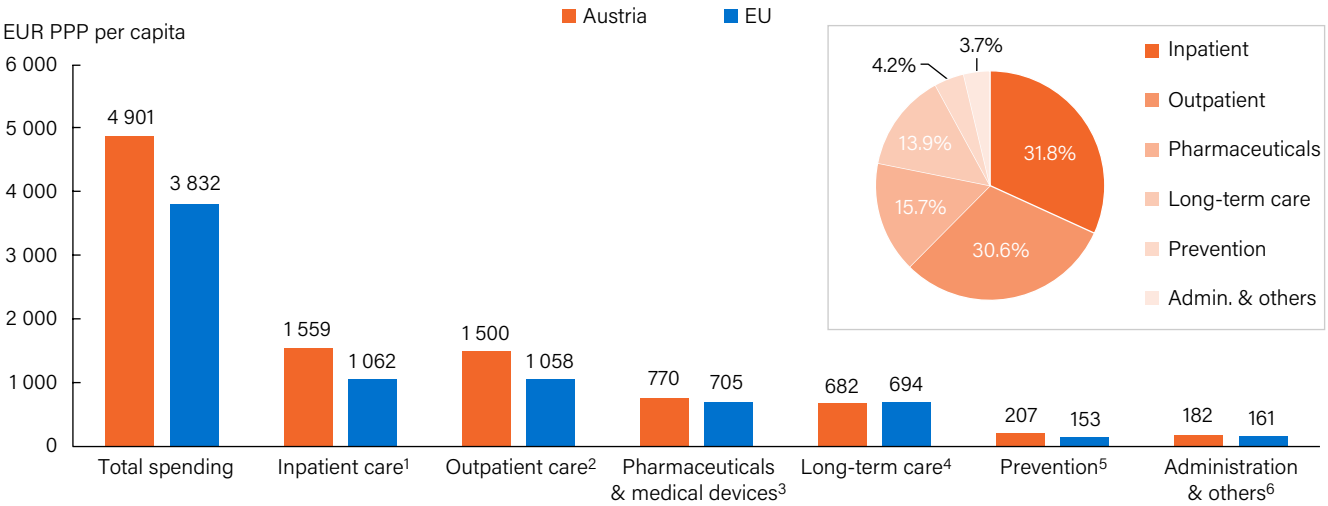
While Austria's SHI provides near-universal coverage, its financing model relies more heavily on private sources than the EU average. In 2023, public sources accounted for 76.7 % of health spending, below the EU average of 80.0 %. The remainder is covered largely by out-of-pocket (OOP) payments and voluntary health insurance (VHI). OOP payments constitute 16.5 % of total health expenditure, a share higher than the EU average of 15.5 %, and they are mostly driven by costs for outpatient medicines, long-term care and dental services, as well as direct payments to non-SHI-contracted doctors (*Wahlärzte*). Furthermore, VHI, which is mostly supplementary (covering better amenities, choice of non-contracted physicians, or faster access), accounts for nearly 7 % of health spending. This reliance on private financing raises equity concerns, as recent evidence links supplementary VHI with shorter waits for elective surgery, suggesting a risk of a two-tier system developing if public capacity is not expanded.

Austria's health spending remains hospital-focused, a structural imbalance now targeted by major reforms

Consistent with Austria's long-term health spending trends, inpatient care represented the largest spending category in 2023 at nearly 32 % of current expenditure, above the EU average of 28 % (Figure 11). For comparison, outpatient care accounted for 31 % of health spending, three percentage points above the EU average. Expenditure on pharmaceuticals and related medical products accounted for 16 %, which is below the EU average of 18 %, but still above the EU average in absolute terms. Spending on preventive care reached 4 %, aligning with the EU average.

Recognising the fiscal pressures inherent in this hospital-dominant model, a 2024-2028 reform explicitly codifies the strategic principle of '*digital before ambulatory before inpatient*' to systematically redirect care delivery, and earmarks substantial new funding. E.g. approximately EUR 300 million for SHI and EUR 600 million for hospitals per year are supposed to foster a shift away from inpatient care, while EUR 51 million should help expand use of electronic health records and integrate telephone and online triage services (Bundes-Zielsteuerungskommission, 2024).

Figure 11. Per capita spending on inpatient care remains comparatively high



Notes: 1. Includes curative-rehabilitative care in hospital and other settings; 2. Includes home care and ancillary services (e.g. patient transportation); 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes; 6. Includes health system governance and administration and other spending. The EU average is weighted (calculated by the OECD).
Sources: OECD Data Explorer (DF_SHA). Data refer to 2023.

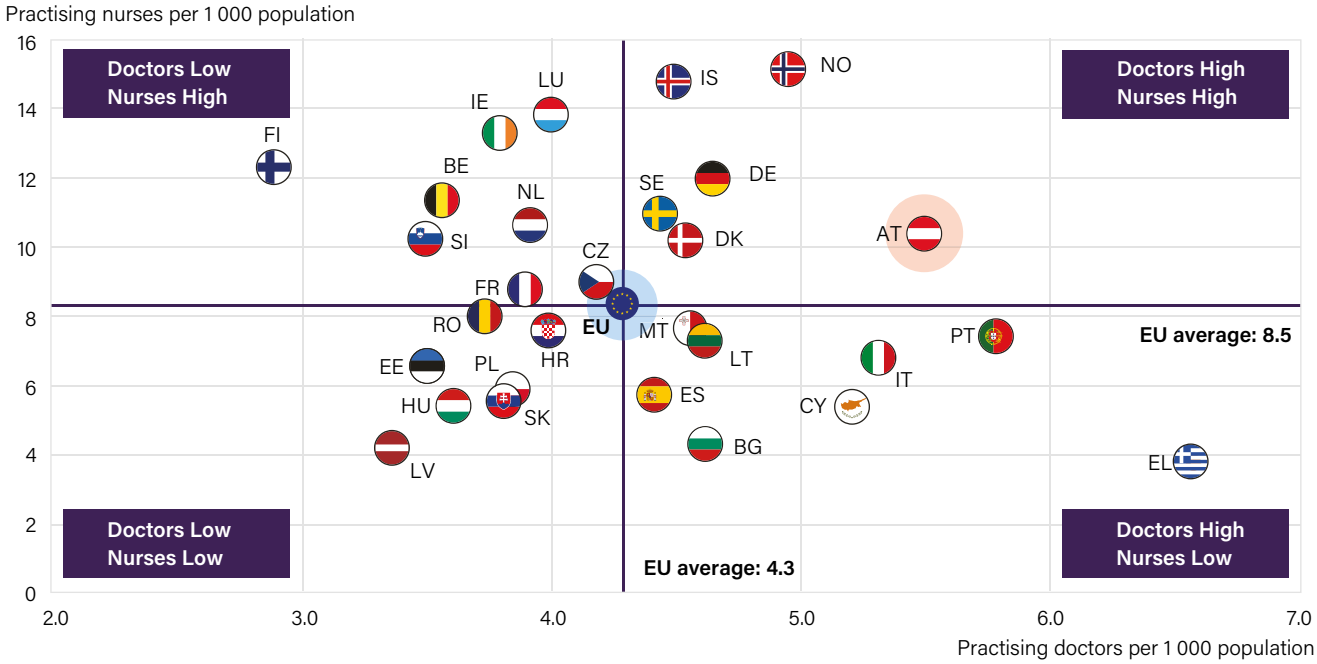
Austria has a high physician density but faces regional gaps and a declining GP population

Austria maintains one of the highest physician densities among EU countries, with 5.5 doctors per 1 000 population in 2023 compared to the EU average of 4.3 (Figure 12). However, this high supply is undermined by geographic maldistribution. In addition, a steady shift of practitioners into non-contracted private practice (*Wahlärzte*) makes it difficult to fill SHI-contracted posts in rural areas (see Section 5.2). This problem is compounded by a low and declining share of general practitioners (GPs), who constituted only 13 % of all physicians in 2023, down from over 16 % in 2010. A similar challenge exists in nursing where ministry projections estimate that around 51 100 additional nursing staff will be needed by 2030 compared to 2023 to meet both replacement and demographic needs (GÖG, 2023).

