

Barriers to Accessing Health Care for People with Chronic Conditions: A Qualitative Study

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Abstract

Background: There is a growing interest in redesigning healthcare systems to increase access to and coordination across care settings for people with chronic conditions. We aim to promote patient-centredness by gaining a better understanding of the barriers faced by (1) children with chronic bronchial asthma, (2) adults with non-specific chronic back pain, and (3) older people with pre-existing mental illness/es while addressing the problem of fragmentation in Austria's healthcare system.

Methods: Using a qualitative design, we conducted semi-structured interviews face-to-face and by telephone with health service providers, researchers, experts by experience (e.g., patient advocates, family members/carers), and employees in public health administration between July and October 2019. The analysis and interpretation of data were guided by Levesque's model of access, a conceptual framework used to evaluate access broadly according to five dimensions of accessibility to care: approachability, acceptability, availability and accommodation, affordability, and appropriateness.

Results: The findings from the 25 expert interviews were organised within Levesque's conceptual framework in four dimensions of barriers. They highlight the lack of coordination and defined patient pathways, particularly at the onset of the condition, when seeking a diagnosis, but also later on. Barriers related to issues such as geography (e.g., longer distances and travel times as well as fewer healthcare services in remote rural regions), coordination of care (e.g., structural barriers and inconsistent care pathways), socioeconomic status (e.g., the ability to pay for healthcare services but also basic health literacy), and comorbidity (e.g., consideration of the patients' state of mental health and holistic therapy approaches).

Conclusions: Barriers to healthcare access are of particular concern for patients with chronic conditions, resulting in an urgent need to improve health services according to patients' specific needs. For health services to be properly accessible, timely and integrated care independent of social and economic resources, continuity of care, and significant improvements in patient-centred communication and coordination of care are paramount. This study has important implications for policy and practice as it highlights provider, expert, and researcher perspectives on access to the healthcare system in Austria and offers a broader look at the changes required by stakeholders in the future.

Background

Barriers to accessing health and social care represent a key factor in causing health disparities. Regardless of their age, people with chronic conditions often face multiple and complex challenges when trying to identify the right patient pathways already at the onset of their illness or when the first signs of chronic disease appear [1]. However, frameworks on access to health care tend to focus less on aspects relevant at the different stages of a patient's illness. In other words, there is little discussion of the lack of coordination between providers or of barriers to identifying patient pathways on behalf of patients at different stages of their illness. Similarly, the WHO's universal coverage framework focuses on what services are covered, aspects of cost sharing, and population coverage but does not capture inequalities in access at different care stages and/or in settings that are particularly relevant for patients with one or more chronic diseases

[2]. This paper aims to fill this gap by highlighting barriers to accessing care at different stages of a patient's illness both from a demand and a supply perspective using qualitative methods.

At a policy level, factors relating directly to the organisation and functioning of national health and welfare systems may have a direct or indirect impact on access to health care. For example, the EU Expert Group on Health Systems Performance Assessment [3] identifies systems financed through a government budget as being preferable regarding their redistributive effects as opposed to health systems that rely heavily on social insurance contributions as the latter link entitlement to employment or payment of contributions and frequently do not account for differences in wealth [4]. Further, a wide range of social determinants at individual and policy level have an impact on the existence of barriers to access. Both upstream determinants (e.g., at the policy level for society as a whole or at the level of healthcare providers) and downstream determinants (at the individual level) may play a role in shaping barriers. Similarly, factors relating both to the demand side (i.e., related to patients) and the supply side (i.e., related to providers) shape barriers to access from the identification of healthcare needs to health outcomes [5].

As a social health insurance (SHI) system, one of the key challenges in the organisation of the Austrian healthcare system is the fragmentation of organisational and financial structures [3, 6]. This applies particularly for people with multimorbidities and/or chronic conditions (ibid.), even if recent reforms have attempted to tackle fragmentation and to shift service provision away from the inpatient sector while expanding outpatient care in the context of target-based governance reforms [6, 7]. In this context, the main stakeholders financing the system (nine provinces, federal level, SHI fund) agreed to continue addressing barriers to access in the reform period 2017-2021 [8].

So far, few studies have systematically analysed barriers to accessing health care in the Austrian healthcare system for people with chronic conditions. We use Austria as an example to highlight such barriers at different stages of a patient's illness in an SHI country setting in Europe. The study aims to identify barriers to access, with a special focus on patient pathways, in the Austrian context, using three case studies of people with chronic conditions and applying the barrier to access model developed by Levesque et al. [5] as a conceptual framework.

