Two-tier healthcare:
An analysis of the healthcare system in Austria

Master Thesis

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DECLARATION IN LIEU OF OATH

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Content

1 Introduction

Over time the demographic realities have changed and therefore, nowadays the society faces not only a positive trend in healthcare to more prevention and body awareness but also a negative trend of growing unreasonableness in private consumption patterns. Typical civilization diseases, such as diabetes and heart failure, can be seen as a result of this negative tendency. In order to counteract the demographic realities one has to take action (Fischer, Breitenbach, & Aigner, 2013, p. 272).

It seems that an optimized care for individuals can only be achieved through self-financed health services. The entire market will focus more and more on economic criteria and consequently the private range of services has to expand, especially in the sectors of general practitioners, specialists and also partly in hospitals. Moreover, the present demographic change and the rapid technical progress in medicine require a suitable system, for instance with clearly limited public guarantees and additional optional privately financed health services. Therefore, the model of two-tier healthcare already has or can become a reality (Breyer & Kliemt, 2015, p. 137; Fischer et al., 2013, p. 272).

1.1 Problem definition

Two-tier healthcare is a type of system that consists of a public healthcare system providing guaranteed care for all citizens, and a parallel system offering the possibility for individuals to purchase care faster and often in a more pleasant environment (Smith, 2007, p. 915). Further, two-tier healthcare is defined as a system in which the society sets minimum standards but also allows individuals to purchase higher coverage with better access or quality by using their own means (Gruber, 2009, p. 12).

Moreover, the topic two-tier healthcare is connected with the system of public and private insurance and has a fundamental effect on doctors and patients. Doctors are looking more and more for positions in the private sector, as the payment in the public sector seems to be no longer adequate and thus there is a shortage of

doctors for statutory health insured patients. This in turn leads to long waiting times for these patients in order to get treatment. Therefore, patients are unsatisfied and feel helpless in this system (Hugo, 2013, p. 42). As a result, there are insured people who have a preference and also a willingness to pay for health services which are not offered by the public catalogue of services as well as for a single room in a hospital or in order to choose the treating doctor. Furthermore, the amount of people who prefer a doctor of one´s choice is rising because of the possibilities of earlier appointments as well as longer doctor´s consultations and the perceived subjectively better quality. These arguments and private payments lead, among others, to a two-tier healthcare system (Pruckner & Hummer, 2013, pp. 42–43).

The topic two-tier healthcare is a current and controversial issue and it splits people into two groups. One group perceives this system as positive and beneficial, the other group considers two-tier healthcare as negative and unfair (Rothbard, 2006, p. 129; Steinbock, 2007, p. 182).

Opponents of the two-tier healthcare system argue for instance that wealth should be morally irrelevant when it comes to the distribution of healthcare and that justice requires similar treatment for related cases. Additionally, people who are against two-tier healthcare claim that the goal of treating a patient should be the preservation and restoration of health. Thus, medical need should be the decisive criterion for distribution but not wealth (Hutt, Heath, & Neighbour, 2005, p. 41; Williams, 1962, pp. 110–131). This in turn leads to the argument that two-tier healthcare is unjust due to the fact that different treatment for relevantly similar patients is allowed in this system (Krohmal & Emanuel, 2009, p. 4).

Proponents of the two-tier healthcare system point out that public funds are scarce, that healthcare is expensive and that resources are finite (Steinbock, 2007, p. 181). Moreover, the defenders state that not everyone can get everything they may need or want due to inescapable scarcity (Eddy, 1994, pp. 1792–1798). Therefore they argue that justice is needed in order to determine those goods or services to which people are entitled (Rawls, 1999, p. 275). In general, people should be entitled to access a wide range of healthcare that is not only basically important but also compatible with providing other vital services. Health is obviously essential for the society but the proponents of two-tier healthcare also demonstrate that this does not

mean that all healthcare services are equally important or that all beneficial treatments have to be provided regardless how unimportant or small the benefit or how high the cost (Brock & Daniels, 1994, pp. 1189–1196; Lie, 2002, p. 336).

In Austria, the debate about two-tier healthcare goes even further, as there is no consensus on whether a two-tier healthcare system exists or not. When it comes to medical care in Austria, one can hear two different kinds of discourse. One of them states that Austria has a two-tier healthcare system and the other one guarantees that health services are equally accessible for everyone. Thus, one can see that different perceptions of the Austrian healthcare system are existing (Flenreiss & Rümmele, 2008, pp. 128–129; Pollak, 2008, p. 50).

1.2 Goals and research question

Health in general is a topic of importance as firstly, health is a necessary condition for managing almost all goals in life (Brock & Daniels, 1994, pp. 1189–1196). Secondly, health is essential in order to achieve and enjoy valuable aims such as rich family life, meaningful work, hobbies and leisure. These are the reasons why access to healthcare is more crucial than access to other resources and why it matters which healthcare system exists in a country (Krohmal & Emanuel, 2009, p. 3).

As already stated in the introduction and problem definition, two-tier healthcare is a current and controversial topic with many different opinions as well as perceptions and the author wants to shed new light on this issue.

The goal of this master thesis is to elaborate on the topic two-tier healthcare, its main characteristics, the different perceptions and perspectives, the benefits and drawbacks as well as the occurrence of this system. Furthermore, the author aims at focusing on Austria and thus will explain the Austrian healthcare system as a first step and as a second step the two-tier healthcare system will be clarified. In addition, the author will put emphasis on Austrian doctors and patients in Tyrol and their perception of the healthcare system in Austria.

Therefore, the research question of this master thesis reads as follows: How do doctors and patients in Tyrol perceive the Austrian healthcare system with respect to its two-tier characteristics?

1.3 Structure of thesis

This master thesis consists of two main parts, namely a systematic literature review and an empirical analysis. Based on a systematic literature review, the author elucidates the topic two-tier healthcare. A special focus lies on healthcare systems in general as well as on the characteristics, different perspectives, the benefits and drawbacks as well as the occurrence of a two-tier healthcare system. Moreover, a qualitative empirical analysis in the form of interviews is conducted in order to find out how Austrian doctors and patients in Tyrol perceive the healthcare system in Austria.

2 Healthcare systems in general

According to Pavolini & Guillen (2013), healthcare systems are very complex policy fields, especially in comparison with other Welfare State´s institutions. Healthcare systems are unique due to the three following characteristics: “they are mostly based on services and not on transfers […]; they are at the same time a capital – and human-intensive sector, which requires a large amount of investments in technology, infrastructures, but also in high skilled professionals; they tend to offer, through various mechanisms, a universalistic-like coverage, with possible limited differentiation among users” (Pavolini & Guillen, 2013, p. 1).

There are two kinds of healthcare systems, namely one-tier healthcare and two-tier healthcare. The universal access to basic healthcare is part of the first tier of a healthcare system and the second tier provides additional care as well as treatment that will be only provided to people who opt into additional insurance or payment (Fourie, 2016, p. 194). The first tier offers a decent minimum of care which is distributed based on the need and equally accessible for everyone, whereas the second tier is based on the ability to pay and provides expanded and potentially better healthcare at private expense (Edge & Groves, 2018, p. 122). In this chapter, the author will clarify both kinds of healthcare systems.

In a one-tier healthcare system, every member of the society receives the same consistent healthcare which is defined in the preliminary stage, no matter, which insurance or social status or financial means an individual has. Nevertheless, this so called standard health service alone is not enough to ensure a one-tier healthcare system. If there is the possibility to buy extra and higher quality healthcare services it will again lead to a differentiation in the end. Therefore, there has to be in addition a prohibition of purchase of different or extra services and preferences. Moreover, a one-tier healthcare system which does not allow differentiation in services can also not allow competition as every kind of competition is the basis for the search of service and quality differentiation. The one-tier healthcare system is only feasible if the medical possibilities do not rise above the financial means. When medical possibilities are growing faster due to progress than the financial possibilities, priorities have to be set and service offers outside of the standard health service are

automatically resulting. A modern healthcare system cannot exist without the efficient impact of competition and medical possibilities are rising everywhere above the financial means. Therefore, from a pragmatical point of view a one-tier healthcare system is not feasible and when doing a realistic evaluation on the growing medical possibilities compared to the financials, one can see the picture of a widening gap. As the gap cannot be closed by this system under the social condition of equal healthcare for everyone, the one-tier healthcare system remains a theoretical construct (Bandelow, 2009, pp. 137–139).

When it comes to the two-tier healthcare system, the public as well as the politics are criticizing the differences in the healthcare. The reason for this is that they mostly have the theoretical ideal of a one-tier healthcare system in their minds even though a one-tier healthcare system with its necessary prohibition policy could not be enforced in a liberally organized state. The main emphasis lies on the different groups and the different access possibilities to healthcare. As a result, one can see service differentiation which, especially in case of social differences, gains in importance. This can be noticed particularly when high-income groups have an easier access to health services whereas all others have increasingly longer waiting times such as for the doctor´s appointment allocation. In general, the two-tier healthcare system is dependent on the public perception and acceptance as well as on the level of the standards of care. The higher the level the less distinctive the endeavor to alternative or higher-quality care or in other words the lower the level of the standards of care the bigger the demand for alternative or higher-quality offers (Ostendorf et al., 2012, pp. 13–15). The characteristics as well as the benefits and drawbacks of a two-tier healthcare system will be explained in more detail in the following chapter 3.

3 Characteristics of a two-tier healthcare system

The underlying concepts of the term two-tier healthcare are based on the presence of a free society and the set competition among healthcare systems. In a free society medical services can only be prohibited if they are obviously dangerous or nonsensical. Due to the existence of a free market as well as a free society, everybody can buy additional health services as long as they are able to afford it. There are no prohibitions that would not allow to buy extra services or that would forbid doctors in hospitals to offer this extra services. Nevertheless, one should take into account that people who cannot afford to buy extra health services are in danger to be left behind (Montgomery, 2012, p. 113).

The demographic change, the higher life expectancy and the more complex and expensive medical procedures burden the healthcare sector. In addition, there are two insurance systems, namely the compulsory and the supplementary, parallel to each other. Due to this systems and the possibility for people with high income to buy extra services, observers see an increasing inequality in healthcare and name this issue as two-tier healthcare. While in the statutory health insurances a relatively high proportion of low-paid workers, sick people and persons with a high risk of disease are insured, the private health insurances mostly insure young and healthy people with a high income. Statutory health insurances are based on the solidarity principle, whereas private health insurances are oriented towards revenue. A needs-based healthcare system cannot only be organized on the basis of market economy as various factors do not fit to those principles. An exclusive protection according to the purchasing power of individuals is subject to risk as it bears the potential to break the boundaries of social justice (Renn, 2008, p. 116).