In response to these complex pressures, Austria has launched a coordinated reform strategy. A new five-year specialty in General and Family Medicine will start in mid-2026. Additionally, time-limited start-up incentives of up to EUR 100 000 have been introduced for SHI posts. A central lever is the expansion of multidisciplinary primary health care units (PHCUs), supported by EU Recovery and Resilience Facility until 2026 to improve first-contact care and make

public-sector practice more attractive. By July 2025, the number of PHCUs in Austria had reached 100. For nursing, a new training allowance (*Pflegeausbildungszuschuss*) and an adult scholarship (*Pflegestipendium*) aim to attract entrants and career-switchers, while large-scale Community Nursing pilots have been rolled out.

Figure 12. Austria boasts one of the highest densities of health professionals in the EU



Note: The EU average is unweighted. The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors. In Greece, the number of nurses is underestimated as it only includes those working in hospital.
Source: OECD Data Explorer (DF_PHYS, DF_NURSE). Data refer to 2023 or nearest year.

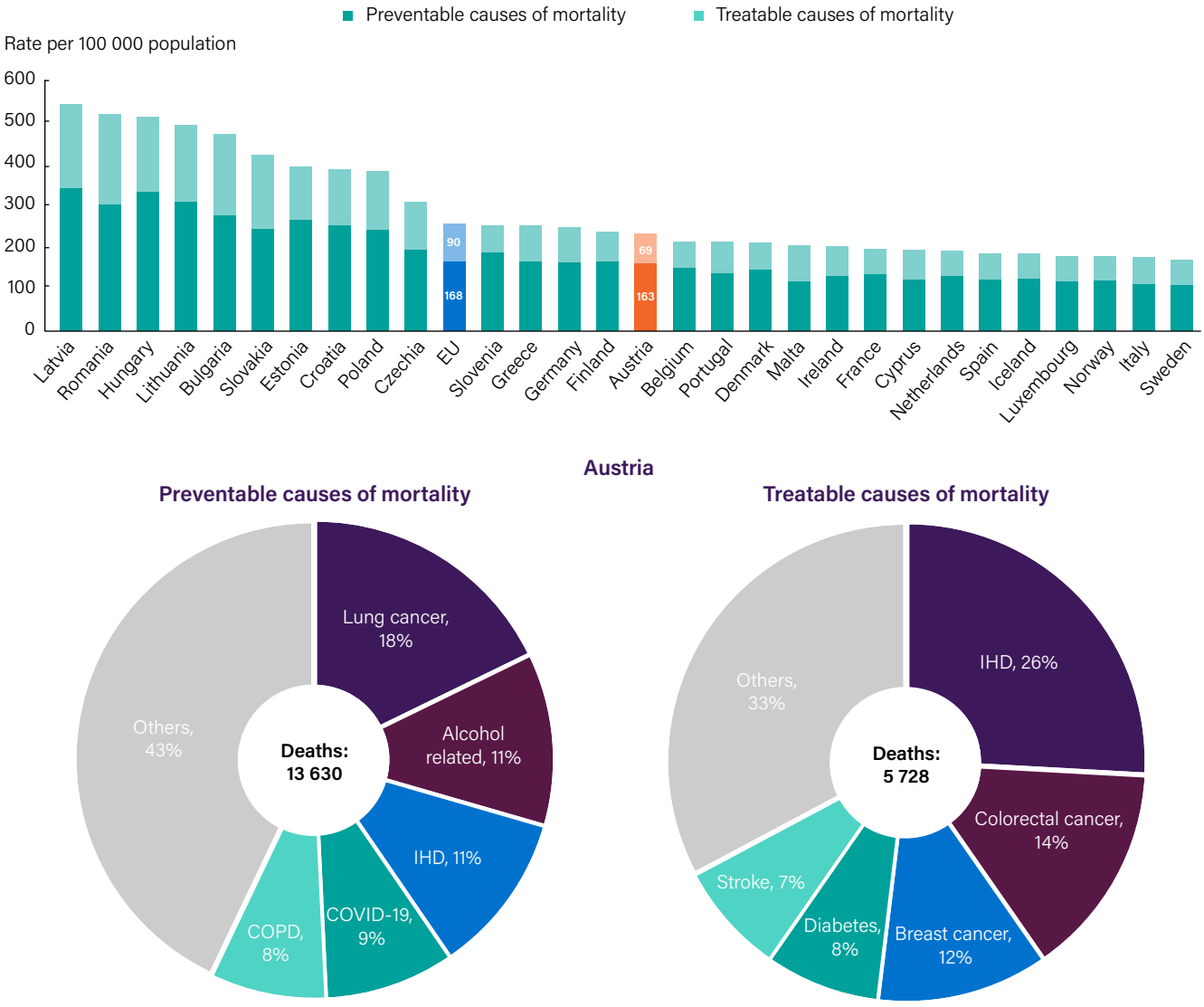
5 Performance of the health system

5.1 Effectiveness

Mortality rates from preventable and treatable causes are below the EU average

Austria's mortality rates from potentially preventable and treatable causes indicate that the country's above average performance in disease treatment contrasts somewhat with persistent challenges in prevention. In 2022, Austria recorded 163 preventable deaths and 69 treatable deaths per 100 000 population - 3 % and 23 % below the EU averages, respectively. Although these figures indicate favourable outcomes, preventable mortality rates remain among the highest in Western Europe (Figure 13). The high burden of preventable mortality is driven primarily by lung cancer (18 % of preventable deaths), alcohol consumption (11 %), and ischaemic heart diseases (11 %). Policy responses to these drivers have been fragmented: for example, while Austria implemented an indoor smoking ban in 2019, smoking prevalence remains high and the rise of alternative products like vaping and nicotine pouches have partially offset declines in traditional smoking (Schmutterer & Akartuna, 2025). Moreover, there is an absence of large-scale national programmes targeting alcohol abuse or comprehensive strategies for preventing heart disease, with interventions limited to regional initiatives (e.g. *Alkohol. Leben können*) or pilot programmes (e.g., the *Herzmobil* disease management programme in several federal states). In contrast, the healthcare system demonstrates considerable effectiveness in delivering care once a patient is ill. Mortality from treatable causes has seen meaningful progress, declining by 13 % between 2012 and 2022, a rate of improvement slightly better than the EU average.

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

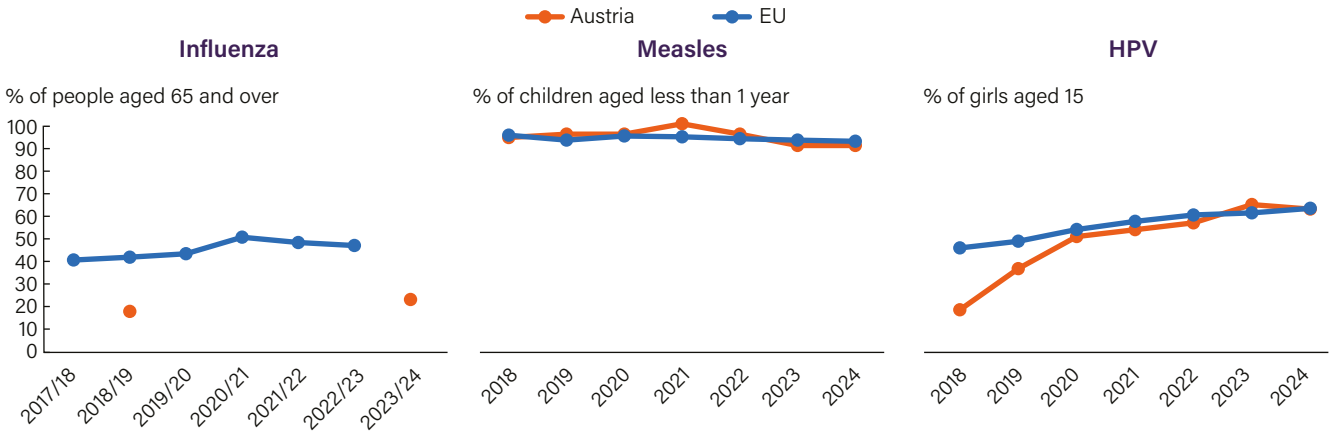


Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths for some diseases (e.g. ischaemic heart diseases (IHD), stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death. COPD refers to chronic obstructive pulmonary disease.
Source: Eurostat (hlth_cd_apr). Data refer to 2022.