Policy context

Austria is a developed welfare state with an SHI system covering around 99 percent of the population. The provision of health services in Austria is characterised by relatively unrestricted access to all levels of care including GPs, specialists, and hospitals, and there is no formal gatekeeping system in place [7]. However, in practice, the density of specialists with an SHI contract is low in some rural areas [9, 10], and the proportion of private providers, i.e., without an SHI contract, is rising. In fact, out-of-pocket payments at the point of service are higher in Austria than in other countries with similar levels of health expenditure (17.7% of health expenditure in 2019) [11, 12]. The proportion of people with voluntary health insurance (VHI) is growing [9, 10]. The latter also enjoy shorter waiting times for elective surgery [13] than patients without VHI. Further, some authors have reported that a greater proportion of Austrian households are faced with health spending that exceeds their ability to pay than in most high-income countries in the EU [14]. While

overall life expectancy is above the EU average (81.7 years in 2017) and rising, healthy life years at birth are substantially below the EU average, with approximately 57 years free of disability at birth versus 64 years in the EU as a whole [9, 10]. Regional variation is substantial, with shorter healthy life expectancy among people living in eastern parts of Austria compared to western parts [15]. Years lived with chronic diseases and disabilities are approximately the same as the EU average [9, 10], albeit with a social gradient: People with only compulsory education have 1.6 times the risk of being affected by chronic disease than people with higher formal education (authors' own calculation based on ATHIS data, 2019 [16]). In addition, despite high coverage with SHI and being continuously among the countries with the lowest levels of unmet needs in Europe, barriers to access exist particularly for people with a changing status, such as students above a certain age limit joining the labour market and third-country citizens. Lower education, a lower income, and the lack of labour market attachment have been shown to increase the risk of remaining uninsured [17]. In addition, different cost-sharing regimes continue to exist across SHI funds, despite recent reforms [7].

The next section summarises existing evidence on barriers to access for people with chronic conditions in the Austrian health system based on a systematic review of the literature (forthcoming by the authors), followed by a description of the methods for data collection and analysis. The empirical results are then presented, followed by a discussion of the main findings and some tentative conclusions for policy.

Barriers for people with chronic conditions in Austria

Fragmentation is a major barrier identified in studies on people with chronic conditions in Austria: Patients with chronic conditions face difficulties identifying the right patient pathways, especially when in vulnerable situations, such as persons affected by homelessness [18, 19]. People in lower socio-economic groups are not only at higher risk of being affected by chronic pain symptoms but also have more difficulties dealing with chronic symptoms due to lower health literacy [20, 21]. Socio-cultural factors also contribute to difficulties managing chronic illness [22-25]. Most studies have focused on specific groups, such as people affected by poverty or homelessness, while studies on chronic disease among children or in the general working age population are much rarer. Regarding mental health care or psychosocial care, the main barriers mentioned in the literature range from stigmatisation, information deficits, and waiting times among people with mental health problems (cf. [26]) to barriers to accessing psychotherapy as well as psychiatric inpatient care and psychiatric care in hospital outpatient departments [19, 26-35]. Previous studies have identified financial barriers to accessing psychotherapy, often in combination with other barriers such as long-term unemployment, risk of social exclusion, or language barriers [28-31]. A main barrier includes the ability to navigate a fragmented system, with patients with mental health problems often facing a lack of coordination between care settings and care providers [19, 29, 36]. The vast majority of studies investigating the accessibility of mental health care, however, focused on the working age population (or explicitly on dementia care) as well as on children and adolescents, while studies relating to chronic mental health conditions for the older population (except for long-term care and dementia) are rare (see, e.g., [37] on older drug dependents in Vienna).

Research question and framework for analysis

The research questions in this study are: what challenges in access patients with chronic conditions face in the Austrian SHI system at different stages of their illness and how barriers to access across a patient's stages of illness may be conceptualised using Austria as an example.

We employed the theoretical framework by Levesque et al. [5] (cf. Figure 1), who conceptualise access to health care across five dimensions (i.e., approachability, acceptability, availability and accommodation, affordability, and appropriateness), along with five corresponding abilities of populations (ability to perceive, ability to seek, ability to reach, ability to pay, and ability to engage), and adapted it for the purpose of our study:

(1) Barriers to perceiving need and the approachability of health care: Perceiving the need for care is often the first step in a patient's journey and is determined by their individual knowledge and skills (including basic health literacy) as well as any existing beliefs about health and illness. The approachability of health services refers to the provider's efforts to make their services more known to their patients and is often related to transparency, outreach, and provision of information [5]. In the context of patients with chronic conditions, approachability is also related to the provision of information, resources, and education about services to current clientele.

(2) Barriers to seeking and reaching health care: Seeking health care relates to cultural and social factors affecting services. It examines whether people will accept services that do not conflict with their personal, social, or cultural values so that they can access them without feeling unsafe or uncomfortable. The ability to reach health care also pertains to patients' ability to physically access services, based on factors such as personal mobility (e.g., the presence of disability, access to transportation) and external circumstances (e.g., occupational flexibility). In the context of chronic care, the availability of services also refers to the general presence of health services and providers needed as well as their accessibility to patients, both physically and in a timely manner [5].

(3) Barriers to utilising health care: According to Levesque et al. [5], affordability refers to patients' economic capacity to spend resources and time in order to use the required services (e.g., direct costs, secondary costs (for getting to an appointment), and opportunity costs (for going on sick leave from work)). The ability to pay for health care refers to patients' economic capacity to pay for actual healthcare services. In the context of patients with chronic conditions, who usually show higher healthcare utilisation rates [38, 39], utilising care particularly includes co-payments and waiting times.