Two-tier healthcare is a controversial topic and therefore, in the following, the author looks at this topic from different point of views, namely from an economic perspective and from an ethical perspective. The economic perspective comprises the distribution of resources and costs with regard to the healthcare sector and the main points will be explained in detail, whereas the ethical perspective will show the aspects related to the society and the personal well-being.

3.1 Economic perspective

The right to health requires that access to healthcare is socially secured and as long as deductibles and co-payments are reasonable and also affordable to all members of the society there is no threat to secure access to healthcare services. When doing so it is essential to have deductibles and co-payments for the poorer strata of the population either adjusted or paid by government, whereas for those who are able to afford it, payments can be made through payroll or at the point of service. Boylan (2008) argues that this approach does not violate the principle of justice from an economical point of view as in this case “no one is made worse off, and indeed all are probably better off” (Boylan, 2008, p. 170).

Furthermore, the richer classes “freely add money to the overall healthcare system through private contributions over and above the tax or employment-based contribution already made”. In turn, this means that private insured people are supporting and paying for the public healthcare system that is not used by them (Boylan, 2008, p. 171). Thus, a differentiation of services can take place without making a substantial difference to health, for instance through the possibility to receive privacy, comfort, and quality of food similar to the standards offered in a five-star hotel (Fourie, 2016, p. 196). On the contrary, Engelhardt (2009) argues that the increase of economic incentives and benefit cuts in compulsory health insurances are leading, among other things, to the occurrence of a two-tier healthcare system and that this is connected with the assumption that there is a better healthcare for supplementary private insured people not least due to the shorter waiting times compared to the compulsory insured (Engelhardt, 2009, p. 95).

In reality, it can happen that certain specific treatments that would actually be seen as a part of basic healthcare regarding their contribution to sufficiency of capabilities are not included in this basic healthcare under the first tier due to their costs. Fourie (2016) argues that in an ideal system, all benefits that would contribute to sufficiency should be covered as part of the first tier but that this is in practice almost not implementable. Resources should be distributed in a way that sufficiency of capabilities will be sustained over time. Therefore, if benefits can contribute to sufficiency but in the same time providing these benefits as part of the basic

healthcare would threaten the whole system due to their costs, they can be justifiably excluded (Fourie, 2016, p. 196).

So it seems that the excluded benefits that ideally should be included in the basic healthcare must have some special moral status in the second tier. This means that a further moral distinction should be drawn between the benefits that contribute to sufficiency and the others that do not (Fourie, 2016, p. 196).

When it comes to waiting times in the healthcare sector, it appears that public insured patients have to wait significantly longer than private insured patients for a medical appointment. This is a form of rationing based on economical and political reasons, which occurs in almost all sectors. There are three preconditions, which need to be fulfilled in order to achieve an appropriate healthcare, namely:

- a needs-based catalogue of services: needs are defined everywhere in a different way, so the catalogues are mostly developed over time and are dependent from the structure of a healthcare sector
- a needs-based financing of the catalogue of services: the type and extend of the catalogue depend on the amount of the available financial resources
- a needs-based remuneration of the service providers: one can only expect high quality service if sufficient financing exists.

In the long run, only needs-based remunerated physicians are motivated physicians and only those will provide adequate medicine. That holds true for physicians in hospitals as well as for general practitioners.

The three mentioned aspects are forming one unit but despite this fact, politics never tried to create a consensus among these aspects. One consequence of this is rationing. A healthcare sector without any rationing is not imaginable as this would mean that every patient could ask for unlimited services and these services would need to be provided. Beske (2008) states that this is unrealistic and it does not exist in any country in the world.

Direct rationing is primarily characterized by the legislator, for example the exclusion of prescription-free medications or visual aids. Indirect rationing can be seen in the continuous extension of the catalogue of services in combination with an insufficient financial basis.

The most common form is budgeting and the consequences thereof are:

- waiting times: by postponing of appointments one tries to strike a balance between entitlement and finance volume and this practice exists almost everywhere
- reduction in personnel: the lack of money leads to redundancies and these apparently affect nursing staff rather than doctors – the result shows insufficient care and decrease of hygiene which has hospital-acquired infections as an outcome (Beske, 2008, p. 6)

The problem of different waiting times for different insured patients would be not very relevant or critical from an economic point of view if there are no problems resulting out of the different waiting times. This holds even true when looking at the incentives from the legislator, as these incentives lead to the result that doctors or hospitals are allocating appointments due to the insurance status because eventually the profit will be higher and this is from an economic perspective neither surprising nor assessed negatively (Duttge & Zimmermann-Acklin, 2013, pp. 112–114).

3.2 Ethical perspective

In terms of justice, an adequate level of health services should be provided but that does not necessarily include all the technological possibilities. Therefore, despite of the before mentioned facts, there is an ongoing debate about whether it is appropriate that individuals are allowed to buy additional health services according to the healthcare system (Fourie, 2016, pp. 44–45).

From an ethical point of view, the private supplementary insurance raises concerns about the justice of a two-tier healthcare system. There are two different kinds of supplementary insurance, namely the one that provides insurance coverage for services or costs that are not covered by the compulsory insurance and the one that provides coverage for services that are covered by the compulsory insurance but it further includes the avoidance of waiting lines for public services or the higher quality of services due to luxurious private hospitals. The first kind of private insurance of providing additional coverage is not as controversial as the second form of providing supplemental coverage (Boylan, 2008, p. 170).

In addition, according to Ostendorf, there are two aspects of the public perception on two-tier healthcare, which are worth to mention. Firstly, the direct observation that someone else gets better access to medical care than oneself and secondly, even more critically, the personal fear that the fundamental ethical values, that in case of need one gets all necessary medical services, will be violated. The accusation of a two-tier healthcare system especially expresses that the people fear that they will not get all necessary medical services anymore in the future. That means that they are worried to get in case of need not everything what is necessary but only the most necessary treatment and that only those, who can afford it, will get everything what is needed (Ostendorf et al., 2012, pp. 13–15).

Moreover, two-tier healthcare systems are raising concerns that go even beyond the impact on health or the liberty of individuals. There are arguments that two-tier healthcare can compromise equal respect for all members of a society, particularly when access to basic health services requires a means test. In addition, two-tier healthcare can affect solidarity, which is also understood as mutual respect, and the commitment to a common cause. A two-tier healthcare system can also worsen the inequities between or within patient groups due to pressures that might be created on basic services (Fourie, 2016, pp. 44–45).

Furthermore, when focusing especially on doctor´s appointments one can see that it is generally understandable that supplementary insured people are getting appointments earlier than statutory insured but nevertheless, this issue is not in all areas of equal importance. Appointment allocation in private practices is related closer to the insurance status than in in-patient care and this in turn means that the problem and occurrence of a two-tier healthcare system is bigger in the sector of private practices than in the in-patient care. Another issue arises due to the longer waiting times for doctor´s appointments, namely that patients face with problems and higher costs because of late or different treatment. (Duttge & Zimmermann-Acklin, 2013, pp. 112–114)

3.3 Benefits and drawbacks of a two-tier healthcare system

Differentiation of services is critically assessed in situations where the basic healthcare is influenced by the offer of different or higher quality services. This can be seen when a better medical care will be provided on the rights of third parties or when it leads to displacements of others due to the limited capacities available. Then the basic healthcare is facing with drawbacks because there are other health services offered and from an economic perspective, so called negative external effects exist. To give a concrete example: does the compulsory insured patient have to wait longer due to preferential treatment of a supplementary insured patient or would the compulsory insured patient also wait the same time if the supplementary insured patient would not be there? The negative external effects describe the uncompensated negative impacts of economic decisions on uninvolved third parties. Thereby, the basic healthcare would get worse and suffer from disadvantages due to the existence of different and higher quality services and in turn, if these extra services did not exist it would be beneficial for the basic healthcare. For medical healthcare the existence of negative external effects means that a two-tier healthcare only is present when the choice of one group of people for relatively high medical care leads in the same time to displacement and deterioration of medical care for others who cannot afford or do not want to pay for higher quality services. Therefore, for the existence of two-tier healthcare in a healthcare system not only the criteria of differentiation of services and quality but also the characteristic of negative external effects must be fulfilled (Bandelow, 2009, pp. 142–143).

The mentioned differentiation in medical services and quality above a basic healthcare level that is regulated by law cannot only affect third parties in a negative but also in a positive way. From an economic perspective, this means that there are also positive external effects, contrary to the before mentioned negative external effects. These positive external effects are describing the uncompensated positive impacts of economic decisions on uninvolved third parties. That means that differentiation of services above the basic healthcare can lead in the same time to betterment for people who did not decide to go for extra or higher quality care. This would be the case if the basic healthcare benefits from the offer of another or different care (Bandelow, 2009, p. 143).

3.4 Consequences of a two-tier healthcare system

According to Renn (2008) the consequences of a two-tier healthcare system could result in a broader scope of the catalogue of services, and that the medical progress will become a privilege for those who can afford it. Furthermore, he mentions the example that transplantations will not be performed according to the need and waiting time but according to economical aspects and that for instance medication for pandemics would be provided to the people with the highest offers. In the past there were also social disparities in the needs coverage but despite this fact one should try to ensure in the future that these disparities will not exceed the social binding framework. Corresponding criteria of what is socially acceptable and indicators for measurement should be developed. Potential indicators could be for example the number of doctors who return their health insurance license in order to work as private doctors, the gaps in service supply for socially weak reasons, recipients of innovative medicines, diagnosis and therapies according to the social status, service catalogue of insurances, and different waiting times for doctor´s appointments for compulsory and supplementary insured people (Renn, 2008, p. 116).

Furthermore, another consequence could be that people are going more and more for supplementary private insurance as they have the feeling that the public system is not standard or sufficient anymore. People who do not trust any longer in the public system do not see the private healthcare as luxury but as the essential norm in order to be able to get adequate healthcare that meet their needs (Pardo & Schott, 2012, pp. 39–42).

Moreover, according to Olson (2012) a two-tier healthcare system provides “a more limited benefit set for lower income people, but a more comprehensive benefit set for those who can afford to pay for extra benefits”. As a consequence, a two-tier healthcare system might have significant gaps when it comes to the benefits between those with the maximum benefits available compared to those who can only afford the minimum benefits (Olson, 2012, p. 250).