Vaccination efforts show mixed progress amid strong political commitment

Despite sustained political will to boost immunisation rates, Austria's performance remains uneven. The country's vulnerability became apparent during the measles outbreak that struck Europe in 2024, when Austria recorded 542 cases - one of the highest notification rates in the EU (ECDC, 2025). The challenge extends beyond childhood immunisation: influenza vaccination coverage among people aged 65 and over reached just 24 % in the 2023/24 season, trailing the EU average and remaining far from the ambitious 75 % goal (Figure 14). To address these gaps, Austria has mobilised a comprehensive policy response centred on removing financial barriers: since 2024/25, influenza vaccination is free for all residents under the national immunisation programme with immunisations obligatorily recorded in the electronic *e-Impfpass* to improve monitoring. Furthermore, the human papillomavirus (HPV) vaccination programme was expanded to be free for everyone up to age 21, and with a temporary offer up to age 30, which reached 170 000 people in the catch-up group (BMASGPK, 2025). Yet early evaluations reveal that achieving coverage targets will require continuous efforts to improve vaccine uptake in the population: the success of these initiatives hinges on addressing operational challenges, including streamlining vaccine ordering processes, improving the usability of the national immunisation information system (*e-Impfpass*) and developing targeted communication that effectively reaches older adults. (GÖG, 2024)

Figure 14. Influenza vaccination rates among older adults are among the lowest in the EU



Notes: The EU average is weighted for influenza (calculated by Eurostat) and unweighted for measles and HPV.
Sources: Eurostat (hlth_ps_immu) and WHO/UNICEF Joint Reporting Form on Immunization (JRF).

Breast cancer screening rates have remained stagnant

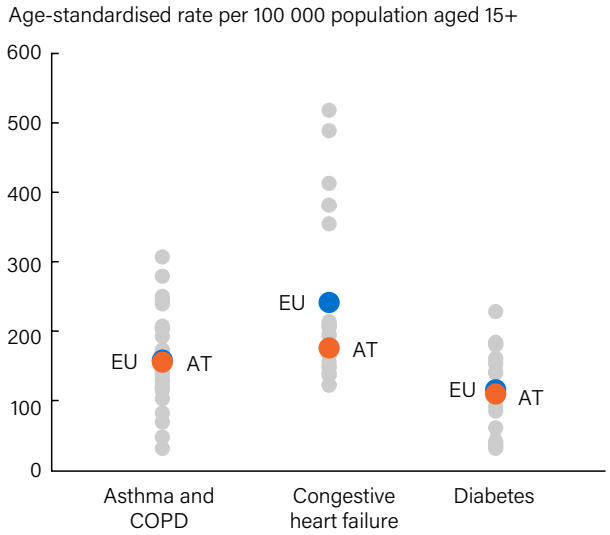
Austria's screening policy combines a single population-based programme for breast cancer with widespread opportunistic testing for other major cancers, producing a mixed performance profile. The breast cancer screening programme consistently struggles with low participation: rates have stagnated at around 40 % over the past five years, a figure well below the EU average of nearly 60 %. This challenge is compounded by some of the EU's largest socioeconomic inequalities in uptake, alongside significant regional disparities. In an effort to boost engagement, reimbursement was introduced in 2023 for doctors who provide consultations and risk assessments for the programme.

By contrast, opportunistic screening records much higher uptake: for cervical cancer, 85 % of women aged 20–69 reported having an opportunistic Pap test within the past year in 2019, a share above the EU average. Self-reported screening rates for opportunistic colorectal cancer are likewise among the highest in the EU, with participation in both stool tests (iFOBT/FIT) and colonoscopies among people aged 50 to 74 years significantly above EU averages (OECD/European Commission, 2025). Recent developments, such as the recommendation from the Austrian National Committee for Cancer Screening in 2023 to set out a population-based colorectal screening programme, signal a strategic shift towards more organised approaches in line with the 2022 EU Council Recommendation on cancer screening[1], even though the colorectal screening programme still awaits implementation.

Avoidable admissions are falling faster than the EU average and acute care outcomes are strong

Austria's progress in reducing avoidable hospitalisations is particularly noteworthy given its health system's lack of a formal gatekeeping function, a structure that typically encourages higher hospital use. Despite this, admissions for ambulatory care-sensitive conditions were 14 % below the EU average in 2023; performance was especially strong for congestive heart failure (CHF), 26 % below the EU average, while admission rates for asthma, chronic obstructive pulmonary disease (COPD) and diabetes were broadly in line with EU levels (Figure 15). However, the trajectory of these figures is more revealing than the absolute levels: between 2018 and 2023, Austria's admission rates for both CHF and diabetes declined at nearly double the EU pace. This was accompanied by a 16 % decline in overall inpatient discharges, suggesting a genuine shift towards community-based care, alongside a more efficient use of resources (daycare) and a reduction of unnecessary hospitalisations. While COVID-19-related disruption was certainly a contributing factor, the concurrent expansion of primary care

Figure 15. Avoidable hospital admissions are on par with the EU average except for heart failure



Note: Admission rates are not adjusted for differences in disease prevalence across countries.
Source: OECD Data Explorer (DF_HCQO). The data pertain to 2023.

[1] Council Recommendation of 9 December 2022 on strengthening prevention through early detection: A new EU approach on cancer screening replacing Council Recommendation 2003/878/EC 2022/C 473/01.

units points to a successful rebalancing of the system away from hospital-centric care (see Section 5.3).

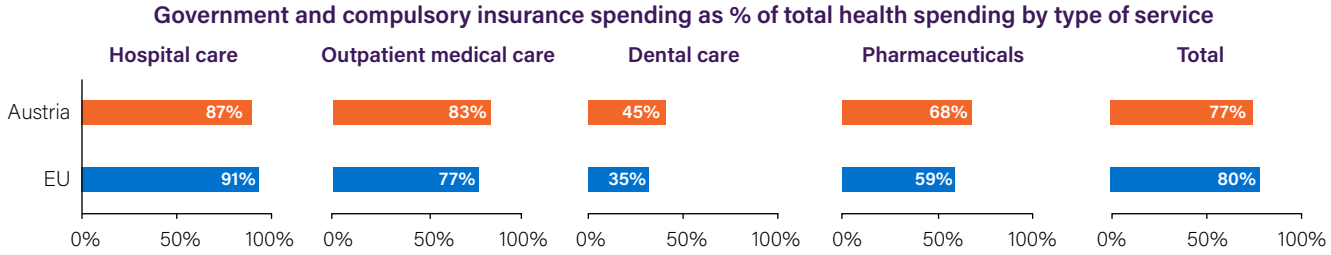
This improved management of chronic conditions is occurring alongside consistently high-quality acute hospital care. Austria's 30-day mortality after hospitalisation for heart attack among people aged 45 and over was in line with the EU average at 6 %, while mortality following an ischaemic stroke was significantly lower at 6 % compared to the EU average of 9 %.

5.2 Accessibility

Coverage is almost universal, offering a broad benefits package

Austria's social health insurance (SHI) system achieves near-universal coverage through expansive eligibility and comprehensive benefits. The system covers 99.9 % of the population, having expanded in recent decades to include people in non-standard work and asylum seekers during basic care. This comprehensive approach includes financial protection mechanisms, such as exemptions and means-tested caps on prescription fees. This extensive public commitment is reflected in public financing rates, although coverage rates vary by service. While outpatient care, dental services and pharmaceuticals enjoy higher public coverage rates than EU averages, public sources covered 87 % of inpatient care spending, a share slightly below the EU average due to OOP payments for per-diem hospital charges and private amenity upgrades. As in most other EU countries, the most significant coverage gap lies in dental care, where only 45 % of spending is publicly-funded. However, Austria's coverage rate remains comparatively high at over ten percentage points above the EU average (Figure 16).

Figure 16. Public coverage of care is higher in Austria than in the EU, except for hospital care



Notes: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA). The data pertain to 2023.