(4) Barriers to obtaining better health outcomes: Health outcomes depend on the appropriateness of care and patients' ability to engage in health care. Appropriateness of care is reflected in the fit between treatment and patients' needs, its timeliness and coordination, and its quality. The patients' ability to engage in health care relates to their participation in decision making and their compliance in therapy [5]. In the context of chronic care, the appropriateness of care relates to coordination, continuity of care, and interdisciplinary cooperation.

Methods

Selection of case studies

A systematic literature review (forthcoming by the authors) served to identify relevant empirical work related to access barriers to health care in Austria. Based on the review, ten topics were identified for further analysis. The suggested topics aimed to fill gaps in the literature and to cover a broad spectrum of potential access barriers, areas of care, and population groups affected. A national expert group, which is also in charge of driving the healthcare reform, evaluated the suggested topics and chose three for further case study analyses. The expert group consisted of representatives of the Federal State of Austria (Ministry of Health), the nine Austrian provinces, and SHI institutions. The chosen case studies focused on different population groups with chronic conditions. All case studies followed the same methodology and interview guidelines.

(1) Bronchial asthma in children:

Bronchial asthma is a chronic inflammatory disease characterised by heterogeneous disease patterns due to different environmental, genetic, and economic risk factors. In Austria, it affects about one in ten children [40].

(2) Non-specific chronic low back pain (LBP) in the working population

Non-specific chronic LBP is a musculoskeletal condition characterised by symptoms in the lumbar area lasting more than three months without a diagnosable underlying pathology. According to the Austrian Health Interview Survey (ATHIS), around 25% of the working population suffered from non-specific chronic LBP in the 12 months running up to their participation in the study [41].

(3) Older people with pre-existing mental illness (excluding dementia) living independently

Disease patterns in old age often differ from their appearance in younger years. The most common mental illnesses in old age include affective disorders such as depression, bipolar illnesses, persistent dementia, acute states of confusion known as delirium, or delusional and schizophrenic disorders [42] [43]. Dementia was, however, excluded in our study.

Expert interviews

Data were collected through expert interviews [44]. Interview partners were identified for each case study following a heterogeneous purposive sampling strategy covering the following four perspectives: health service providers (in and outpatient services), experts by experience (patients or their advocates), research, and public health administration. A semi-structured interview guide was developed following the four dimensions of barriers to access adapted from Levesque et al. [5]. In total, 25 interviews were conducted (see Table 1) between July and October 2019. They took 40 to 90 minutes: three were conducted by

telephone and the others face to face. The results of the expert interviews were analysed using framework analysis [45].

Table 1
Overview of interview sampling

Interview	Gender	Perspective	Type of care provided (where applicable)	Region	Medical specialities (where applicable)	Setting (where applicable)
1A	F	research	-	Vienna	general medicine	urban
2A	M	provider	inpatient	Vienna	paediatric pulmonology and allergology	urban
3A	M	provider	inpatient	Salzburg	paediatrics	rural
4A	M	provider	inpatient, rehabilitation services	Styria	paediatrics	rural
5A	F	expert by experience	carer, patient advocate	Austria	-	national
6A	M	expert by experience	patient advocate	Austria	-	national
7A	M	expert by experience	patient advocate	Austria	-	national
8A	M	expert by experience	patient advocate	Austria	-	national
9B	M	research	-	Styria	-	national
10B	F	provider	outpatient	Vienna	clinical psychology	urban
11B	F	provider	outpatient (rehabilitation)	Vienna	physical medicine and rehabilitation	urban
12B	M	provider	inpatient	Upper Austria	neurology	national
13B	M	provider	inpatient	Carinthia	anaesthesia and intensive care medicine	national
14B	F	public health administration	-	Styria	-	urban and rural

A: bronchial asthma; B: non-specific chronic lower back pain; C: mental health

Interview	Gender	Perspective	Type of care provided (where applicable)	Region	Medical specialities (where applicable)	Setting (where applicable)
14B	F	expert by experience	patient advocate	Austria	-	urban
15C	M	research	university, consulting	Vienna	psychiatry	(inter)national
16C	F	provider	outpatient	Vienna, Austria	general medicine	urban and rural
17C	F	provider	outpatient (home treatment)	Vorarlberg	nursing	urban and rural
18C	M	provider	outpatient	Vienna	psychiatry	urban
19C	M	provider	outpatient	Styria	psychiatry	urban
20C	M	provider	inpatient	Styria	geronto-psychiatry	urban
21C	F	expert by experience	service user	Vienna	-	urban
22C	F	expert by experience	service user	Upper Austria	-	rural
23C	F	expert by experience	carer	Vienna	-	urban
24C	F	expert by experience	carer	Vienna	-	urban

A: bronchial asthma; B: non-specific chronic lower back pain; C: mental health

Results

The findings are organised along the four dimensions adapted from Levesque et al. [5] and summarised for each case study: (1) bronchial asthma in children, (2) non-specific chronic LBP in the working population, and (3) older people with pre-existing mental illness/es (excluding dementia). In addition, Table 2 provides a summary of barriers to access by dimension, taking the different perspectives into account, namely whether barriers refer to demand side (the patient's perspective) or supply side factors (the provider's perspective).