4 Healthcare system in Austria

4.1 Key information and demography

Austria is a democratic republic in central Europe that covers a territory of about 84.000 square kilometers. As a federation, the country has nine provinces and Vienna is its capital city. Austria has been a member of the United Nations since 1955, and it joined the European Union in 1995. This country is one of the richest ones in the world with a gross domestic product (GDP) of EUR 39,390 per capita in 2015 and its total GDP amounted to EUR 339.9 billion (Austrian Federal Ministry of Health, 2013, p. 2; Statistik Austria, 2016b). In the UN Human development Index of 2015 Austria ranked 24th out of 188 countries which put Austria in a very high human development category and reflects a high living standard (United Nations Development Programme, 2016, p. 2).

Austria had 8.42 million inhabitants in 2011 and demographic forecasts predict that the population of Austria will grow to more than nine million by 2030. Nowadays, the chances for a long and healthy life in Austria are better than ever before as in 2011 a newborn girl had a life expectancy of 83.4 years and a newborn boy of 78.1 years. The life expectancy in Austria has increased by more than eight years and infant mortality has decreased by more than 75 percent over the past 30 years (Austrian Federal Ministry of Health, 2013, p. 2). Moreover, almost 70 percent of the Austrian population older than 15 state that their general health status is either very good (30.6 percent) or good (28.3 percent) (Austrian Federal Ministry of Health, 2013, p. 5).

4.2 Overview of the healthcare system

First of all, Austria has its main principles when it comes to the healthcare system, namely solidarity, affordability and universality. This means that healthcare in Austria “is based on a social insurance model that guarantees all inhabitants equitable access to high quality health services – irrespective of their age, sex, origin, social status or income” (Austrian Federal Ministry of Health, 2013, p. 11).

Since the mid-nineteenth century the Austrian healthcare system has been formed in its development by three essential institutional characteristics, namely "(1) the constitutional make-up of the state with healthcare competences being shared between the federal level and the regional level ("Länder"); (2) a high degree of delegation of responsibility to self-governing bodies; and (3) a mixed model of financing, where the state and social health insurance contribute almost equal shares" (Hofmarcher, 2013, p. 17).

In Austria, the state, private non-profit organizations and individuals who are operating independently are offering healthcare facilities to the population. However, the provisioning of healthcare facilities and the governance of the healthcare system are largely seen as the job of the state. The Austrian healthcare system is 75 percent financed by income-based social insurance contributions and public income generated through taxes, while 25 percent comes from private sources in the form of direct and indirect co-payments such as out-of-pocket payments and private health insurance.

It is defined by the Federal Constitutional Law that the responsibility for the regulation concerning most of the Austrian healthcare system areas lies primarily with the federal government. Nevertheless, the hospital sector represents the most important exception to this rule as only the basic requirements are set at the federal level. The actors of the regional level are responsible for the specifics of the legislation as well as the implementation and they have to ensure that there is adequate hospital capacity available for in-patient care (Hofmarcher, 2013, p. 17).

4.3 Healthcare resources

The Austrian healthcare system offers a high density of easily accessible healthcare facilities. In 2011, a total of 273 hospitals with about 64.000 beds for in-patient care were available and about 23.000 physicians were employed in hospital as well as more than 85.000 other healthcare professionals. Additionally, there are about 900 out-patient clinics that ensure a high level of out-patient healthcare. The amount of physicians available in Austria is above the European average, namely 43.693 or in other words there were 4.7 physicians (excluding dentists) per 1.000 inhabitants in 2011 (Austrian Federal Ministry of Health, 2013, pp. 4–5).

Moreover, the nation-wide patient transport and emergency ambulance service ensures with 2.040 ambulance cars and 35 helicopters easy access to health services (Austrian Federal Ministry of Health, 2013, p. 17).

4.4 Health insurance system

According to the Austrian Federal Ministry of health, the social insurance system of Austria "is based on the principles of compulsory insurance, solidarity and self-governance and is primarily funded through insurance contributions" (Austrian Federal Ministry of Health, 2013, p. 7). The system consists of 22 social security institutions and their umbrella organization is the Main Association of Austrian Social Security Institutions. The affiliation of people to a particular health insurance fund depends on the place of work and the profession of the insured (Austrian Federal Ministry of Health, 2013, pp. 7–8). The social insurance system is a supporting pillar of the Austrian healthcare system. It comprises the health, accident, and pension insurance and is based on the model of a compulsory insurance (Bundesministerium für Gesundheit und Frauen, 2017).

Figure 1 shows how the Austrian social insurance system is organized. There are 22 social security institutions listed under their umbrella organization, the Main Association of Austrian Social Security Institutions (HBV).

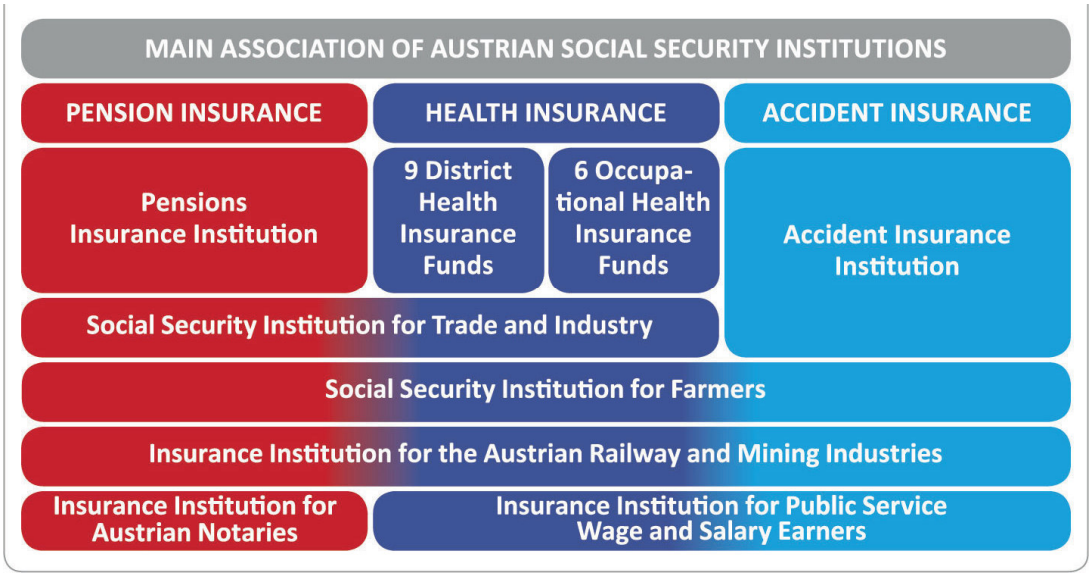

Figure 1: Organigram of the Austrian social insurance ssystem
Source: (Austrian Federal Ministry of Health, 2013, p. 7)

The compulsory social insurance is statutory and there is no possibility for insured people to choose their social security institution. Between these institutions there is no competition and this ensures that the risk is spread in an effective way (Austrian Federal Ministry of Health, 2013, pp. 7–8).

About 98 percent of the people who are living in Austria are protected through health insurance due to this legally anchored compulsory insurance. Around one-third of the Austrian population has a private supplementary insurance in addition to the existing social health insurance (Bundesministerium für Gesundheit und Frauen, 2017).

In general, the compulsory insurance is linked to employment and thereby also family members and life partners can be co-insured. Additionally, there are regulations for pensioners and unemployed people. Furthermore, the Austrian social insurance system offers the possibility of self-insurance under certain conditions. People without health insurance have to pay their own costs of health services with the exception of first aid services (Bundesministerium für Gesundheit und Frauen, 2017). In terms of the regular insurance, the personal risk of an insured person does not influence the insurance contribution to be paid as this is not dependent on risk factors (Austrian Federal Ministry of Health, 2013, pp. 7–8).

The healthcare of the Austrian population is covered by the social health and accident insurance. Its services comprise for instance medical attention (out-patient care), hospital care (in-patient care), medical rehabilitation, medicines, medical in-home care, and services from midwives, psychotherapy and clinical-psychological diagnosis, treatments through medical-technical services, Mother-and-Child Pass examinations, medical check-ups, transport and travel costs, grants for therapeutic aids, sickness benefit, and maternity allowance (Bundesministerium für Gesundheit und Frauen, 2017).

The health services are also embedded in the Austrian health targets as the tenth target that implies to secure sustainable and efficient healthcare services of high quality for all (Bundesministerium für Gesundheit und Frauen, 2016, p. 51).

4.5 Current situation of the Austrian healthcare system

The Austrian healthcare system ensures easy access to healthcare but still there is space for improvement in terms of quality especially in the cancer care as well as in the reduction of hospital admissions through the strengthening of the medical primary care. Moreover, the Austrian healthcare system has a strong focus on in-patient care and potential for development in the area of out-patient care (OECD, 2015, pp. 1–3).

In Austria the life expectancy at birth raised by 11 years since 1970 and this means that the life expectancy is even half a year higher compared to the OECD (Organisation for Economic Co-operation and Development) average. In general, the Austrian healthcare system performs well when it comes to the access to healthcare. Even though the amount of self-payments for healthcare products and services compared to the total consumption expenditure is slightly higher than the OECD average, only a small part of the population officially report difficulties in terms of access to medical care due to financial burdens, long waiting times or journey ways. However, in terms of the care quality a mixed picture is resulting. The amount of potentially avoidable hospital stays is an indicator for quality in the medical primary care but in this case Austria does not perform as well as other countries and it lies for example regarding diabetes far above the OECD average. The Austrian healthcare system is strongly characterized by in-patient care. Austria has 60 percent more hospital beds per 1.000 inhabitants compared to the average of all OECD-countries. Along with the high availability of hospital beds, Austria has in relation to its inhabitants the highest number of hospital treatments in the OECD, namely 70 percent more than the OECD average. Furthermore, Austria has development potential in the out-patient care regarding surgical interventions as the low amount of these surgical interventions in the area of out-patient care is one reason for the high hospitalisation rate in the in-patient care. Despite the fact that the amount of the surgeries in day-care hospitals has risen significantly in the last years it is still considerably less than in most of the other OECD countries (OECD, 2015, pp. 1–3).

When it comes to the health status of the population of a country, one can take, among others, the disability-adjusted life expectancy (DALE) as an indicator. This

indicator of healthy life years shows the expected average amount of years a person lives without physical or mental disability or impairment. Austria lies with a disability-adjusted life expectancy of 71.4 years for people born in 2002 slightly above the average of the EU-15, that includes all member states of the European Union before the EU eastward enlargement (Leopold, Habl, Morak, Rosian-Schikuta, & Vogler, 2008, p. 12).