Unmet needs for medical care are low in Austria

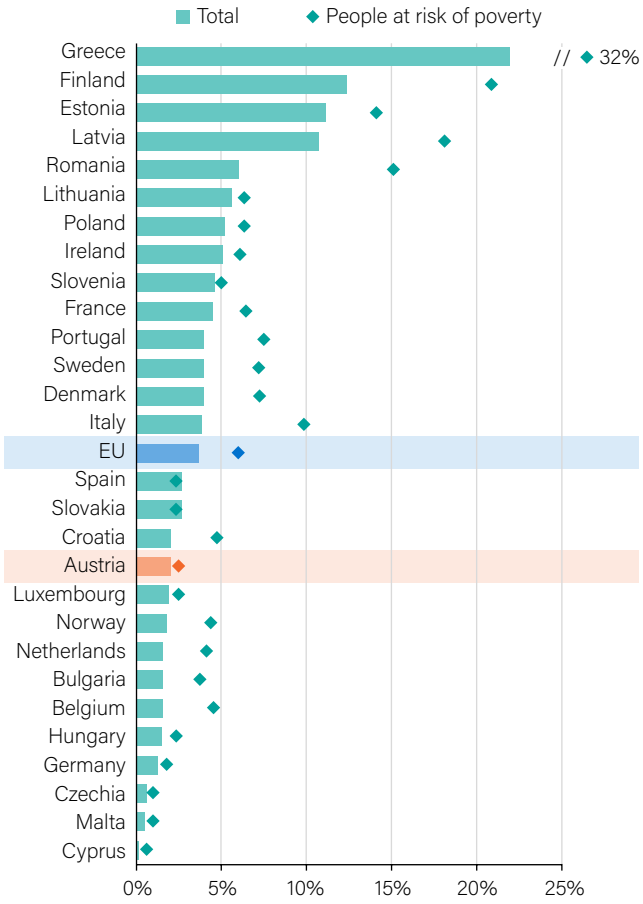
Austria is one of the EU's better-performing countries in meeting the population's medical needs. In 2024, among people that reported experiencing some medical need, only 2 % of them reported being unable to meet it due to costs, travel distance or waiting time. A figure that rises modestly to 2.4 % among those at risk of poverty, in stark contrast to the EU average of 6 % (Figure 17). Factors contributing to these relatively low levels of unmet needs include free access to outpatient departments in hospitals and some providers, particularly in large cities, who serve uninsured persons free of charge. However, this aggregate success masks a fundamental structural tension that shapes how different population groups experience access to care. While the number of publicly contracted doctors has stagnated, the number of non-contracted private physicians (*Wahlärzte*) has surged by 61 % since 2004. This creates a trade-off for patients, who can either endure sometimes long waits for a fully-covered appointment with a contracted doctor, or pay upfront and later claim a partial refund for quicker access with a private one.

By rule, *ÖGK* generally reimburses 80 % of the SHI tariff for an equivalent contracted service - often well below the private fee, so a non-trivial co-payment remains unless a supplementary policy covers it. Empirically, patients with private cover are offered shorter waits for elective surgery, and there is documented evidence of offers to reduce waiting times via informal payments, raising equity flags in an otherwise universal system (Kraus, Stacherl, Czypionka, & Mayer, 2024). To address this issue, high-volume non-contracted physicians are required to support patient reimbursement by directly submitting claims to the SHI, and are also obligated to use the ELGA system to ensure better integration with national health records.

Affordability is a concern for services not fully covered by public schemes

Despite Austria's extensive SHI coverage, gaps in financial protection for certain services drive a relatively high level of private spending. Private expenditure accounted for nearly one-quarter of total health spending in 2023, a higher share than the 20 % average across the EU. OOP payments by households represented 17 % of total health spending, slightly above the EU average of 16 % (Figure 18). Medicines place the greatest OOP burden on households, with more than one in five euros of health expenditure going to retail pharmaceuticals, while outpatient medical care, long-term care and dental care each account for 18 % of OOP spending.

Figure 17. Unmet medical needs among people at risk of poverty are among the lowest in the EU



Notes: The EU average is weighted. Data refer only to individuals who reported having medical care needs. People at risk of poverty are defined as those with an equivalised disposable income below 60 % of the national median disposable income.
Source: Eurostat database (hlth_silc_08b). Data refer to 2024.

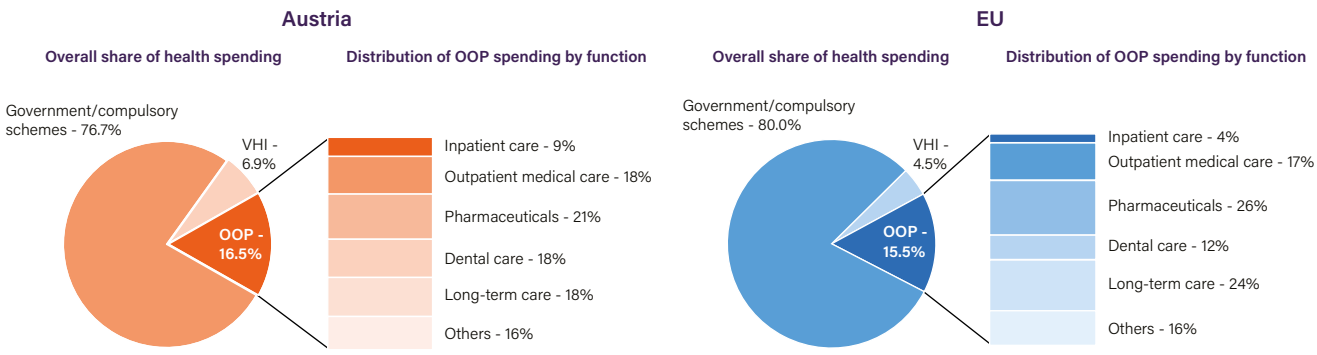
By contrast, EU households on average devote a larger share to long-term care (24 %) and a smaller share to dental care (11 %). These patterns reflect benefit design and provider choice: dental care is only partially included in the SHI package, and patients who use *Wahlärzte* face sizeable OOP costs. The comparatively large role of VHI, which accounts for 7 % of total health spending, is consistent with this profile: approximately 39 % of the population holds some form of supplementary policy.

The supply of physicians across regions is uneven, contributing to access inequities

Austria's high overall physician supply masks substantial access gaps driven by significant geographic and specialty maldistribution. While the national average is a robust 553 practising physicians per 100 000 population, this figure conceals a stark imbalance, with densities ranging from 705 in Vienna to just 446 in Upper Austria (Figure 19). The problem is particularly acute in primary care, where a chronic shortage of GPs has led to 80 unfilled SHI-contracted posts. As of mid-2024, these gaps were concentrated in largely rural states like Lower and Upper Austria, while Vienna and other urbanised areas enjoyed near-full coverage, highlighting the depth of the urban-rural divide (Austrian Medical Association, 2023). These workforce gaps translate directly into significant and inequitable barriers for patients, most notably in the form of long and variable waiting times.

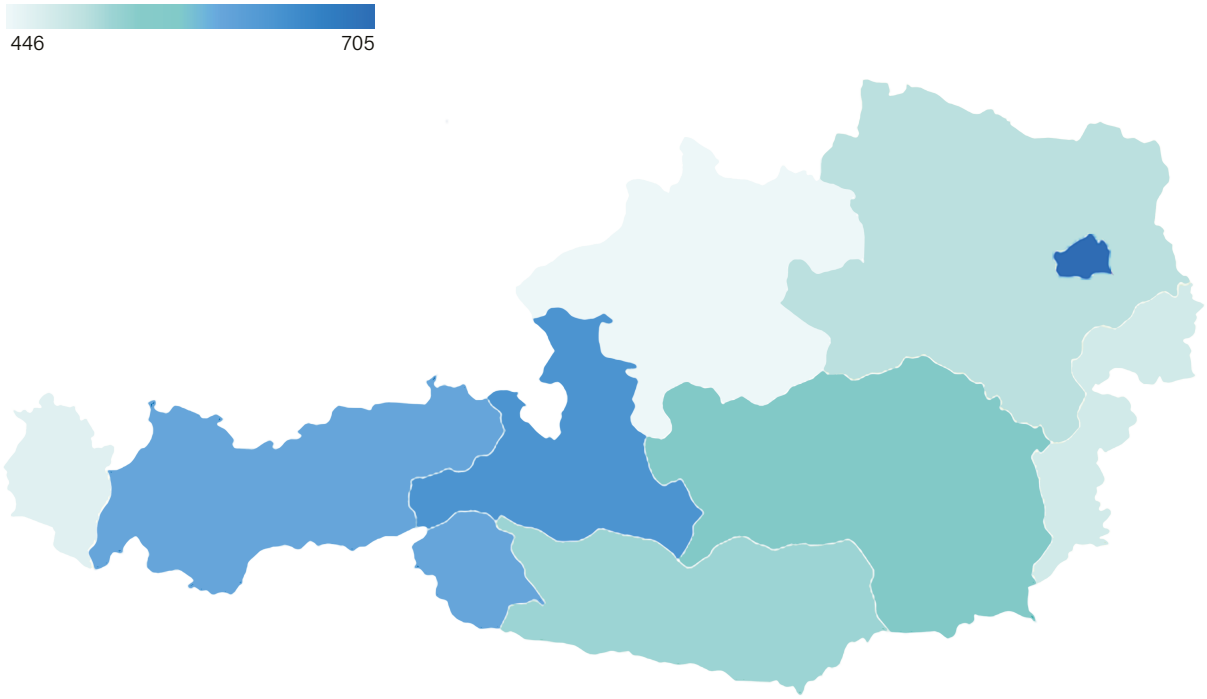
Waiting times for elective surgery vary dramatically by location; for example, in 2024 the median wait for a hip replacement at Vienna's largest hospital was six weeks but can extend to over 30 weeks in smaller Viennese hospitals (Vienna Health Network, 2025). National survey evidence confirms these long waits and reveals a critical equity concern, with shorter waiting times consistently associated with holding supplementary private insurance (Kraus, Stacherl, Czypionka, & Mayer, 2024). In response, Austria has launched a series of reforms to strengthen non-hospital care and address workforce shortages. Under the 2024–2028 government initiative, the country is expanding team-based primary care centres (PHCUs) and offering a '*Startbonus*' of up to EUR 100 000 to attract physicians to hard-to-fill posts in underserved areas (see Section 4).

