

CHAPTER 8. SICKNESS BENEFITS

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In 2003, public expenditure on health care provision (according to ESSPROS) amounted to Euro 16 billion. This is approx. 7% of the GDP or 25% of the social expenditure.

The majority of the expenditure is spent on benefits in kind. 15% are attributable to income substitutes of the employers (See Chapter 13) and of the statutory health insurance in the case of temporary inability to work due to illness.

8.1. Eligibility conditions

The statutory health insurance is linked to gainful employment, but it reaches far beyond the limits of insurance for the employed, extending also to their family members.

Approx. one third of all persons insured under the health insurance scheme are co-insured without paying contributions (e.g. children, housewives).

Since 2001, an additional amount of 3.4% of the gross income is payable for co-insured spouses and partners. However, the majority of the concerned group remains co-insured for free due to exemptions. This group includes:

- Persons dedicated to child care or persons who cared for a child for at least 4 years in the past;
- Persons in need of long-term care (from level 4) and those family members caring for them;
- Persons who require special social protection;

Due to these exemptions, contributions must only be paid for about 4% of these co-insured partners (ca. 25.000 persons).

Persons, who are not covered by statutory health insurance, have the possibility of voluntary insurance within the statutory health insurance. On the average in 2004, 112.000 persons were voluntarily insured.

For persons who are not covered by health insurance, social assistance covers either their health insurance contributions or the cost for necessary medical treatment in in cases of financial neediness.

In total, about 98% of the population is covered by statutory health insurance.

All persons covered by health insurance are entitled to medical treatment by a contracted doctor or in a hospital – regardless the level of their health insurance contribution.¹

In the case of temporary incapacity for work due to illness, employed persons are entitled to sickness benefit after the entitlement to continued payment of wages (between 6 and 12 weeks) by the employer has ceased (see Chapter 13).

For the period of 8 weeks before the birth of a child and 8 weeks after the birth of a child, mothers obtain confinement benefit at the level of their actual income from gainful work.

8.2. Benefits in kind

Benefits of the health insurance are mainly granted as benefits in kind, either by special facilities (above all out-patient clinics) or – to a much larger extent – by institutions under special contract (hospitals) or physicians under special contract. If services from other doctors or institutions are consumed, costs are (partially) reimbursed.

¹ For care services and benefits – with the exception of the medical home care, which is covered by health insurance – the system of care provision/provision for long-term care is responsible (see Chapter 10 and Chapter 12).

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Generally, persons covered by health insurance have a choice in selecting the physician. However, if treatment is provided by a physician who is not under contract with the health insurance, the medical service must be paid at first by the insured. On application, the costs are reimbursed up to 80% of the amount, payable by the health insurance institution for an identical treatment by a contracted physician.

Medical treatment

Persons covered by health insurance are entitled to treatment by a contracted physician upon presentation of a health fund voucher. The health fund voucher serves as evidence for the patient's entitlement and also as mean for the clearing procedure for the medics' services to the patient with the health insurance institution. For the issue of a health fund voucher, a fee of Euro 3.63 per voucher is to be paid (2005). Pensioners, children, persons with low incomes as well as persons with notifiable contagious diseases are exempted from this fee.

From 2006 onwards, the health fund voucher will be replaced by an electronic chip-card (e-card). This new nationwide system will present a considerable facilitation for access to medical treatment. At the same time the bureaucratic charge of work will be distinctively reduced, thus leading to cuts in administrative costs. The name of the insured, the personal insurance number, the insurance institution and applicable exemptions from fees are stored on the card. It is readily available and serves as a proof of insurance coverage.

Self-employed persons and civil servants must principally make a co-payment of 20% for each service by a medical doctor; farmers pay the unified amount of Euro 7.30

per consultation (2005). However, there is no fee for health fund vouchers for this group. For employees under private law and pensioners no corresponding co-payment is due.

Some individual services, particularly in dental treatment, e.g. crowns or bridges, are not covered by the health insurance. For these benefits the insured person receives only a small reimbursement towards the costs. For persons in need, resources from the support funds of the health insurance institutions are available in such special cases.

If required, every insured person is entitled to hospital care without a time limit. The health insurance institutions have concluded contracts with the public and most private hospitals. For in-treatment a hospital care contribution between EUR 8 to 10 per day has to be paid (the amount varies according to the Laender). For family members, 10% of the hospital care rate (Pflegegebühreersatz) must be paid (however this is only due for a maximum of 28 days per year). Hospital care related to motherhood is exempted from this.

Pharmaceutical Products

If the medical treatment requires the use of medicines, patients must pay a fixed prescription fee of Euro 4.25 (2005) for every medicine prescribed by a doctor. Medicines for the treatment of notifiable contagious diseases are exempted from this fee. Further exemptions from the prescription fee are possible on application for persons with low incomes, and persons with low incomes who can provide proof of above-average expenditures due to illness or infirmity, e.g. the chronically ill.

In order to guarantee high quality and the control of costs for medicine, the

Federation of Austrian Social Insurance has drawn up a register of medicines (“Erstattungskodex”) containing all medicines which are available at the expense of the health insurance fund. A part of these medicines require special approval from the medical superintendent of the health insurance institution.

Therapeutic appliances and technical aids

Therapeutic appliances and technical aids include spectacles, crutches, wheelchairs etc. Employees have to pay a contribution of 10% or a minimum of EUR 24.50 (2005) towards the costs; self-employed persons have to pay 20% of the costs. For spectacles, a co-payment EUR 72.60 must be made. However there is a ceiling for the costs for therapeutic appliances covered by the health insurance funds. In the case of need or in the case of children with disablements lower co-payments are to be made.

Psychological and social services and treatment by health professionals other than medical doctors

The treatment by health professionals other than medical doctors as e.g. physiotherapists, ergotherapists, psychotherapists and clinical psychologists is principally considered as a benefit in kind. In most cases physiotherapeutic and logotherapeutic services are covered by health insurance after a hospital stay. For the treatment by a psychotherapist, the health insurance contributes towards the costs.

Further important benefits in kind are measures of the primary and secondary illness prevention as well as the coverage of follow-up services (rest cures, rehabilitation measures).

8.3. Cash benefits in the case of sickness

The most important benefits to replace income in the case of illness are the continued payment of wages by the employer (see Chapter 13) and thereafter a claim to sickness benefit under the statutory health insurance. If the period of sickness exceeds the period covered by sickness benefit and the conditions for eligibility are fulfilled, invalidity pension can be granted. (See Chapter 6).

Sickness benefit is granted for a period between six months and one year, depending on the insurance period. The minimum level of the monthly sickness benefit amounts to 50% of the gross pay inclusive proportional special bonus pay, after 43 days of incapacity for work it is increased to 60%.

In the case of sickness, self employed persons, obtain cash benefits up to the duration of one year only, if they are covered by a special voluntary insurance. In the case of a farmer's inability to work, temporary help (...) can be granted.

The past several years, have seen a decline in sick leave per employee at an average of 13 to 15 days.