Concerning the responsiveness, in the last years the issue of effectiveness of healthcare system and the free access to quality assured healthcare services became more and more important. Additionally, there is a consensus that the needs of patients should not only be considered in terms of services provided but also regarding information and respectful treatment. Therefore, the indicator of patient satisfaction and subjective health status is taken into account. According to the Eurobarometer survey, in Austria the self-assessment of the health status is located in the lower third of the EU-15 comparison. However, regarding the patient satisfaction with the healthcare system the Austrian population is very satisfied with their system (Leopold et al., 2008, pp. 18–19). A further indicator for the efficiency of healthcare systems is the access to medical care in the area of established physicians. In this context, Austria lies significantly above the OECD and EU-15 average and this means that Austria has a good infrastructure concerning established practices (Leopold et al., 2008, pp. 18–23).

Further important factors to evaluate the current situation of the healthcare system in Austria are social compatibility, sustainability and equity. This can be measured with the indicators private versus public health expenditures because co-payments constitute a barrier as well as with the frequency of medical consultation with regard to income. Concerning the distribution of health expenditures Austria ranks in the middle, between the OECD and the EU-15 average and this means that the Austrian patients have to pay around 20 percent of the health expenditure on their own. When looking on the Austrian situation regarding the frequency of medical consultation one can see that there is almost no difference between the different income groups. Differences only occur in the type of medical consultation as members of the lowest class of the population go significantly less often to a specialist or to the out-patient clinic but if they do so they also have to wait there longer (Leopold et al., 2008, pp. 25–27).

All in all, it is important to emphasize that the Austrian expenses for health related to the economic situation and the comprehensive range of health services is low compared to other OECD countries. Thus, the Austrian healthcare system does not only belong to one of the best healthcare systems in Europe but it is also one of the most efficient one (Leopold et al., 2008, p. 31).

4.5.1 Austrian population and healthcare

According to the population survey 2016, Austrian people perceive their health status and their work ability as good. In general, Austrians feel healthy and only 12 percent indicated that they feel bad. At the same time, over 60 percent of the respondents stated that they take care of their health and only four percent that they feel extremely vulnerable to diseases. In the last year, 81 percent of the Austrian population had contact to a general practitioner, 60 percent to a dentist, 17 percent used hospital out-patient departments and 12 percent had an in-patient stay in the hospital. (Bundesministerium für Gesundheit, 2016, p. 3)

The way to the doctor is not the first priority of the Austrian inhabitants. In case of first signs of disease almost half of the population first uses household remedies, one quarter waits until it disappears by itself and 12 percent treats themselves with non-prescription drugs. Around three-quarter evaluate the healthcare system positively with regard to the duration for the doctor-patient conversation, the cooperation between general practitioners and specialists and the coordination between doctors and hospitals. The medical care provided by general practitioners and specialists is perceived as very positive and also hospital out-patient departments show good satisfaction values (Bundesministerium für Gesundheit, 2016, p. 3).

Moreover, the Austrian population especially expects that the doctors listen to them, take time for them, and have expertise as well as that after the visit to the doctor it should be clear what to do. Less important are services concerning information and patient management as for example that all other attending physicians are informed about the individual medical history (85 percent), that home visits are made (72 percent), or that the general practitioner takes on the appointment organization with

other specialists or medical institutions (57 percent) instead of the patient itself (Bundesministerium für Gesundheit, 2016, p. 4).

Regarding healthcare reforms, 62 percent of the Austrian population feels adequately informed about the current situation. Important topics from the perspective of the population are the improvement of the medical care and medical check-ups as these topics are related to the personal benefit of the medical care compared to improvements in the healthcare system that are not so crucial for the respondents. Most commonly, Austrians fear that the waiting times could increase in the future and that personal expenses could rise. Information concerning health topics are mainly gathered via media (52 percent) and on homepages (38 percent), only afterwards doctors (30 percent) and friends (29 percent) are included (Bundesministerium für Gesundheit, 2016, p. 5).

4.5.2 Healthcare in the region of Tyrol

In the following chapter 5 Methodology and intended research methods the author will put the focus on the region Tyrol as the scope of this master thesis is limited and therefore, it is not possible to elaborate all nine federal states of Austria.

Tyrol is one of the nine federal states of Austria and it has a population of 736.176, which constitutes 8.5 percent of the Austrian population. Therefore, Tyrol is the fifth largest federal state of Austria measured by the number of inhabitants (Statistik Austria, 2016a).

The population structure of Tyrol is characterized by a higher amount of younger people and a lower amount of older people compared to whole Austria. However, the demographic structure adapts more and more to the country´s one. In 2006, Tyrolean citizens were admitted around 134.000 times to hospital in-patient departments. The most common reasons for hospitalisation are injuries for both, women and men and the probability for a hospital admissions tend to rise for both genders with increasing age. When it comes to the personal perception of the well-being, around three quarters of the Tyrolean population feel with regard to their health status either very good or good (ÖBIG, 2008, p. 91).

The in-patient care is mainly covered by the 12 funds-hospitals and in these funds-hospitals 4.260 beds were provided and 280.000 in-patient cases were treated in 2006. The average duration of hospital stay were 4.2 days in 2006 and the final costs in the area of in-patient care were around 580 million euro or 830 euro per inhabitant (ÖBIG, 2008, p. 92). In the 12 fonds-hospitals almost 860.000 patients were treated in the out-patient departments in 2006 and 810 doctors were employed. The final costs for this area amounted in 2006 around 119 million euro or 171 euro per inhabitant (ÖBIG, 2008, pp. 81–82).

Since 1996 the yearly preventive medical check-ups performed has increased by approximately 37 percent and this shows that the health awareness among the Tyrolean population is rising significantly (ÖBIG, 2008, p. 42).

4.6 Occurrence of two-tier healthcare in Austria

First of all, it should be emphasized that the discussion about the potential two-tier healthcare system in Austria is different than in other countries as for example in the United States. In these countries there are a lot of inhabitants uninsured or underinsured and therefore the two-tiers are consisting of whether a patient gets care or in the worst case no care at all or only at their own expense. In Austria, there is not a debate whether a patient gets care or not. It is more about which type of treatment and in which timeframe one gets a medical appointment. Despite all the debates, it is stated, that there is no real or theoretical system in which it would not come to a two-tier healthcare because it will be always the same, some patients get faster, better or different treatment compared to other ones. Even if one thinks about the fictious condition of a uniform insurance for all citizens, the same question would occur, namely if all patients get the same treatment in this system and the answer would be most probably *no*. This is the case due to the fact that also relationships play a role, for example if a patient knows the doctor very well or they are family members, there is a high possibility that this patient will get an earlier medical appointment. Furthermore, patients could also go abroad to receive healthcare on their own expenses in order to get faster and better treatment. So another question arises, namely if there were punishments on the mentioned examples would it lead to a one-tier healthcare system. Here the answer is again *no* as not all doctors have

the same skills and this in turn means that there will be always patients who will get worse treatment than others (Flenreiss & Rümmele, 2008, p. 129).

In the framework of an equitable care, the catchword two-tier healthcare often comes up. In the opinion of some health politicians, this system is unfair and that it should be abolished (Flenreiss & Rümmele, 2008, p. 129).

Others argue that the two-tier healthcare system is already reality and that it is basically depending on the insurance status (compulsory insurance or supplementary insurance) but especially on the social status (Ärzte Zeitung, 2005, p. 10). The insurance status plays an important role as some people assume that the preference of private patients with supplementary insurance is one of the main reasons for the existence of a two-tier healthcare system. According to the ministry of health, there are more and more complaints of compulsory insured patients about the longer waiting times for medical specialists compared to private patients (Ärzte Zeitung, 2006, p. 1).

The waiting times of compulsory insured people in the out-patient care are considered as significantly higher than the waiting times of private patients. Certain politicians and parts of society evaluate this kind of two-tier healthcare as unjust. Consequently, waiting times are also affecting the patient satisfaction. Different studies on waiting times, for instance the scientific work from Mielck and Helmert (2006), are showing that compulsory insured patients have to wait longer than supplementary insured for medical appointments and in practices. Furthermore, one can see that individuals from poorer social classes and with less generous insurance services are disadvantaged concerning the state of health as well as the use of services (Amhof, Böcken, & Braun, 2007, pp. 95–96). This contradicts with the generally prevailing conception of justice to which the use of medical services should not be dependent on the financial means of an individual but only from the medical need (Wagstaff & van Doorslaer, 2000, pp. 1803–1862).

According to Werner (2012) the developments in the healthcare sector are dramatically and it looks like there will not be any improvement in the future. In addition, experts of the field of medicine, science, economy and politics state that the situation will get worse. Werner (2012) mentions that the two-tier healthcare

which has always existed will more and more disadvantage low-paid workers in the context of medical care and therefore, the saying from the Middle Ages "*because you are poor, you have to die earlier*" gains again cruel timeliness (Werner, 2012, p. 16).

The former healthcare minister of Austria and other experts state that there is two-tier healthcare in Austria not least because of the existence of supplementary insurance. One of these supplementary insurances even made an advertisement related to this topic, saying that "*there are no differences between compulsory and supplementary insured patients – and the earth is a disc*" (Flenreiss & Rümmele, 2008, p. 129).

Furthermore, it is predicted that the state will not be able anymore to provide all-round care for all members of the society. On the one hand, the market for health services is growing because of new offers such as therapies and diagnostic methods, which have to be paid on one´s own expense but on the other hand, a lot of providers are using the potential uncertainty of patients in order to do lucrative business. There is also the fear that the arising debate concerning prevention will lead to a point where diseases are seen as individual failure and absence of one´s own provision. In the case of leisure accidents the discussion has already begun and smoking as well as overweight will follow (Flenreiss & Rümmele, 2008, p. 129).

The central question of this development is whether the changes in the healthcare system will strengthen this trend towards two-tier healthcare. Flenreiss & Rümmele (2008) answer this question with yes as it is unlikely that the public sector will have less influence on the service area. Therefore, the economical pressure will remain the same. Furthermore, they think that the demographic change and the massive increase of chronic diseases will lead to rationalization as well as rationing in the system. Just as hospitals concentrate on their core area medicine and outsource other areas such as logistics, kitchen, radiology, and laboratory diagnostic, also the system will develop in a way that it will focus on core areas or in other words on basic healthcare. Economists expect that small treatments have to be paid by everyone itself in the future and that only exceptional costs such as expensive surgeries or chronic diseases will be covered by public compulsory insurance (Flenreiss & Rümmele, 2008, p. 129).