Figure 18. Austrian residents spend a comparatively large share of out-of-pocket spending on outpatient and dental care



Note: VHI also includes other voluntary prepayment schemes. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA). Data pertain to 2023.

Figure 19. Physician density is highest in Vienna



Note: refers to all practising physicians
Source: Statistik Austria (2025). Data pertain to 2023.

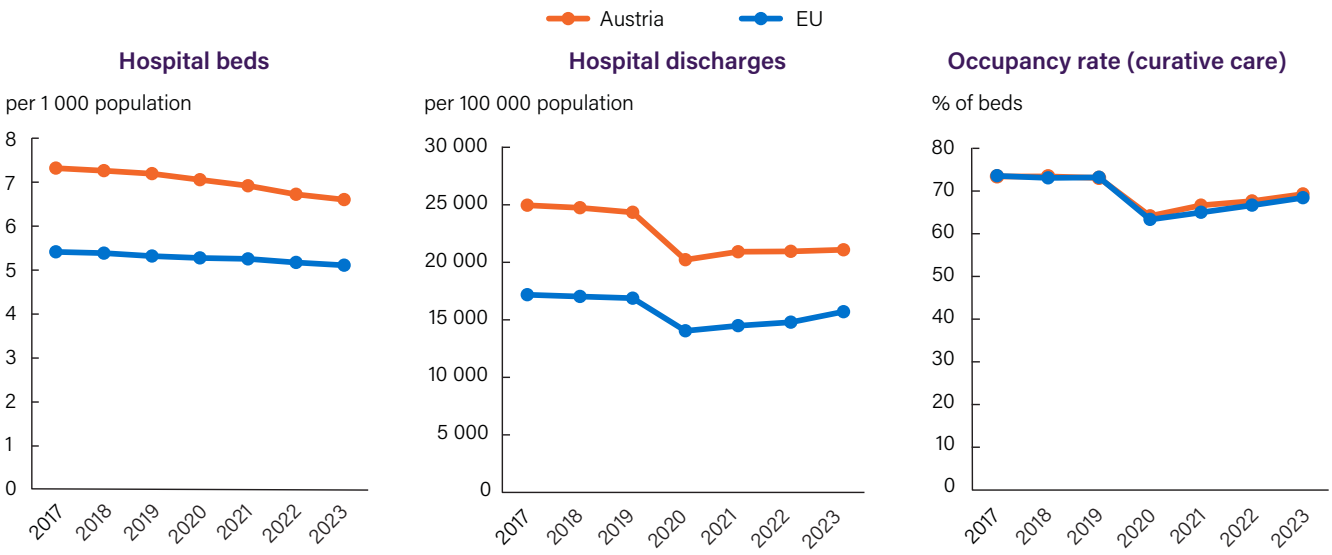
5.3 Resilience

Health system resilience - the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks and structural changes - has become central to policy agendas. Key priorities include easing pressures on service delivery, strengthening health infrastructure and workforce capacity, adapting crisis preparedness strategies, supporting digital innovation, and safeguarding long-term sustainability.

While inpatient activity remains high, Austria is gradually reducing hospital capacity

Austria is actively reducing its hospital capacity as part of a broader strategic shift toward strengthening outpatient care. Between 2017 and 2023, the number of hospital beds per capita fell by 10 %, a deliberate rebalancing that corresponds with a 15 % decline in overall inpatient discharges over the same period. However, this transition is proceeding from a high baseline: at 6.6 beds per 1 000 population, Austria's

Figure 20. Austria's hospital bed capacity declined by 9 % over the past five years



Note: The EU average is weighted for hospital beds and hospital discharges.
Source: Eurostat (hlth_rs_bds1) and OECD Data Explorer (DF_KEY_INDIC).

hospital capacity remains around 30 % above the EU average (Figure 20). This high capacity is mirrored in high levels of hospital activity: for instance, the volume of common elective procedures such as hip and knee replacements remains 39 % and 51 % above EU levels, respectively. Although these procedures saw a sharp, pandemic-related decline in 2020, their persistently high volumes highlight the system's longstanding reliance on hospital-based care.

Following the pandemic spending surge, Austria is tackling persistent cost pressures and budget overruns

Austria's public healthcare spending in recent years has been defined by an unprecedented shock from the pandemic followed by a period of budget consolidation. Between 2015 and 2019, real public spending per capita grew by a modest 1.7 % annually, slower than the EU average of 2.9 %. This trajectory was dramatically reversed from 2019 to 2021, when spending surged by 17 % in real terms, driven by massive outlays for testing and vaccination. As these emergency programmes were wound down, this pandemic-specific spending was rapidly curtailed, bringing Austria's public spending growth rate slightly below its pre-pandemic path (Figure 21). However, this return to the prior public spending trajectory masks persistent underlying cost pressures on core health services. While the trend appears moderate, it originates from an already high level, with nominal spending on inpatient, outpatient and long-term care continuing to rise, fuelled by wage increases, energy costs and various fee adjustments. This creates a challenge for Austria's 2024-2028 cost-containment policy administered by the health reform partnership *Zielsteuerung-Gesundheit*, which sets binding expenditure ceilings (Ministry of Health, 2024). These ceilings have been consistently surpassed since the pandemic, underscoring persistent cost pressures and the need to continue shifting activity out of hospitals.

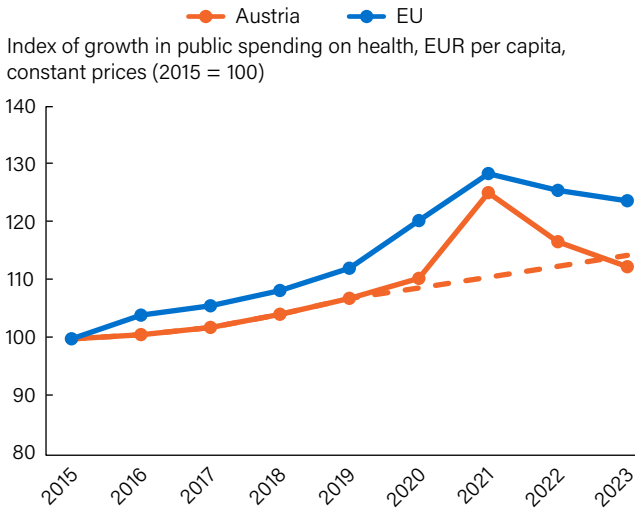
To support structural rebalancing without re-inflating baseline current spending, Austria has been allocated EUR 254 million through the EU's Recovery and Resilience Facility (RRF). These funds are strategically targeted to strengthen the system's foundations, with investments focused on expanding primary care units, developing community nursing and establishing a new centre for precision medicine among other priorities.

Austria's levels of capital investment in health ICT are the second-largest in the EU

Austria is a leading EU country for capital investment in health, driven by major spending on digital infrastructure. Annual ICT capital investment grew by 24 % in real terms since 2015, reaching more than EUR 9 million per 100 000 population, about four times the EU average (Figure 22). This high level of expenditure is mostly driven by the national electronic health record (ELGA). However, while the investment is substantial, ELGA has been hampered by persistent implementation challenges (Box 1), which partly explain Austria's relatively low uptake of digital health services. In 2024, only 28 % of Austrian residents reported making a medical appointment online compared with an EU average of 40 %, while 23 % accessed their own electronic health records compared to 28 % in the EU.