Table 2
Summary of barriers to access by dimension

	Factors primarily influencing the demand side	Factors primarily influencing the supply side
<p>Barriers to perceiving need and the approachability of health care</p>	<p>» Low or limited health literacy affects patients' perceptions of health needs, their ability to navigate the health system and follow appropriate treatment pathways as well as to accept and follow indicated therapy.</p> <p>» Fear of stigmatisation is prevalent and often accompanied by a rejection of the psychological component of the disease, resulting in individuals potentially avoiding and/or delaying seeking professional help for mental health problems.</p>	<p>» Patterns of poor patient-provider communication or ineffective patient-centred care restrict the approachability of health services and information exchange, often leading to reduced quality of care.</p> <p>» Lack of awareness of the patients' social and family background prevents providers from identifying individual help-seeking behaviour and specific treatment needs.</p> <p>» Insufficient consideration of comprehensive therapy approaches including psychological and social treatments is a major hurdle to successful treatment.</p>
<p>Barriers to seeking and reaching health care</p>	<p>» Previous experiences of treatment can have a significant influence on the behaviour of those seeking help.</p>	<p>» Structural barriers such as a lack of infrastructure, inadequate transportation, or waiting times affect families and patients particularly when their socio-economic situation does not allow them to switch to the private sector.</p> <p>» The urban-rural divide exacerbates barriers to accessing specialists accompanied by longer distances and travel times to reach (specialist) care.</p> <p>» The limited (regional) availability of specialists with an SHI contract results in individuals delaying specialist examinations or consulting primary healthcare providers instead, who often have limited knowledge of or experience with a certain condition and its associated specific needs.</p> <p>» The strict separation between social care and the healthcare system highlights the lack of structured cooperation and consistency throughout the system.</p> <p>» Holistic therapy approaches (bio-psycho-social) such as multimodal pain therapy in primary care settings or outpatient rehabilitation options are lacking.</p>

	Factors primarily influencing the demand side	Factors primarily influencing the supply side
Barriers to utilising health care	<p>» Co-payments (e.g., for psychotherapists, physiotherapists, etc.) or private practice consultations, as a result of limited public capacities or waiting times, are a financial burden especially for patients with limited economic resources.</p> <p>» Waiting times are long for those patients who cannot afford (to switch to) elective private practice consultations.</p> <p>» Language and cultural differences do not only affect the quality of consultations and treatment but also adherence to and the handling of certain treatment measures.</p>	<p>» Limited consultation times reflect the lack of representation of doctor-patient time in the SHI reimbursement scheme.</p>
Barriers to obtaining better health outcomes	<p>» Inconsistent and uncoordinated care pathways lead to doctor hopping on the part of patients, self-medication, avoiding seeking care, decreasing trust, and inefficiencies within the care process.</p> <p>» A lack of continuity in care especially in transition phases (e.g., paediatric to adult medicine) may lead to gaps in care or reduced adherence to therapy.</p>	<p>» Missing or insufficient (adherence to) treatment guidelines lead to incorrect recommendations or even to manifestation of the disease concerned.</p>

Barriers to perceiving need and approachability of health care

Bronchial asthma in children. Despite high standards of health care in Austria, patient organisations pointed out that it can be challenging for parents to find their way around services and obtain advice. Limited health literacy on the part of children or parents was also mentioned as a main concern, the importance of *“mutual communication and a good quality of conversation between doctor and patient”*(1A) being emphasised. Cultural and linguistic differences as well as the parents’ educational level may also influence a family’s perception of children’s health needs and the success of training measures, according to the experts, making it difficult to reach immigrant mothers (e.g., from Turkey), for example, and to raise awareness for the importance of therapy (for their children).

Non-specific chronic LBP in the working population. Provider interviews revealed that patients with non-specific chronic LBP frequently have poor body perception and/or health literacy. In almost all interviews (providers, patient advocates, public health administration), it became clear that non-acceptance of the psychological component of the disease and, consequently, rejection of comprehensive therapy including psychological and social treatments is a major hurdle to successful treatment. Fear of stigmatisation was mentioned as a possible cause. Providers and the patient representative also mentioned a lack of information and inadequate doctor-patient communication as barriers to access. Examples included “*Your spine looks terrible*”, “*You are imagining it*”, “*Pull yourself together*” (11B). The interviews showed that poor linguistic competence or an inability to express oneself is especially problematic in the outpatient sector, where consultation time is usually very limited. Cultural differences relating to how pain is perceived and expressed were mentioned by the providers as being a hurdle to treatment.

Older people with pre-existing mental illness. In the case of mental illness, all experts stated that a disease-related lack of perception and/or a distorted perception of the patient’s own health status (“*I am fine, I am not ill*”) and their associated health needs (“*I do not need help*”) can be a central barrier; according to one outpatient provider, home visits often reveal “*catastrophic conditions, e.g., open wounds*” (17C). The experts interviewed pointed out that limited health literacy and low awareness of mental and somatic health problems make it difficult for those affected to recognise their need for help.