5 Methodology and intended research methods

For this master thesis qualitative research was used as it contributes to an authentic record of the living environment and perceptions of the subjects due to its relatively open access. Furthermore, qualitative research provides information that often gets lost by using a quantitative approach because of the standardization (Mayer, 2012, p. 25). Therefore, expert interviews were conducted as the theoretical part of this master thesis already gives a detailed overview of the Austrian healthcare system and the characteristics of two-tier healthcare and thus, concrete questions could be formulated. In the framework of the interviews the respondents should be considered as representatives of behaviors and perspectives of a particular group of people (Heistinger, 2006, p. 6).

Based on the data collected, concrete statements on the topic two-tier healthcare should be derived and due to this reason an interview guideline was created which is set out in the Annex A1. The interview guideline is characterized by open formulated questions, which can be answered by the respondents in a free way. The interview guideline is used in order to enhance the comparability of the data as well as to structure the data through the questions. In addition, the interview guideline can be used as an orientation and it should ensure that the essential aspects of the research question will not be missed during the interview. The interviews did not all take place in the exact same way as the interview guideline only served as a framework and as in some situations the questions of the interview guideline needed to be adjusted or asked in more detail (Flick, 1999, pp. 112–114).

The author chose two different groups of people in order to elaborate on the Austrian healthcare system and two-tier healthcare from different perspectives. The two groups are represented by doctors and patients as these are, among others, most related to the healthcare sector and as they are representing two contrary points of view. In this context, five doctors and five patients were interviewed according to the interview guideline. Moreover, also two borderline cases were taken into consideration, namely one physiotherapist and one nurse. These two people could not be clearly assigned to one of the mentioned groups of people but their statements were perceived as important as they could talk from two different points of view at the same time, namely from the perspective of a health provider as

well as from the perspective of a patient. Moreover, the author put the focus on one region of Austria and only chose people who are living and working in Tyrol as interview partners in order to gather representative results.

The interview partners were chosen according to their involvement to the healthcare sector and they are considered as experts of their groups. The doctors represented three different categories of health providers, namely the group of panel doctors, doctors of one´s choice and hospital doctors. The patients represented the group of very or at least involved patients in the healthcare sector due to various diseases or experiences with the healthcare offer and services in Austria. The borderline cases were chosen due to experiences in both categories and represented the group of health professionals who received healthcare. The following people were interviewed in the corresponding order:

- Interview 1: Doctor: Dr .med. Sebastian Kalbhenn (36 years), general practitioner and surgeon, Interview took place on 30.05.2017 at 10 p.m. in the hospital in St. Johann in Tirol and lasted 3 min 35 sec
- Interview 2: Doctor: Dr. med. Ana Cecilia Kröll (35 years), general practitioner, interview took place on 31.05.2017 at 1 p.m. via Skype and lasted 6 min 49 sec
- Interview 3: Doctor: Dr. med Winfried Bodner (62 years) specialist for surgery and endoscopy, doctor of one´s choice with own practice, interview took place on 31.05. 2017 at 2 p.m. in the doctor´s own practice in St. Johann in Tirol and lasted 8 min 25 sec
- Interview 4: Borderline case: Margarethe Steger (47 years), qualified nurse, interview took place on 31.05.2017 at 7 p.m. at the home of the respondent and lasted 15 min 17 sec
- Interview 5: Borderline case: Helmut Mayerhofer (48 years), qualified physiotherapist, panel doctor with two own practices, interview took place on 31.05.2017, at 9 p.m. at the home of the respondent and lasted 4 min 29 sec
- Interview 6: Patient: Rosa Unterrieder (64 years), pensioner, interview took place on 01.06. 2017 at 11 a.m. at the home of the interviewer and lasted 11 min 16 sec
- Interview 7: Doctor: Dr. med. Krainz Elisabeth (58 years), general practitioner, doctor of one´s choice with own practice and company doctor, interview took place on 01.06.2017 at 12:30 p.m. via telephone and lasted 6 min 54 sec

- Interview 8: Doctor: Dr. med. Maria Krepper (46 years), general practitioner, panel doctor with own practice, interview took place on 01.06.2017 at 3 p.m. in the doctor´s own practice in St. Johann in Tirol and lasted 3 min 29 sec
- Interview 9: Patient: Daniela Miggitsch (52 years), housewife, interview took place on 01.06.2017 at 4 p.m. in the hospital in St. Johann in Tirol and lasted 7 min 22 sec
- Interview 10: Patient: Erika Scheiber (56 years), saleswomen, interview took place on 01.06.2017 at 4 p.m. at the home of the respondent and lasted 4 min 09 sec
- Interview 11: Patient: Marina Gallab (24 years), clerk, interview took place on 01.06. 2017 at 9 p.m. at the home of the respondent and lasted 3 min 41 sec
- Interview 12: Patient: Friedrich Kohlhofer (72 years), pensioner, interview took place on 02.06.2017 at 3 p.m. at the home of the respondent and lasted 3 min 46 sec

All 12 listed interview partners, who are representing behaviors and perspectives of doctors and patients in Austria or more concretely Tyrol, were questioned according to the interview guideline, whereby every respondent individually contributed to this master thesis. The interviews lasted differently long, between three and sixteen minutes as every respondent defined one´s position and some also cited additional information. All interviews could be conducted in a quiet environment, at the home of the interviewer or the respondents, in the hospital or in the private practices of the doctors in an open and undisturbed way without any kind of interruptions.

In the beginning of every interview the situation was briefly explained to the respondents by clarifying that the topic of this master thesis is the healthcare system in Austria. In addition, it was mentioned that the literature will be compared with the personal perceptions of the interview partners in order to obtain an overall picture of the situation in Austria regarding the healthcare system. Furthermore, before starting the conversation, it was pointed out that the interview will be recorded with the laptop as well as with the mobile phone and that the sound recordings will only be used for the purpose of transcription. Moreover, the respondents were told that the interview material will be used for the master thesis in the form of direct and indirect quotations and they agreed that they will be mentioned by name in the master thesis. Afterwards the respondents were interviewed based on the interview

guideline and generally a good atmosphere prevailed during the discussion. In the end of the interviews the respondents were asked about their personal wishes concerning the Austrian healthcare system in the future in order to conclude the interviews in the best possible way.

The audio files of the interview partners were transcribed according to a standard system which is based on Dresing and Pehl (Dresing & Pehl, 2013, pp. 20–22). In this case, a literal transcription takes place and dialects will be transferred as exactly as possible into an analogous proper language. In addition, breaks will be marked with three dots and signals of understanding of the not speaking person such as “mhm, aha, yes, exactly” will not be transcribed. Emotional nonverbal expressions of the interviewed person and the interviewer that support or clarify the statement like laughing or sighing will be indicated with the usage of brackets and not understandable words will be noted with a question mark in brackets. Furthermore, the interviewer will be characterized by “I” and the respondent by “R”.

Afterwards, an analysis and evaluation of each interview took place by reducing content-related relevant passages and listing them with the usage of line numbers. In the next step, they were generalized to extract generally valid statements out of the interviews and subsequently grouped content-related in order to make key statements. Finally, the sub-processes were evaluated and the interpretation of the findings resulted (Mayring, 2003, pp. 61–64).

Two out of ten interviews took place in English and ten interviews were conducted in German. The German interviews were transcribed and paraphrased in German but the generalization and the categorization were translated into English. The direct quotes were translated from the German transcripts into English in order to be able to cite it accordingly in the results part of this master thesis.

6 Results

6.1 Perception of the Austrian healthcare system

In the last few years, “all national and international public surveys on satisfaction with the health-care system have given the health-care system an excellent approval rating”. This means that Austria is among the leading EU nations in this area as in Austria about 95 percent of the respondents said that the Austrian healthcare system is good or very good (Eurobarometer, 2010, p. 59; Hofmarcher, 2013, pp. 245–246).

In general, there is a good perception of the Austrian healthcare system especially when it is compared to other countries (Interview 2, lines 86-87 & Interview 7, line 739-743). People who are coming from other countries such as Germany are telling that their healthcare system is not comparable as in Austria one can have every medical examination that is needed without being concerned and therefore most people are totally satisfied (Interview 9, lines 918-922).

> I am really satisfied with the healthcare system, I have all doctors I need in my surroundings (Interview 10, lines 1025-1026).

In Austria, a good coverage of healthcare services exists and people are satisfied with the healthcare system (Interview 10, 1031-1032 & Interview 8, line 834).

> I have to say, I was in the hospital and I had the impression that one really gets everything what is needed or what could be needed. The offer is really good in any case, does not matter in which field, whether it is psychological care or the team of doctors or the nursing area, that was really one package and I felt to be in good hands (Interview 9, lines 926-930).

Some people even perceive the healthcare system as excellent and they have the feeling that they can get nowhere else a better treatment than in Austria, particularly in the region of Tyrol between the Alps (Interview 12, lines 1190-1192).

> I think we have general a very good perception of the general public healthcare system because we have one of the most advanced systems in the world (Interview 1, lines 13-14).

Most Austrian people have the impression that the healthcare system in their country is still quite good but very expensive. Therefore, some have the fear that it might get worse in the future due to rising costs which the state cannot compensate anymore like it is the case in some other countries (Interview 3, lines 183-188). Thus, Austrian patients appreciate that they actually can get everything they need (Interview 5, lines 516-518).

Furthermore, despite of the basically good perception of the Austrian healthcare system, some people have the feeling that it is not accessible for everyone in the same way because not all patients can go wherever they want, especially not on the countryside (Interview 4, lines 294-297).

In addition, some people have the feeling that the healthcare status is getting lower especially for older people and that it is not appreciated anymore what they did in their life or how they contributed to the society (Interview 6, lines 614-616).

Basically, the general perception is difficult to evaluate because everyone has a different health status and healthy people cannot complain a lot about the healthcare system as they are not as involved as ill people (Interview 11, lines 1105-1108).

> I personally would say I have no problems with the healthcare system (…) because I have never had something severe that I could complain and I also do not have such a good insight into the whole thing (Interview 11, lines 1108-1111).

Nevertheless, healthcare is a sensitive topic and everyone perceives it or reacts on it in a different way as it is often connected to the personal feelings of an individual (Interview 4, lines 305-307 & lines 320-322).