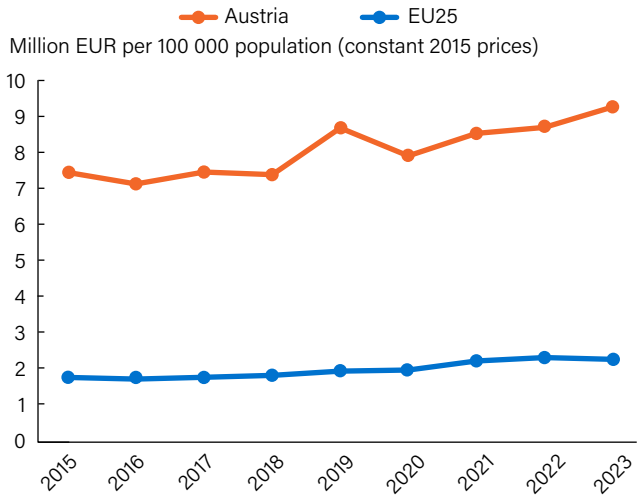
To address these shortcomings and accelerate the digital transition, a series of recent reforms are being implemented: as part of the 2024-2028 health reform, approximately EUR 51 million is earmarked annually to expand digital services. This includes plans for upgrading the national health hotline (1450) into an appointment-booking centre and, crucially, mandating that all ambulatory care providers - including *Wahlärzte* - connect to and use the ELGA system.

Figure 21. Austria's public healthcare spending per capita has returned to its pre-pandemic growth rate trend in 2023



Notes: The EU average is weighted, calculated by the OECD. The dashed line represents the projected trend based on pre-pandemic (2015-2019) data.
Source: OECD Data Explorer (DF_SHA).

Figure 22. Austria's investments in ICT in health are far above the EU average



Note: Values refer to gross expenditure and include ICT equipment and computer software and databases. Data refer to human health and social work activities (Q).
Source: Eurostat database (nama_10_a64_p5).

Box 1. Austria is overhauling the governance of its e-health system

Austria's national electronic health record, *ELGA*, has long struggled to fulfil its potential, hampered by governance and implementation problems. Although designed to provide a comprehensive view of patient data to improve quality and avoid duplication, ELGA's development has been marked by diffuse steering, with responsibilities spread across more than 20 committees, leading to significant gaps in its content and utility. As a result, while ELGA holds some 80 million electronic reports, these come mostly from hospitals; data from ambulatory specialists are rare, and links to private laboratories are partial, with imaging data only partly connected and the e-medication function also lacking consistent recording of dosages.

Corrective steps are under way: A 2024 overhaul of the Health Telematics Act will, from 2026, mandate the uniform storage of key documents such as discharge letters and lab results. In parallel, a new national e-Health Strategy seeks to clarify institutional roles and strengthen governance. These reforms are matched by preparations to join the EU-wide data exchange via MyHealth@EU, starting with e-prescriptions and the roll-out of a cross-border Patient Summary.

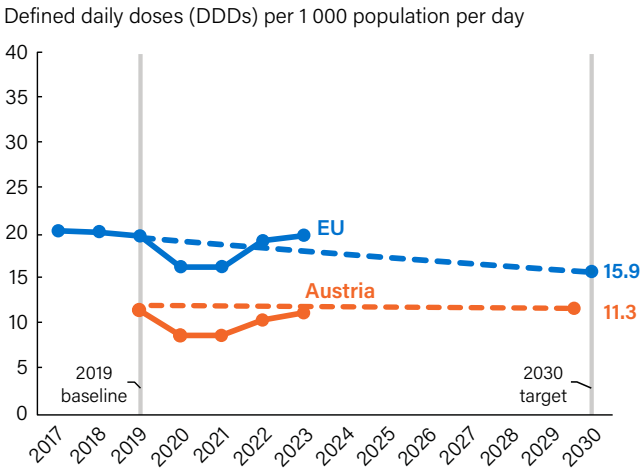
Sources: Austrian Court of Auditors (2024), BMASGPK (2024).

Antibiotic consumption in Austria is among the lowest in the EU

Curbing excessive antibiotic use is a central pillar in Austria's strategy to address antimicrobial resistance (AMR), with sustained monitoring becoming increasingly important in light of the EU Council's 2030 reduction targets adopted in 2023.[2] As in many EU countries, Austria experienced a marked decline in antibiotic consumption during the COVID-19 pandemic, driven by lower infection rates and reduced healthcare interactions. However, reflecting broader EU trends, consumption began to rebound in 2022 and 2023 as infection rates normalised (Figure 23). Despite this uptick, Austria remains among the countries with the lowest antibiotic use in the EU: in 2023, consumption stood at 11.3 defined daily doses (DDDs), which is 43 % below the EU average. Austria has already met its national 2030 target consistently between 2020 and 2023; whether this progress can be maintained post-pandemic remains uncertain in light of recent increases.

Austria's efforts are framed by a national AMR action plan, first introduced in 2013 and most recently updated in 2021. The strategy adopts a "One Health" approach, recognising the links between human, animal, and environmental health. Its overarching objective is to slow the emergence and spread of antimicrobial resistance while safeguarding the effectiveness of existing treatments.

Figure 23. Antibiotic consumption in Austria decreased during the COVID-19 pandemic and rebounded afterwards



Note: The EU average is weighted. The chart shows antibiotic consumption in hospital and the community. The dashed line illustrates the policy target pathway to meet the 2030 reduction targets.
Source: ECDC ESAC-Net.

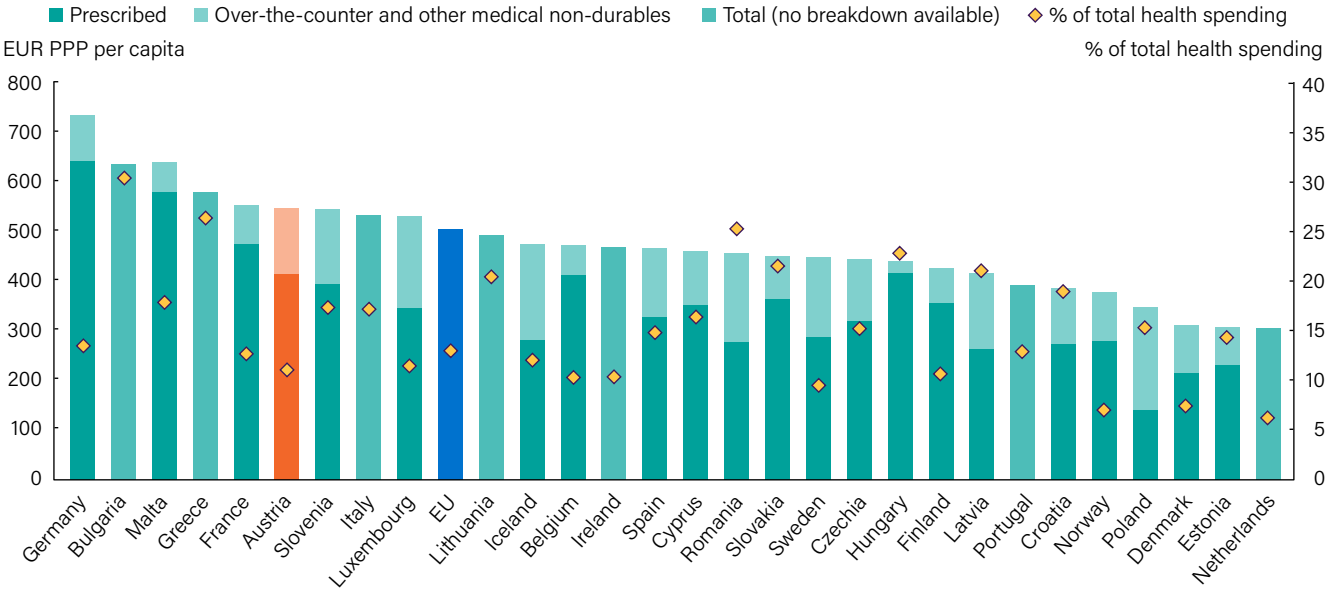
[2] Council Recommendation on stepping up EU actions to combat antimicrobial resistance in a One Health approach, 2023/C 220/01.