The general concern expressed by most healthcare providers was that the stigma for patients with mental illness significantly affects their help-seeking behaviour. Shame or pride often prevents people from seeking and/or accepting help from health and/or social services. Others avoid “the system” or being associated with it for various reasons (negative experiences, not wanting to declare themselves mentally ill, etc.): “*Someone could see that I am different*”, “*I don’t want to do that to my family, going to a psychiatric hospital*”, or “*What will people think?*” were reasons listed by one provider (17C). The family background, including behaviour, can play a crucial role in perceiving a health problem and influences whether help is sought: “*It is not so much about education, but how mental illness has been dealt with in the family (openly or covertly)*” (22C). Patient advocates, providers, and family members pointed out that previous experiences of treatment can also have a significant impact on the behaviour of those seeking help: “*If the first contact does not go well, I no longer go, I feel excluded*” (21C). It is also perceived to be stressful “*having to explain yourself again and again*” or “*having to explain again and again what you need*” (21C, 22C).

Barriers to seeking and reaching health care

Bronchial asthma in children. According to the interviewees, a clear urban-rural divide with longer distances and travel times as well as a lower number of paediatricians in rural areas represents a barrier to adequate care for asthma patients. Consequently, GPs, who are usually located closer to families’ homes, are consulted more frequently than paediatricians. Experts considered this situation to be problematic as many GPs have rather limited knowledge of asthma and allergies, especially among children, leading to specialist examinations often being carried out too late or the causes of symptoms not being properly recognised. An example for improper treatment mentioned by one patient representative is that “*asthma attacks in a child*

have been treated with cough syrup for a long time” (6A). According to the interviewees, the issue of limited knowledge also applies to hospitals in rural areas.

As children spend a substantial amount of time at school, the school system is a critical environment for their asthma management. Additionally, the school setting may offer access to health care to those who may not otherwise use the healthcare system consistently. However, many experts criticised the current, strict separation between school and healthcare environments. The lack of structured cooperation or links between these two areas leads to considerable stress, including unfavourable effects on children’s success at school, but may also result in serious health disadvantages. As many children need constant medication and quick help from adults in an emergency, a collaborative effort between the healthcare system and schools is critical for improving asthma outcomes and reducing asthma-related barriers to learning.

“Teachers must be aware of the importance of their educational actions: Sensitive measures are needed and an open discussion with the class about the health of the child concerned” (1A) is how one expert put it.

Non-specific chronic LBP in the working population. Structural barriers such as poor infrastructure or long waiting times were mentioned most frequently by the experts interviewed. Especially for patients whose socio-economic situation does not allow switching to the private sector, there were long waiting times for accompanying therapy such as physiotherapy or psychotherapy which ranged from two weeks for an outpatient practice appointment, two months for SHI-contracted psychotherapy, and three to six months for outpatient pain clinics. As waiting times sometimes prolong the length of patients’ sick leave, one provider highlighted workplace fears (absence from work, losing one’s job) as an additional mental stressor.

Expert interviews revealed that people with non-specific chronic LBP tend to wait too long before seeking care, risking symptoms getting worse. One reason for this wait-and-see attitude mentioned by the research expert interviewed might be the impacts of illness and therapy on a person’s everyday professional life, in which therapy sessions or sick leave is not always easy to integrate.

The topic of infrastructure was addressed by all interviewees. All experts highlighted multimodal pain therapy as the most suitable form of therapy. However, there was consensus among providers, researchers, and patient advocates that especially in primary healthcare settings, facilities offering guideline-based multimodal pain therapy are lacking in Austria. This is aggravated by the fact that the number of outpatient pain clinics is decreasing. Another hindering factor is heterogeneous regional distribution, not only of outpatient pain departments but also of outpatient medical and therapeutic practices with SHI contracts.

Older people with pre-existing mental illness. Barriers to seeking and reaching healthcare services might be due to general, age-related limitations but also in the individual circumstances of a person’s living situation according to experts. Factors such as poorer vision and/or hearing, insecurity, dizziness, forgetfulness, or multimorbidity on the one hand and living in rural areas, being confronted with long distances, and limited (public, private) mobility options on the other hand may lead to withdrawing, less confidence, and can deter older people with mental illnesses from seeking and accessing health services.

Providers and affected individuals indicated that social psychiatric services are not well equipped for the needs of older people with mental illness, especially for those with physical comorbidities or special age-related requirements. The physical needs of this group sometimes may not be addressed sufficiently. According to several statements from experts (providers, relatives), ageism, or a distorted public image of the elderly, could well be a general societal issue. As one provider commented in this context, “*society has great problems approaching the issue of old age*” (20C).

Barriers to utilising needed care

Bronchial asthma in children. Social factors may affect the possibility to access services. According to the experts interviewed, the lack of paediatricians with an SHI contract may place increased social burdens on patients and caregivers in the context of utilising healthcare services. While, on the one hand, many contracted doctors no longer accept new patients or long waiting times are the norm, the cost of consultations and treatment by elective doctors in private practices can put a high financial burden on socially disadvantaged families; in other words, it is not an affordable option for them.