6.2 Differences between public and private insured people

Almost the whole Austrian population is covered by comprehensive health insurance but still in Austria the level of out-of-pocket payment is high when compared for example to the Nordic countries. According to a Eurobarometer survey which was conducted in 2007, almost 90 percent of the Austrians stated that the hospital care was affordable for them and therefore, among other things, Austria has an internationally high ranking. Hofmarcher (2013) indicates that the supplementary private insurance does not play an essential role with regard to providing financial protection (Hofmarcher, 2013, pp. 243–244).

As mentioned above, Austrian people perceive the healthcare system in different ways and thus, there are also various perspectives concerning possible differences between public and private insured people.

Some people think that there are differences between private supplementary insured patients and public compulsory insured (Interview 6, line 624 & Interview 7, line 748). Differences are mainly perceived because supplementary insured patients are getting earlier appointments than compulsory insured patients. The compulsory insured patients will also get healthcare but it takes longer in certain cases than for the compulsory insured patient. This happens, among other things, due to the fact that some leading persons reserve appointments in advance for supplementary insured patients. Therefore, these private insured patients can get appointments earlier because the leading persons are earning more money with them. The public insured patients will also get appointments but they have longer waiting times and they also cannot choose certain things like a private insured patient (Interview 5, lines 523-528). There are different examples where supplementary insured people are getting earlier appointments such as MRI examinations and also in the out-patient departments of hospitals are differences concerning the waiting times (Interview 8, lines 841-842 &Interview 9, lines 945-946).

> I would say that especially in the out-patient sector the waiting times are still long and one can see that the patients are asking why another patient comes first at it, before them. There are many (…) who are recognizing this (Interview 9, lines 945-948).

Some people also think and some politicians illustrate that these differences occur due to the differences in the social status and assume that the upper class can do whatever they want but this is seen as critical by other people and discussions are arising (Interview 3, lines 204-210).

Many Austrians think that there are differences in certain cases but that the primary care is available and appropriate for everyone (Interview 10, lines 1037-038).

> It is true, there are some differences but I think more in the way of luxury things maybe as the hotel character of staying in the hospital and less waiting times for some tests or for visitations of doctor (Interview 1, lines 20-22).

In the healthcare sector one can distinguish between the medically necessary services and the additional comfort and luxury components and everybody can personally decide if these extra components are needed and wanted (Wasem, Staudt, & Matusiewicz, 2015, p. 342).

Some people, especially doctors perceive the differences in the healthcare sector not as bad because according to them the treatment and the outcome will always be the same. However, there are people who think that they have a disadvantage because they are compulsory insured and do not have supplementary insurance (Interview 1, lines 27-29). Even if there are differences, these are not big (Interview 2, line 92).

> It might be that when you don´t have a case with an emergency that you have to wait a little bit longer, while if it´s an emergency than everybody is the same (Interview 2, lines 92-49).

Moreover, it can also occur that one has to wait for an operation that is not life-saving a little bit longer (Interview 2, lines 98-99).

Regarding healthcare on the countryside, in previous times the situation was better than now as the people had contact with the general practitioner and one knew each other. Nowadays, it seems like the connection will get less and less due to the fact

that there are not so many general practitioners on the countryside anymore and some patients miss this connection (Interview 6, lines 628-632).

When it comes to the access to healthcare and healthcare services, it appears that most people think that there are not big differences. The mentioned differences are more related to the time factor rather than to the access. One thing that might happen is that supplementary insured people are getting examined and diagnosed more precisely because they are paying and therefore, the doctor can take more time for this patient (Interview 3, lines 194-199). Furthermore, there are some differences related to what kind of healthcare the patient needs. If a general practitioner is needed there is normally no problem to have access but if special facilities as for example orthopedics are needed it gets more special and in this cases the waiting times will be longer for compulsory insured patients compared to supplementary insured patients (Interview 4, lines 328-333).

However, some people even perceive that everyone is the same regarding the access to healthcare and that there are no differences at all (Interview 11, line 1120).

6.2.1 Impact of differences on social harmony, peace and social conflicts

The differences mentioned above sometimes have impacts on the social harmony, peace and social conflicts in Austria. It might happen that a patient perceives it for example as unfair that another patient gets an earlier appointment and treatment (Interview 8, lines 847-848).

However, some people do not see an impact of differences on the social harmony, peace or social conflicts. They perceive that supplementary insured patients get earlier appointments, such as for a CT compared to compulsory insured patients but that in the end everyone gets the same (Interview 9, lines 935-937).

> It is not happening that a supplementary insured person is preferred and gets for example a CT and the other one only an X-ray or that someone cannot get a MRI examination when it is needed. Everything what is offered is accessible for every patient (Interview 9, lines 937-940).

Austrian people seem to be satisfied with their healthcare system and even though they might perceive some differences it does not affect the social harmony in the country too much (Interview 10, line 1043).

> I think that the people are quite happy how it is, it´s how we notice it. It might be that they notice that a patient with a private insurance has a nicer room and they have to be in a 4-bed room, that might be a big difference but as in the diagnosis and the treatment of the doctors with their patients in the stations where I have been working I haven´t noticed there have been two types (Interview 2, lines 105-109).

When comparing the Austrian healthcare systems to other countries as for example America, one can see that Austria has a very good healthcare system. In America there are people who are uninsured and there is a social problem as some people cannot access the healthcare system. In contrast, the healthcare system in Austria is accessible by everyone who has a compulsory insurance and even if this is not the case there is always a possibility to receive the needed treatment for example covered by the state (Interview 4, lines 349-356).

People think that there are no big social conflicts in Austria due to the fact that everyone can get everything (Interview 5, lines 533-534).

> I think everyone who is here gets a treatment and that it is accessible. (…) I do not think that there is a great social dissatisfaction due to healthcare (Interview 4, lines 359-363).

Some Austrians also think that there are no big social conflicts because people do not yet really realize and feel the consequences and therefore, there has been no reaction from the society but it seems like it will come in the future (Interview 7, lines 757-760).

Another argument is, even if there are differences in the care it has no impact on the social harmony or peace in Austria because it is seen as well deserved to get better or faster treatment when one can afford to pay more (Interview 12, lines 1203-1204).

6.2.2 Impact of differences on the health status

Many people think that everyone gets the same treatment as every case of a hospital department is discussed with all doctors so that every doctor knows everything from every patient at the department. Therefore, the only thing what could occur is that a patient with compulsory insurance has to wait a little bit longer for an appointment but the access and the diagnoses are the same (Interview 2, lines 115-119).

> (…) there is no difference in the therapy concerning coming-out and surviving. There is just some luxury status on the patients who have a private insurance like less waiting time and the hotel character (Interview 1, lines 36-38).

Furthermore, people trust doctors and believe that they do their best in terms of diagnoses and treatment no matter how much one pays for it. Nevertheless, the choice of a specialist when needed is easier for a supplementary insured person (Interview 3, lines 216-220).

It can happen that especially chronically sick people or people suffering from cancer sometimes have to wait longer in the Austrian healthcare system. The reason for this is that it takes time until the diagnosis and therapy can be made due to long waiting times for MRI examinations and CT or not available special facilities on the countryside and this can have an impact on the health status of patients (Interview 4, lines 370-385).

> (…) there are waiting times of seven to eight weeks and the patient who is facing this situation (…) it can have a deterioration of the health status or chances of recovery as a result. Nobody will openly admit this, one will say, ok because of this I will not get healthier or sicker but I think it is sometimes related to it because it is also affecting the psyche of a person because when they get sick they want to be treated immediately (Interview 4, lines 383-389).

However, some people think that differences regarding waiting times or preferences cannot have any impact on the health status of patients because when it comes for example to surgeries, only the doctor who can master it will do it (Interview 5, lines 540-542).

In contrast, others perceive that there are differences in the treatment and that it has an impact on the health status of patients but that the reasons for these are multifactorial and that anyway not everyone can have the same health status (Interview 7, lines 765-770).

Some doctors argue that differences in treatment cannot have an impact on patients as they do not make any difference between compulsory and supplementary insured people and therefore, the health status is not affected (Interview 8, lines 854-855).

> I think that everyone who gets to the hospital will get the same treatment. If I am a supplementary insured patient then I might have some more comforts but in principle I will always get a treatment, they cannot ignore me or not treat me or not provide care (Interview 10, lines 1049-1052).

Nevertheless, there are some distinctions that should be taken into account. In Austria everyone who is Austrian will get the same treatment but if a foreigner comes to Austria as a guest or tourist it gets more difficult regarding some treatments (Interview 11, lines 1131-1135). Moreover, if one has a special status or is famous like for example an actor one can most probably see a difference regarding the care and the treatment (Interview 12, lines 1210-1213).

6.2.3 Waiting times when accessing healthcare

The waiting times for doctor appointments are perceived in different ways. Some people, especially doctors state that the waiting times are mostly appropriate.

> I think they are in most cases convenient. There are some special cases, some single cases on a very low count who could profit from a faster appointment (Interview 1, lines 43-44).

In addition, doctors see differences within Austria as they state that in the western part of Austria such as in Tyrol the waiting times are not too long but when looking at Vienna with regard to the waiting times for a doctor appointment it is getting worse (Interview 3, lines 225-227).

> I think here in western Austria it works well. When I have a patient who has something special and I need to send him/her somewhere particularly, I honestly have to say that I get immediately an appointment and there it is the second question if he/she is supplementary insured, the first question is what he/she has (Interview 3, lines 227-230).

Others perceive that the waiting times are strongly related to the specifications as for example in the field of dermatology, psychiatry, ophthalmology, pediatrics and dentistry there are not enough doctors available and therefore, one has to wait sometimes far too long for an appointment in these fields (Interview 2, lines 124-127 & Interview 7, lines 775-779 & Interview 9, lines 960-962).

> In some cases they are too long, when it comes nowadays to the artificial joints the normal mortals have a relatively long waiting time because the other one will just outpace him/her (Interview 5, lines 565-567).

Some people also think that the waiting times would be too long for compulsory insured people but when one refuses to accept it and says that it is really needed then one has better chances to not wait too long for an appointment (Interview 6, lines 659-661).

> When you do not have someone who is looking for an appointment for you than it will be never your turn and you will only get an appointment when you have supplementary insurance, it is like everywhere else, when you do not pay for it (…) among doctors there is not much from the Hippocratic oath left (Interview 6, lines 661-665).

A reason why the waiting times are sometimes too long is the fact that there are not enough healthcare facilities where one can be treated as well as doctors available.

Therefore, the supplementary insured patient will certainly get an earlier appointment than a compulsory insured (Interview 4, lines 397-400).