6 Spotlight on pharmaceuticals

Austria's per capita retail drug spending is moderately above the EU average, with access governed by the tiered EKO reimbursement system

Austria's retail pharmaceutical spending remains moderately above the EU average, reaching EUR 554 per capita in 2023, around 10 % higher than the EU average of EUR 510 (adjusted for purchasing power). This represents 11 % of total health expenditure, slightly below the EU average of 13 %, reflecting comparatively high overall health spending rather than unusually large pharmaceutical budgets (Figure 24). Access to reimbursed outpatient medicines is governed by the reimbursement codex (*Erstattungskodex - EKO*), Austria's positive list of medicines covered by SHI. The EKO's three-tier box system ranges from unrestricted access for 'green' box medicines, to additional authorisation or documentation requirements for those in the 'yellow' box, and temporary reimbursement for 'red' box medicines still under evaluation for reimbursement. In 2024, the EKO listed 7 720 medicines - about 80 % in the green box and fewer than 0.2 % in the red box. Austria counted 9 310 approved medicines in 2024 (PHARMIG, 2025).

Figure 24. Expenditure on retail pharmaceuticals per capita is about 10 % higher in Austria than the EU average

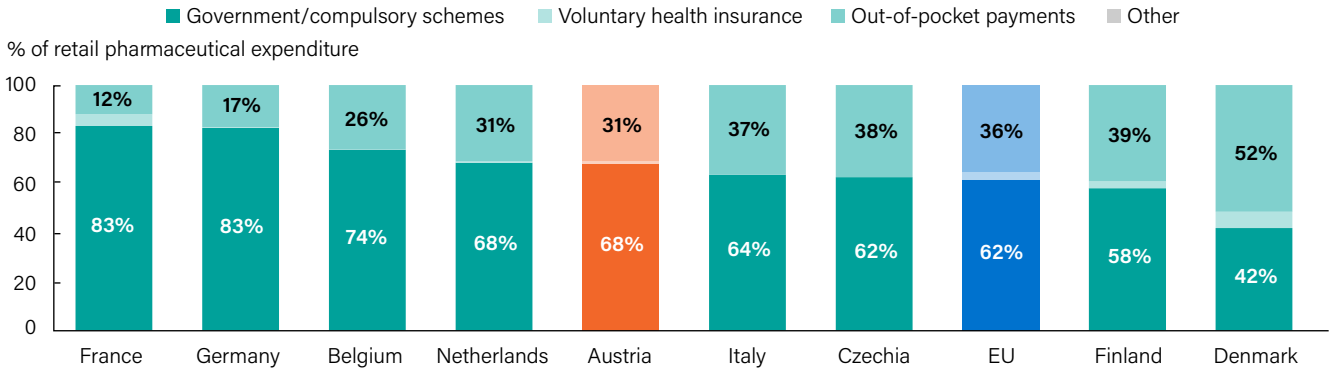


Note: This figure represents pharmaceutical expenditures dispensed through retail pharmacies for outpatient use only. It excludes medications administered in hospitals, clinics or physician offices.
Source: OECD Data Explorer (DF_SHA). Data pertain to 2023, except for Norway (2022).

The Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection, advised by the Pricing Committee, sets maximum ex-factory prices for reimbursable medicines based on the EU average; retail prices incorporate wholesale and pharmacy mark-ups and a 10 % VAT. The Austrian Social Insurance determines whether a medicine will be included in the EKO. Patients pay a fixed prescription fee of EUR 7.55 per reimbursed medicine; while traditionally indexed to inflation, the government plans to freeze the fee at its current level until 2026, and subsequently lower the exemption threshold from 2 % to 1.5 % of net annual earnings. There is also a general exemption for certain population groups, which includes, for example, the exemption from co-payments for medical products in addition to the exemption from prescription fees.

SHI covers 68 % of retail pharmaceutical expenditure and patients directly contribute 31 % (Figure 25). OOP payments cover the prescription fee, non-reimbursable medicines and over-the-counter purchases.

Figure 25. About two thirds of expenditure on retail pharmaceuticals are covered by SHI in Austria



Note: The EU average is unweighted.
Source: OECD Data Explorer (DF_SHA). Data pertain to 2023, except for Malta (2022).

Retail pharmaceutical spending is being tightly controlled, while spending for hospital-procured medicines has increased rapidly

Austria's pharmaceutical spending landscape is shaped by two contrasting dynamics: effective cost containment in the outpatient sector and mounting expenditure pressures in hospitals. Between 2015 and 2023, retail pharmaceutical spending grew by less than 1 % annually in real terms, reflecting a combination of patent expirations and stringent pricing regulation. Notably, a 2023 rule change reduced the allowable price corridor between the highest-priced medicine and the lowest-priced medicine of the same active ingredient in the "green box" of the EKO from 30 % to 20 %, with non-compliant products subject to EKO delisting. In contrast, inpatient pharmaceutical expenditure, estimated at EUR 1.3 billion, or roughly one-third of total pharmaceutical spending, is rising steadily, driven by increased use of high-cost specialised medicines. Cost pressures in this sector are exacerbated by a fragmented procurement and governance model: hospital medicines are acquired through decentralised negotiations at the facility level, with tendering used only in rare cases. Similarly, managed-entry agreements[3] (MEAs) for new expensive therapies are often hospital-specific, contributing to regional variation in pricing and access, unlike the nationally-coordinated system for outpatient medicines (Vogler, 2022).

To alleviate these budget pressures, the 2024 healthcare reform established the Federal Appraisal Board (*Bewertungsboard*). The board provides guidance on the use of high-priced and specialised medicines and aims to enhance coordination across Austria's hospital sector. It represents a political and institutional compromise, emerging after proposals for a binding EKO-like prescribing framework for hospitals met prolonged opposition from the *Bundesländer*. By closing a long-standing gap in inpatient health technology assessment (HTA), the *Bewertungsboard* also supports Austria's implementation of the EU HTA Regulation from 2025, which can bring potential benefits through joint HTA activities at the European level.

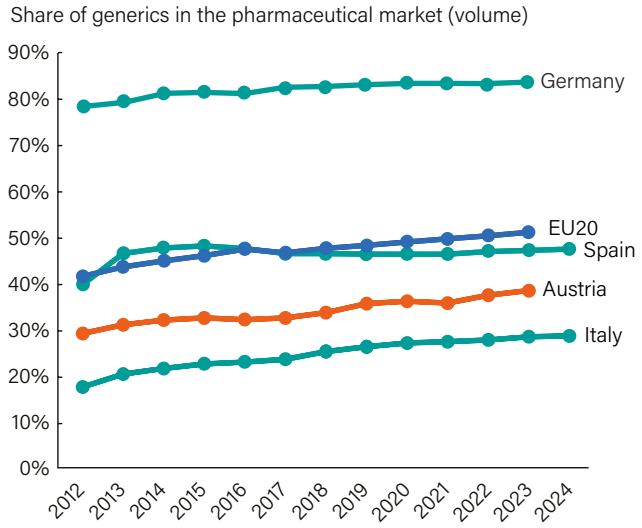
Austria's uptake of generic and biosimilar medicines is comparatively low

Austria continues to lag behind many EU countries in the use of generic and biosimilar medicines, limiting potential savings in pharmaceutical spending. In the largely reimbursed outpatient market, generics accounted for 38 % of volume in 2023, below the EU average of 51 %, well behind Germany and Spain, though above Italy (Figure 26). While Austria's generic share has risen by about 45 % since 2010, faster than the EU average increase of roughly 32 %, it still trails peers with higher within-market penetration. Biosimilar uptake is uneven: although Austria outperforms the EU average in oncology-related biosimilars (92 % compared to 83 %), adoption is considerably lower in other high-cost therapeutic areas such as tumour necrosis factor inhibitors used for autoimmune diseases (48 % compared to 77 %). Overall, Austria remains below the EU average in seven of ten analysed biosimilar categories and above average in three (IQVIA, 2025).

Efforts to expand generic use in Austria have faced mixed success, reflecting both policy ambition and institutional resistance. As part of the 2023 health reform, the government proposed introducing international non-proprietary name (INN) prescribing, requiring physicians to prescribe by active substance rather than brand name to reduce costs and encourage generic uptake. However, the measure was abandoned following opposition from the Austrian Medical Chamber and the pharmaceutical industry, who raised concerns about patient safety and treatment adherence. Additionally, Austria does not have generic substitution, making it the only EU member state that has neither INN prescribing nor generic substitution.