One factor hindering effective communication between patients and providers is the very limited appointment time SHI paediatricians have with their patients. According to one interviewee, “*it is difficult to achieve the necessary commitment and understanding for asthma training*” (2A). Training on the implementation of certain measures such as inhalation and physiotherapy techniques or hygienic use of specific equipment is strongly influenced by (understanding) language and culture. Care pathways are not sufficiently clear, indicated by many cultural groups taking hospitals as the first point of care.

Non-specific chronic LBP in the working population. The topic of diagnostic imaging was very prominent in the interviews. Although current guidelines do not recommend diagnostic imaging, a potential oversupply had been observed by the experts (providers, researcher). Experts viewed this development critically, as diagnostic imaging might lead to wrong diagnostic associations as well as to unfavourable and rigid disease concepts, making patients more likely to adopt passive attitudes and to shift responsibilities to medical personal, which could lead to iatrogenic chronification. Patients’ demands for diagnostic imaging as well as legal protection for doctors and the principle of economic efficiency (equipment utilisation) were mentioned as possible reasons for the repeated prescription of imaging procedures.

According to providers and patient advocates, detailed counselling interviews are important to understand the complexities (physical, psychological, social) of the disease, but also to build trust between patients and their doctors. However, both providers and patient advocates stressed the limited time frame for a detailed medical consultation, especially in outpatient practices. One explanation suggested by both groups is the current SHI reimbursement scheme, which does not sufficiently reflect the needs of patients with non-specific back pain, namely sufficient doctor-patient time and active rather than passive treatment measures.

The patient representative and the expert working in public health administration mentioned individual co-payments as a barrier, especially when it comes to elective medical or therapeutic services (e.g.,

physiotherapy or psychotherapy). Patients with limited economic resources are hit hardest by this barrier, with therapy being more complicated or even impossible.

Older people with pre-existing mental illness. All interviewees reported deficiencies in the provision of care often accompanied by long waiting times and a high financial burden. Some noted that patients are often “forced” to switch to elective doctors in private practices due to long waiting times in the public (outpatient) sector. Those whose financial resources do not allow this are at a disadvantage and face less choice, longer waiting times, and delayed treatment. One expert admitted that “*those who cannot afford to pay are left behind*” (15C) and one affected person commented that “*if you pay for it yourself, you will get it faster*” (22C).

Several providers noted that co- or multimorbidity (i.e., mental and somatic) as well as medication (i.e., changes in medication, their interactions, and polypharmacy) are complex for this patient group. The research expert found that providers often lack knowledge and experience in the field of drug administration but also emphasised that “*evidence is difficult to transfer into practice*” (15C). In some cases, medication may be discontinued too early due to providers’ and/or patients’ lack of knowledge (i.e., effect of antidepressants only after 6-8 weeks).

Barriers to obtaining better health outcomes

Bronchial asthma in children. Well-managed outpatient paediatric asthma care generally leads to better asthma control. However, effective strategies to improve childhood asthma outcomes rely on a multidisciplinary, cross-sector approach, with an emphasis on addressing social determinants. From a provider’s point of view, a societal trend reversal can be observed: while in the past parents first consulted paediatricians, nowadays they tend to consult specialised physicians such as pneumologists or allergists directly given that there is no gatekeeping system in place for access to specialist care in Austria.

Patient advocates repeatedly pointed out that there is no standardised concept for the transition of chronically ill young people to adult medicine in Austria and that the quality of further care “*depends purely on whether the paediatrician in charge knows a specialised colleague or is committed to find one*” (5A). The interviewees all agreed that in this phase adequate care is of particular relevance as adherence to therapy often starts to decline from puberty onwards and “*a certain resistance is noticeable among patients*” (3A). In the experience of the patient advocates, “*insufficient compliance at this age often leads to an acute deterioration in the patient’s state of health and serious long-term effects*” (6A).

Non-specific chronic LBP in the working population. Insufficient application of current national guidelines was repeatedly mentioned by researchers and providers, with the providers reporting a lack of knowledge about guideline-based treatment (e.g., multimodal pain therapy) in the outpatient sector, in particular among GPs and orthopaedists. According to these experts, ignorance of guidelines is particularly problematic at the onset of a patient’s pain symptoms. Incorrect recommendations (e.g., passive treatments) or even iatrogenic suggestions (e.g., immobilisation) may promote the manifestation of the disease. Further, pain medicine is, according to the interviewed experts, not sufficiently represented in the

curricula of medical study programmes and there may not be enough incentive to obtain post-graduate qualifications.

All interviewees addressed a lack of interdisciplinary coordination, with patients seeking several medical opinions, self-medication, and fragmented patient pathways at all levels of care (hospitals, hospital outpatient departments, GPs, and specialists). Information gaps among practitioners compound inefficiencies within the care process as a whole (e.g., repeated imaging).