> That is in Austria like this as well as in Germany, so I mean we have a compulsory insurance and a supplementary insurance. In Germany you can choose your compulsory health insurance on your own or respectively if you suffer from a chronical disease you have to find at first an insurance, a compulsory insurance which will include you to the healthcare system at all because it is connected with costs and then you have to look which one takes me and I do not hope that it will come in Austria like this (Interview 4, lines 401-407).

The problem of the lack of doctors, especially for compulsory insured people results due to the strict time constraints panel doctors have to meet. Therefore, many doctors decide to change this situation and open a private practice on their own where they can take more time for the patients but then the patients have to pay these private doctors on their own (Interview 4, lines 411-415).

When it comes to the differences between compulsory and supplementary insured patients regarding the waiting times, people perceive that there is no differentiation when visiting a panel doctor because there everyone is treated in the same way and there are no appointments. In the hospital it is a bit different as the compulsory insured patient has to wait for some special surgeries much longer than the supplementary insured (Interview 5, lines 558-561 & Interview 8, lines 864-866).

> Partially they are a little bit longer but for emergencies one gets always treatment, there is always something available, but examinations such as MRI or something like that when one needs this it is obviously in some instances a longer waiting time (Interview 10, lines 1057-1059).

Generally, it is difficult to generalize as the waiting time always depends on the time when one goes to the doctor or the hospital (Interview 11, lines 1140-1141).

> When you go at the peak times (…) then you have to wait longer (…) but it is generally the case that emergencies get anyway earlier treated, so when you are not an emergency case you have to wait (Interview 11, lines 1141-1143).

Some Austrians perceive the waiting times in the healthcare sector as too long, especially on the countryside. The reason for this is that on the countryside there is not so much healthcare offer than in cities and therefore, the waiting times in the periphery are getting even longer (Interview 6, line 670 & Interview 4, lines 341-344).

> I have to say, in the hospital I experience a lot of things where I can see that there is a difference, when I sometimes ask "how long did you wait for an appointment until you somehow got the surgery or the special examination" (…) one says I went at three in the afternoon to the doctor and on the next day at seven in the morning he laid on the operating table (…) and the other one has to wait (…) three months. This difference obviously exists and it will always exist (Interview 4, lines 333-341).

The lack of healthcare offer on the countryside exists due to difficulties for filling positions as nowadays not so many doctors want to take a panel doctor position in the periphery anymore. Therefore, there are some villages in Austria where there is almost no medical offer and development and until now no effective counterstrategy was implemented (Hasenhündl, 2016, p. 12).

In general, people think that the waiting times are too long but that the healthcare providers are not doing it on purpose but that it is caused due to time problems and because there is more demand than offer (Interview 12, lines 1218-1219).

6.3 Reasons for a supplementary insurance

There are various reasons why Austrian patients decide to have a supplementary private insurance. Firstly, one advantage of a supplementary insurance is that one can choose the doctors who provide the treatments. Secondly, there is more privacy

available during the treatment and care (Interview 1, lines 52-53). The possibility to lie in a two-bed room instead of a four-bed room is also a main reason why people are going for supplementary insurance as well as the extra comfort and luxury one can receive with this kind of insurance (Interview 3, lines 247-249).

> I have it because I don´t want to be in a 4-bed room, that´s my reason, not because I don´t trust in the doctors who will treat me. I just want to have like… If I´m sick I just want to feel a little bit private, I don´t want to be in a big room (Interview 2, lines 131-133).

In general, everyone wants to get the best possible treatment and especially doctors state that they want to choose the treating doctor on their own because they have some perceptions of who is the best in his/her field (Interview 3, lines 239-241).

6.4 Characteristics of the Austrian healthcare system

Austrians perceive their healthcare system in different ways when it comes to its characteristics. Some see the Austrian healthcare system as one-tier system while others recognize it more as two-tier system and there are many who think that it has influences from both kinds of systems.

Only a few people perceive the Austrian healthcare system as a pure one-tier system but mostly Austrians see their healthcare system as a combination of one-tier and two-tier. They think that everyone is equal and that everyone has the same access to healthcare but that there is still the opportunity to go for a private doctor but that everyone has to decide it on one´s own if it is worth to pay more (Interview 2, line 140 & Interview 11, lines 1152-1158).

> Because I think, what I have seen, if you only see it from the point of view how the care about the patient and how you think what he might have, what diagnosis then it´s a one-tier. If it´s because it´s the way you have to be in a… if you have a private room or a room for both then it´s a two-tier system. It´s a difficult question to say. I think also you need the private insurance to be able to finance the way we do the medicine (Interview 2, lines 144-148).

It is also argued that from the doctor´s perspective there is a tendency to a one-tier system but regarding the comfort which one can gain with a supplementary insurance it represents the characteristics of a two-tier system (Interview 3, lines 254-256).

> But I say that this is not so tragical, I pay a lot of money in order to have the comfort. (…) I trust our doctors and say when diseases are treated then it is a one-tier medicine (Interview 3, lines 256-259).

It is mostly stated by patients rather than doctors that the Austrian healthcare system is influenced by the one-tier as well as the two-tier characteristics. On the one hand it is assumed that everyone is treated in the same way but on the other hand it takes for some people longer until they receive the treatment. The crucial difference is the time factor which plays a role but not if someone is treated in a better or worse way and one exception is obviously the case of emergency where everyone is treated immediately (Interview 9, lines 967-978).

Some Austrian patients think that there is a two-tier healthcare system in Austria but they do not feel disadvantaged because of that (Interview 10, lines 1070-1071). Those who see the Austrian healthcare system as a two-tier system have several reasons for stating this (Interview 1, line 58). Firstly, it is mentioned that it is automatically a two-tier system because it is no one-tier system, even though nobody openly admits this and politicians try to hide it. A one-tier system would exist if the system is accessible for everyone in the same way but this is not the case due to different healthcare offers of doctors on the countryside and in the cities (Interview 4, lines 420-426).

> On the countryside, there is in the whole district no ophthalmologist available anymore who takes you. Then there is only one ophthalmologist in the district Kitzbühel or maybe two who are panel doctors and they do not take you anymore. Or at the dentist, there are already so many people and then you have to go as a private patient or you have to go further away and if this is not the case it would be a one-tier medicine but due to the fact that it is totally like that it is a two-tier medicine (Interview 4, lines 427-433).

Secondly, people believe that a two-tier healthcare system exists in Austria because of too many health insurance funds and their differences (Interview 5, lines 572-577 & Interview 6, lines 680-681).

> We have 22 health insurance funds in total and there is actually a big difference regarding the range of services (Interview 5, lines 576-578).

Furthermore, the Austrian healthcare system is perceived as two-tier system because the supplementary insured patient has more possibilities compared to the compulsory insured one (Interview 5, line 576 & Interview 6, line 675). Austrians think that the treatment is strongly related to the type of health insurance and that there are differences with regard to the time a doctor takes for the patient or the waiting times for an appointment (Interview 7, lines 788-792 & Interview 8, line 880). Moreover, people are characterizing the Austrian healthcare system as a two-tier system because they have the impression that wealthy patients are getting appointments faster or earlier (Interview 12, lines 1230-1235).

6.5 Future of the Austrian healthcare system

6.5.1 Expected changes of the Austrian healthcare system in the future

Some people assume that there will be no big changes in the future due to the good Austrian health standards and the equal access to healthcare (Interview 11, lines 1163-1165). In addition, especially doctors hope that they can do as much as they have been doing so far and that the framework and the quality of the Austrian healthcare system will stay the same (Interview 2, lines 153-154).

> I think there won´t be any big changes in the next years, maybe 10 years, because most people know that the private insurance is cross-financing the public insurance system and that in the end everybody is having a profit of this (Interview 1, lines 63-66).

Others think that there will be more specialisation in the next years and that more patients will start to go for other hospitals in the European Union. The reason for this is that patients want to get specialized care as well as a second opinion regarding their disease or want to be treated in a specialist hospital (Interview 9, lines 983-988).

Furthermore, Austrians believe that the offer of panel doctors will get less because more and more doctors will go for the supplementary insured. In addition, there will be also practices which will join together to group practices and offer various services to patients. Regarding the situation of hospitals it is assumed that it will continue like it is that for example the supplementary insured patients will get earlier appointments and more extensive examinations. People in Austria hope that the healthcare system will not get worse but they think that patients have to pay more money for their own health in the future. Moreover, people are getting older, sicker and survive more diseases due to the medical progress and therefore, the healthcare system will get more expensive in the future and when the state will not invest money the healthcare system will not improve (Interview 4, lines 442-465).

Austrian people think that money plays a too important role in the healthcare sector and therefore, it will get worse as the state or the insurances do not want to pay the deficits and due to this the hospital services as well as the health insurance benefits will get cut or in the worst case it is not financeable anymore. One result of these cuts will be that not everyone will have the same access to all doctors anymore and that the two-tier medicine is getting more and more (Interview 3, lines 264-269 & Interview 9, line 995 & Interview 6, lines 690-691).

> It will cost a lot further on, it will get even more expensive because more people are making use of services earlier and therefore, (…) it will certainly not get cheaper but I think it will still stay how it is over a long period of time (Interview 5, lines 586-589).

People have the feeling that the two-tier healthcare is getting worse because the poor are getting poorer and the rich are getting richer and the gap widens even a bit further when looking into the future (Interview 8, lines 892-894).

6.5.2 Desired changes of the Austrian healthcare system in the future

A lot of Austrian doctors as well as patients are satisfied with the Austrian healthcare system and perceive it as advanced and therefore, they cannot think of desired changes in the future (Interview 1, lines 69-70).

> I would wish that it stays like it is or how it was. In my opinion any change is a deterioration (Interview 3, lines 278-279).

Despite the fact that people are satisfied with the current healthcare system there are also many people in Austria who have some changes for the future in their minds.

> I wish we would have smaller rooms for everyone, so two beds in one room and not these four beds in one room because that´s not… if someone is really really sick then that´s not nice for them, they know they have to be cared much more, there have to be taken much more care of them, there will be change in the bed and everybody else is watching, even though we try to maintain a little bit the privacy but it´s not always easy. So I think that would be really good. Otherwise the care from the doctors and the nurses I think it´s the same (Interview 2, lines 163-168).

Furthermore, there is the wish that there is more equality and that everyone has the same access to healthcare as well as the same treatment and that it has to be regulated on a high-level namely on the government level that more money is available for the healthcare sector. It would be desirable that all patients can afford every kind of health service and that the competent authority thinks about options for the elderly and how the relevant costs can be covered. The population is getting older due to the good medical care and the patients survive longer and get more treatment and these correspond to high costs. Although these changes would be good for the future it is often a subjective feeling how one feels because there are differences from one person to another concerning the personal perception of the healthcare system (Interview 4, lines 470-496 & Interview 6, line 705).