[3] MEAs are confidential contracts between manufacturers and public payers that link payment of expensive therapies to real-world outcomes. While MEAs can enable earlier access and maintain affordability, they also increase data collection burdens and impede competition on prices due to intransparency.

Figure 26. The share of generics in Austria's pharmaceutical market has increased markedly over the past decade, but remains lower than the EU average



Note: The EU average is weighted. Because countries can report different market scopes, figures should be read as within-market penetration rather than total-market shares.
Source: OECD Data Explorer (DF_GEN_MRKT).

Austria uses stringent price-linking for medicines and mandated economic prescribing to control pharmaceutical spending

Austria maintains one of the most stringent price-linking mechanisms for generic and biosimilar medicines in Europe. The first generic added to the reimbursement list (EKO) must be priced at least 50 % below the originator (38 % for biosimilars), with the second entrant required to undercut the first by an additional 18 % (15 % for biosimilars). Within three months of generic market entry, the originator must reduce its price by at least 30 % or lose reimbursement status. When a third generic or biosimilar medicine enters reimbursement, the originator must lower its price accordingly to the newly set price level. This pricing policy significantly lowers originator prices upon generic entry, thereby reducing the additional savings typically gained by expanding generic market share, particularly when compared to countries without such mechanisms. However, while the lowering of the originator price may generate savings, it is likely to achieve less than more competitive approaches, such as tendering-like policies. Although only a few countries require originator prices to be reduced in the generic/biosimilar price link policy, generic/biosimilar price link policies are rather common in Europe.

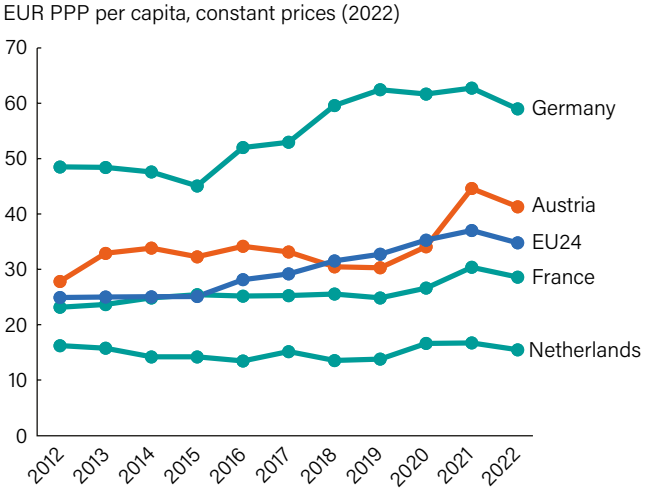
Prescribing behaviour is further shaped by regulatory and monitoring tools. Under the SHI directive on economic prescribing (*Richtlinie über die Ökonomischen Verschreibweise - RÖV*), physicians are required to prescribe the cheapest available option. A digital decision-support system assists with compliance, and individual prescribing patterns are routinely monitored and benchmarked against peers in the same specialty.

Austria's pharmaceutical industry is R&D-intensive, supported by generous tax incentives

Austria has demonstrated a significant expansion in pharmaceutical industry research and development (R&D) investment since the onset of the COVID-19 pandemic. In 2022, per capita business R&D investment in the pharmaceutical sector reached EUR 41, adjusted for purchasing power. This figure stands 19 % above the EU average and represents a 36 % increase in real terms from 2019 (Figure 27).

A key factor supporting this investment trend is Austria's expenditure-based fiscal support for R&D, which benefits the pharmaceutical sector across all stages of innovation. The system allows for the full deductibility of all qualifying R&D expenses. Additionally, companies receive a 14 % refundable R&D premium on qualifying expenditures (*Forschungsprämie*); this premium is non-taxable, is credited directly to the tax account regardless of corporate profits and can be claimed even if the company is loss-making, effectively reducing the upfront costs of R&D.

Figure 27. Austria's spending on pharmaceuticals R&D per capita was above the EU average in 2022



Note: The EU average is weighted (calculated by the OECD).
Source: OECD Data Explorer (DF_ANBERDi4).

7 Key findings

- Austria's life expectancy reached 82.3 years in 2024, surpassing its pre-pandemic peak and sitting about half a year above the EU average. However, marked inequalities persist: highly educated men live over six years longer than their least-educated counterparts. Reductions in cardiovascular disease mortality drive longevity gains, yet cardiovascular disease still accounts for over one third of deaths, with incidence well above EU levels. By contrast, cancer mortality is comparatively low, though cases are projected to rise sharply by 2040.
- Behavioural and environmental risks account for 29 % of deaths in Austria, led by diet-related factors, with air pollution adding a further 4 %. Smoking remains elevated among adults and adolescents and may have risen post-pandemic, while alcohol consumption is high. Obesity has increased to 17.4 % of adults, with adolescent overweight and obesity reaching nearly 23 %. These risks are concentrated among lower-education groups, where obesity is nearly twice as prevalent, underscoring the need for intensified prevention.
- Austria's social health insurance system ensures near-universal coverage but ranks among the most expensive in the EU. In 2023, per capita health expenditure reached EUR 4 901 – 28 % above the EU average. Although public spending is high in absolute terms, its share of total health expenditure is below the EU average, resulting in a comparatively greater reliance on out-of-pocket payments. Despite having one of the highest physician densities in the EU, Austria continues to face regional disparities, a declining share of general practitioners and significant projected nursing shortages. These challenges have prompted a continued expansion of multidisciplinary primary care models.
- Austria delivers strong outcomes once patients enter care, but prevention remains a weak link. In 2022, treatable mortality was 23 % below the EU average, while preventable mortality was only slightly below and remains high for Western Europe, driven by lung cancer, alcohol and ischaemic heart disease. Immunisation performance is mixed, with low influenza uptake despite expansion of free vaccination and a sizeable measles surge in 2024. Screening is uneven: organised breast screening stagnates at relatively low participation, while opportunistic cervical and colorectal testing is widespread.
- Coverage is near-universal and benefits are broad, yet access is becoming uneven as an expansion of private non-contracted practice raises out-of-pocket costs and creates longer waits for public contracted practices. While overall unmet needs remain low, regional workforce gaps, especially in general practice, sustain variability in waiting times. Ongoing reforms seek to expand team-based primary care and introduce targeted workforce incentives.
- Austria is gradually rebalancing care away from its hospital-centric model. Bed supply fell 10 % between 2017 and 2023, yet capacity remains high at 6.6 per 1 000 inhabitants and elective volumes are well above EU levels. Health ICT investment ranks second in the EU, though uptake of the ELGA electronic health record lags; new reforms mandate its use and expand telehealth services. Conversely, antibiotic consumption is low at 11.3 DDD per 1 000 per day, well below EU levels, representing a key strength.
- Austria's retail pharmaceutical spending is about 10 % above the EU average per capita, reflecting high overall spending and broad insurance coverage. While robust retail price regulation has helped contain outpatient pharmaceutical spending, rising pressures stem from hospital-procured medicines; to address this, a newly established Federal Appraisal Board is tasked with improving HTA for high-cost therapies. However, the scope for savings is limited by low generic penetration, uneven uptake of biosimilars and the absence of international non-proprietary name prescribing and pharmacy-level substitution. In contrast, pharmaceutical R&D investment is comparatively strong, supported by generous tax incentives.

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Country abbreviations

Austria	AT	Czechia	CZ	Germany	DE	Italy	IT	Netherlands	NL	Slovakia	SK
Belgium	BE	Denmark	DK	Greece	EL	Latvia	LV	Norway	NO	Slovenia	SI
Bulgaria	BG	Estonia	EE	Hungary	HU	Lithuania	LT	Poland	PL	Spain	ES
Croatia	HR	Finland	FI	Iceland	IS	Luxembourg	LU	Portugal	PT	Sweden	SE
Cyprus	CY	France	FR	Ireland	IE	Malta	MT	Romania	RO		

State of Health in the EU
Country Health Profiles 2025

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

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

The 2025 edition of the *Country Health Profiles* provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- an account of the pharmaceutical sector and policies within the country.

Complementing the key findings of the Country Health Profiles is the *Synthesis Report*.

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

Please cite this publication as: OECD/European Observatory on Health Systems and Policies (2025), *Country Health Profile 2025: Austria*. *State of Health in the EU*, OECD Publishing, Paris/ European Observatory on Health Systems and Policies, Brussels.

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