The interviewees from research and public health administration reported compliance problems in the treatment of chronic non-specific LBP with very time-intensive therapies not always being compatible with personal commitments. This may be especially problematic for shift workers as well as those with family and private obligations. Equally, the cost of elective therapies represent a barrier in this group. Another factor influencing sustainability and the outcome of treatment is a patient's employment status. The lack of daily structures for the unemployed may prevent patients from keeping appointments, and at the end of their working lives, the prospect of retiring early may add a secondary gain to being ill (pension payments).

Older people with pre-existing mental illness. Shortcomings in coordination, cooperation, and communication between different service providers were stated as a source of frustration by all interviewees and were among the most frequently mentioned barriers to care for older people with mental illness. The importance of continuity of care and trust was emphasised. An expert by experience pointed out that *"it is difficult to gain or build new trust when practitioners change and there is always a new face in front of you"* (21C). On the other hand, selective information provided by patients was mentioned as one reason for inaccurate and discontinuous care. Relatives reported that patients tend to describe symptoms as being less serious in order to avoid potentially necessary inpatient treatment.

Affected individuals had the impression that somatic providers were overwhelmed by the mental symptoms of their patients: their mental symptoms were not thematised, no efforts to coordinate were made by the providers, and there was little dialogue between different providers and with patients. Rather, communication and coordination were delegated to the patients and their relatives for the reason that providers *"want to get rid of them [the mentally ill elderly] as soon as they are more or less stabilised"* (23C). Consequently, a holistic view of a patient's health status and information on previous consultations with other doctors was fragmented: *"healthcare providers are not informed about others unless the patient reports it"* (24C).

Discussion

Beyond questions of who is covered, what services are covered, and what proportion of costs is covered, countries with almost universal coverage may still have barriers in their healthcare systems for people with chronic conditions. Using the examples of children with bronchial asthma, adults with non-specific chronic LBP, and older people with pre-existing mental illnesses, our study provides insights into existing inequalities and inequity when navigating the healthcare system and identifying the right patient pathways. Its findings suggest that there are gaps and barriers to accessing health services for people with chronic

conditions regardless of their age; as a result, they experience considerable challenges when trying to navigate the health system to access the services they need. While studies on unmet needs suggest a very low level of barriers to accessing health care in the Austrian context [46], our study highlights potential 'invisible' barriers that go beyond structural factors such as universal coverage.

The case studies were chosen to reflect populations that are particularly susceptible to inequalities and inequity of access to healthcare services and which were previously under-researched; we thus aimed to cover a broad spectrum of barriers to areas of care for people with chronic illness. While the Levesque et al. [5] framework was helpful in guiding our review of barriers to healthcare services and offered an insightful way of examining the case study populations included in this study, the importance of barriers in coordination among care providers was only partially captured by the framework, although this is particularly relevant for people with chronic conditions.

Our findings confirm the importance of an integrated approach in care, especially for people with chronic conditions. It is well known that people with chronic disease are often affected by more than one illness, which is why moving away from a single-disease framework towards a patient-centred model [47] is recommended, or towards a function-oriented approach focusing on "whether a patient can function in a way that they find acceptable" rather than focusing on single parameters such as blood pressure reduction [48]. The gradual introduction of a primary healthcare model in Austria is a first step towards such an approach as it often comprises multidisciplinary teams, including physicians, nurses, physiotherapists, social workers, and mental health staff [49]. Primary care models are patient-centred, and collaboration between professionals as well as the distribution of their roles change according to patient needs [50]. Further, innovative approaches such as the piloting of so-called social prescribing models in Austria may help patients with chronic conditions to benefit from non-medical referral options that can be delivered alongside existing primary care services [51]. Embedded in the voluntary and community sectors, social prescribing can address complex health, psychological, and social issues presented in primary care, and there is increasing interest in its potential to reduce health inequalities and emergency department service demand [52, 53].

A wide range of social determinants at individual and policy level create and influence access barriers, from the identification of healthcare needs to health consequences. Significant and recurring challenges to access reported by providers and patient advocates alike predominantly focused on patients' ability to perceive a need and to subsequently seek and reach healthcare services. Across all case study populations, insufficient health literacy was identified as affecting patients' perception of health needs and impeding individuals' ability to navigate the health system. Further, communication issues affect the approachability of health services and adequate information exchange. In the cases highlighted by our study, a number of barriers were found to be unique to, or more prominent among, certain populations. For instance, while fear of stigmatisation and discrimination is highly prevalent among older people with mental illnesses and adults with non-specific chronic LBP, bronchial asthma is a condition generally accepted by society. It was highlighted that a lack of awareness of mental and/or somatic illnesses and insufficient consideration of comprehensive therapy approaches on the part of patients and providers alike often result in individuals avoiding or delaying seeking professional help for mental health problems. These results are in line with

previous findings indicating that specific knowledge about treatment improves help-seeking and service use and that gaining knowledge about mental illnesses is one motivation to seek help [54].