Another preference is that there are not 22 different health insurance funds but only one or two as the differences are too serious right now. In addition, it should not be allowed that doctors operate in a private practice besides the public hospital or to get private remuneration in public hospitals (Interview 5, lines 593-600).

Furthermore, people wish that the differences between one-tier and two-tier healthcare is not so big anymore and that panel doctors are available in an appropriate number as in some specialties there are only a few panel doctors represented (Interview 7, lines 811-814).

> There should be more panel doctors or more health centers, more offer for out-patient treatment, because for example general practitioners are declining on the countryside as they are overburdened with the bureaucracy and with the patients, because the relation what you earn and what the practice costs in order to maintain it is so bad, so bad that nobody is ready to work as a general practitioner on the countryside anymore (Interview 7, lines 811-820).

In addition, it is desired that no barriers are put in the way of doctors concerning their education and the very difficult entrance examinations in order to get more doctors also on the countryside (Interview 12, lines 1248-1250). Moreover, some people think that it would be good that also non-Austrians have easy access to the Austrian healthcare system (Interview 11, lines 1171-1172).

Furthermore, people think that it would be beneficial if there is a better cooperation as well as coordination between hospitals and general practitioners. In addition, patients would wish that the social insurance covers everything what is needed with regard to healthcare (Interview 9, line 1006 & Interview 9, lines 999-1009).

7 Discussion

In general, Austrian doctors and patients perceive the Austrian healthcare system as good and advanced, especially compared to other countries. In the last two decades the health priority was determined to expand the insurance coverage and to maintain the access to health services for the whole population. Since 1970 a significant improvement of the health status of the Austrian population can be noticed. These improvements of the state of health in combination with the relatively unlimited access to healthcare are the reasons, among other things, that the satisfaction of the Austrian population regarding healthcare is sustainably and comparatively high (Hofmarcher & Rack, 2006, p. 229).

Even though the perception of the Austrian healthcare system is good there are still differences, which concerns doctors as well as patients. These differences occur mostly due to the different insurance status one can have, namely compulsory insured and supplementary insured. The insurance status can have an essential influence on the quality in the healthcare system with regards to access and treatment. The access to healthcare comprises the waiting times for doctor appointments or medical examinations in the practices as well as in the hospitals. Furthermore, also the availability of healthcare facilities and doctors in cities and on the countryside is taken into account. When it comes to the treatment, diagnoses and comfort are considered as the main factors, which make a difference. Due to these existing differences in the Austrian healthcare system the debate about whether a one-tier or a two-tier healthcare system exists arose.

Most of the Austrian doctors and patients in Tyrol expect that there will not be any big changes in the healthcare system in the next years except of the impression that it will get more expensive in the future. However, when it comes to the desired change there is the wish that the healthcare system stays like it is. Nevertheless, they still see space for improvement in terms of more equality with regard to access to the healthcare system and the provided treatment.

Throughout all the interviews there are no significant differences apparent and one can only differentiate the opinions of the interview partners through the more detailed wording in their statements.

More than half of the respondents, namely eight out of twelve stated that they do not perceive any differences regarding the treatment and four interview partners indicated that there are differences but merely with regard to the hotel character. Only one doctor said that there are differences with regard to treatment and that not everyone can have the same state of health. When asking about the equal access to healthcare, half of the interview partners answered that everyone has the same access to healthcare facilities and services.

In terms of waiting times, ten out of twelve respondents answered that patients have to wait too long, especially for specialists or when they have no supplementary insurance. Only two out of twelve interview partners stated that the waiting times are convenient. However, all respondents had a consensus on the fact that in case of emergency everyone is treated immediately.

Half of the interview partners mentioned that money plays an important role in the Austrian healthcare system. In addition, it is assumed that the healthcare system is getting more expensive due to medical progress and the demographic change. Due to this expectation and also because of other reasons people use the possibility to get extra benefits. A supplementary insurance is mostly purchased due to the possibility of choosing a preferred doctor and to have more privacy and comfort in the hospital.

A clear result can also be seen in the question about the characteristics of the Austrian healthcare system. Eight out of twelve respondents indicated that the Austrian healthcare system is characterized as a two-tier system whereas four said that they see it more as a one-tier system but still with characteristics of a two-tier system. Moreover, three interviewees even said that there will be more and more two-tier healthcare in the future.

Most of the respondents emphasized that they are satisfied with the Austrian healthcare system, especially when comparing it to other countries. However, four interview partners have the impression that there are less possibilities on the countryside than in the cities with regard to healthcare as there are not so many doctors and healthcare facilities in the periphery.

The reason why there are not enough doctors available anymore on the countryside is, among other things, that the doctors do not want to go for panel doctor positions any longer as these are not very attractive anymore. One third of the interview partners also mentioned that more and more doctors prefer private practices in order to have more time for the patients. Furthermore, almost half of the interviewees think that there will be no changes in the Austrian healthcare system in the future.

8 Conclusion

The goal of this master thesis is to find out how doctors and patients in Tyrol perceive the Austrian healthcare system with respect to its two-tier characteristics. Information on this topic is gained from a literature review as well as from qualitative interviews.

There is a high satisfaction of the Austrian population with their healthcare system. According to the population survey of the Austrian medical association, which was conducted in the end of the year 2016, 81 percent of the Austrians are satisfied with the Austrian healthcare system. Overall, the people in Austria are rather or very satisfied with the situation of their healthcare system. For 75 percent of the respondents the free choice of doctor is very important. 68 percent always went to the same doctor when there was the possibility as continuity of the treatment and a healthcare provider´s location nearby still play a big role. For the majority of the Austrian population the general practitioner is still the first point of contact in case of health problems. Only one third of the respondents classified the current developments in the healthcare system as right whereas 51 percent showed concern. This concern is mostly related to the fear of significant savings as well as benefit cuts and longer waiting times (Ärzte Zeitung, 2017).

In general, two-tier healthcare is mentioned and debated in connection with the expectation of a basic healthcare. People do not mainly expect politics to do something against the service differentiation but more to guarantee that there will not be further cuts in their own medical care in the future. This in turn means that the agreeing with the statements that a two-tier healthcare is more and more expected, represents only the fear of people that in the future not everything will be done in case of need but only the most necessary (Ostendorf et al., 2012, pp. 13–15).

It is argued that it should be allowed to buy additional, faster or higher quality services when the provided services in the first tier are set at an adequate level and the second tier is not undermining the sustainability or quality of the services in the first tier. In general, the argument for this point of view is that the permission to buy second-tier services leads to a pareto improvement, or in other words advantages for one person without harming anyone else. Moreover, the prohibition of buying

additional services presents a restriction of the liberty of individuals who normally have discretion to spend their income as they think, it is appropriate. Especially, when the first tier provides services, which are sufficient and are not impaired by those which are provided in the second tier, it seems difficult to justify such a restriction (Fourie, 2016, pp. 44–45).

Among the service providers´ competition is imaginable but this should take place only in form of quality competition. Billing systems should be reformed insofar as they give incentives to offer good quality to everyone. Moreover, patients need to be informed significantly better about the type as well as the extent of the performed services and also about any arising costs. Quality assurance and control need to be essentially stronger expanded in order to increase the efficiency and effectiveness in healthcare and it should be applied nationwide. Furthermore, the patient rights should be strengthened noticeably. In any case, quality assurance and control of the universal access are closely linked and important when one wants to avoid two-tier healthcare (Raza, 2005, p. 131).

In Austria, the lack of doctors is attaining a critical size and the population is affected the most by this development. The resulting consequences of the lack of doctors are bottlenecks, which lead to delays and waiting times for the patients as well as to enormous working pressure for the employed doctors. Due to this situation, many doctors in the public healthcare system are not satisfied with their working and living conditions compared to doctors of one´s choice despite of a secure and good income. The working conditions are far away from the ideal and bureaucracy hinders the work routine in an unreasonable way. Therefore, a better compatibility of family and work, flexible working arrangements, less bureaucracy, an adjustment of the catalogue of services and better salaries in the hospitals are necessary in order to counteract the lack of doctors (Hasenhündl, 2016, pp. 12–13).

All in all, the healthcare system in Austria can only be strengthened by taking into consideration all involved parties in the future. A two-tier healthcare system has different characteristics and it can have an impact on different levels of healthcare. On the one hand a two-tier healthcare system can be perceived through differences in treatment and this is seen as very critical. However, this characteristic of a two-tier healthcare system does not exist in Austria as equality is one of the main

principles of healthcare and therefore, the treatment level is not affected by differentiation due to two-tier healthcare. On the other hand, the two-tier healthcare character is apparent due to the service level in terms of more privacy and comfort of single or two-bed rooms but this form of two-tier healthcare is perceived in an unproblematic way as it has no impact on the health status of a person. This two-tier characteristic applies to the Austrian healthcare system as one can pay in order to get more privacy and comfort as well as to receive treatment from the doctor of one´s choice (Austrian Federal Ministry of Health, 2013, p. 11; Jörg, 2015, p. 38).

In the future, the further development of the Austrian healthcare system will be essentially characterized by more efficiency, more individual responsibility, the defense against the impending financing problems and the protection of the high quality and solidary healthcare system (Tálos & Obinger, 2006, p. 224).

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Annex

Interview Guideline

1. What do you think, how is the general perception of the society on the Austrian healthcare system and how do you personally perceive it?

2. Are in Austria big differences with regard to their access to health care between public and private insured people?
   - If yes, how bad are these differences? Which impact do they have on the social harmony and peace? To what extend do these differences contribute to social conflicts?

3. Many people think that all patients have equal access to treatment, while others think that some patients have a better health status because they get better treatments than others.What is your opinion on this matter?

4. Do you think that the waiting times for a doctor´s appointment are convenient or too long for people with public health insurance?

5. Do you have private insurance? If yes, why? (extra question if necessary)

6. Regarding our discussion so far, would you characterize the Austrian healthcare system as two-tier or as one tier-system?

7. What do you think, how will the Austrian healthcare system develop or change in the next years, also regarding the issues discussed so far and how would you wish that the healthcare system will be changed?

Topics:

- Austrian healthcare system
- Differences between public and private insured people (treatment, waiting times)
- Impact of differences on social harmony, peace and social conflicts in Austria
- Two-tier and one-tier healthcare system in Austria
- Future of the Austrian healthcare system

Transcription and analysis

See CD in Annex