Limitations in the ability to seek and reach healthcare services are particularly evident when it comes to navigating the healthcare system. In Austria, the context of this study, the fragmentation of the healthcare system as well as the social sector in relation to organisational and financial matters often poses a challenge and was described as complex, confusing, and difficult to navigate for patients. Such fragmentation across sectors is an additional complicating factor as social issues such as unemployment, low income, allowances, or care needs disproportionately affect people with multimorbidities and/or chronic conditions. Structural barriers such as a lack of infrastructure, inadequate public transport, long waiting times, and the limited (regional) availability of specialists with an SHI contract were frequently cited challenges for chronically ill patients. These findings are similar to those in a relevant study that found structural factors, such as access to transport or financial resources, to be a prerequisite for generating self-management capacity in patients with multimorbidity [55]. Likewise, patients of low socioeconomic status face additional barriers to accessing care. Our findings suggest that system-based barriers disproportionately affect families and patients who experience challenges organising themselves and whose socioeconomic situation does not allow them to compensate for these potential disparities with financial or social resources. More drastically, patients with the greatest support needs, such as those with multimorbidities or chronic conditions, may often be left behind.

The results also reveal certain particularities for our case study populations. With regard to bronchial asthma, children's health capital is dependent on their parents' social situation and ability to utilise healthcare services. Still, according to our interviewees, asthma care pathways are usually better defined compared to non-specific chronic LBP or mental illnesses. Strict separation between school and other social settings and the healthcare system as well as disrupted continuity of care, especially in the transition phase from paediatric to adult medicine, were found to pose specific barriers for children's health outcomes, however. The issue of transitioning asthma care from adolescents to adults is of major importance as the risk of respiratory morbidity increases in adulthood [56]. A recent review also found that once patients are transferred to adult medicine, limited knowledge of their condition, limited understanding of how to manage related symptoms and comorbidities, and limited comprehension of medical indications often persist [57]. Similarly, the burden of non-specific chronic LBP has implications for both ageing employees and employers. Many obstacles are faced by people with chronic pain when looking for employment or returning to work after a period of absence. If the cause of back pain is associated with workplace factors, a return to an unchanged workplace may not be successful and recovery may be impeded, regardless of appropriate treatment for the disorder [58].

Our findings underline the role of structures and conditions of health and social care. By examining the results along the dimensions given in Levesque et al.'s [5] framework, we found that barriers involving coordination among care providers are strongly interlinked and that patient-centred communication is key if health outcomes are to be improved. Further, shortcomings in coordination, cooperation, and communication at the very beginning of patients' treatment pathways are likely to impair the course of future treatment, leading to an exacerbation of existing barriers. The close interactions between poor

communication, uncoordinated care pathways, and, ultimately, poorer health outcomes become particularly visible when addressing chronic conditions, confirming the importance of a holistic and patient-centred approach.

A particular strength of this study was the inclusion of four different perspectives. The heterogeneous sample consisting of health service providers, experts by experience (patients or their advocates, carers), researchers, and public health administration enabled a comprehensive, multidisciplinary assessment of the accessibility of the healthcare system in Austria for people with chronic conditions as well as a broader view of the changes required by stakeholders in the future. While we have captured some patients' perspectives by proxy through provider interviews, we acknowledge that this gap may have significantly limited our insights into their unique experiences of access. Nevertheless, our interview partners demonstrated a high level of agreement concerning the key issues for people with chronic conditions, including timely and accessible care independent of social and economic resources, continuity of care, and the need for significant improvements in patient-centred communication and coordination of care. Although this article only concerns barriers to accessing the Austrian healthcare system, the results may also be useful in countries with similarly functioning systems, that is decentralised health and social care systems and other developed welfare states with a social health insurance system.

Our findings offer several implications for future research. Firstly, it would be important to expand this qualitative study to include more patient perspectives on barriers so as to obtain their views on how their needs and resources can be better supported. Secondly, future studies may investigate if and how ongoing reforms in health and social care systems (e.g., primary care units) address access barriers for people with chronic conditions identified by our study. Finally, further research will be helpful in conceptualising access along the different stages of a patient's illness within a framework that is applied not only at the end of the care process but throughout. There is currently a gap in the evidence that would capture not only structural barriers to accessing health care but underpin indicators that are specific to the experience of people managing chronic conditions. This study contributes to the evidence by providing in-depth qualitative research – considering provider, expert, and researcher perspectives – on how patients with chronic conditions access care, including their barriers, and possible areas for improvement in health services to respond appropriately to patients' specific needs.

Conclusion

Barriers to healthcare access particularly concern patients with chronic conditions, resulting in an urgent need to improve health services according to patients' specific needs. Based on our findings, barriers are strongly interlinked and relate to issues such as geography (e.g., longer distances and travel times as well as fewer healthcare services in rural, remote regions), coordination of care (e.g., structural barriers and inconsistent care pathways), socioeconomic status (e.g., the ability to pay for healthcare services but also basic health literacy), and comorbidity (e.g., the consideration of patients' mental health states and holistic care/therapy approaches). For health services to be properly accessible to patients with chronic conditions, timely and integrated care independent of social and economic resources, continuity of care, and significant improvements in patient-centred communication and coordination of care are paramount.

Further, shortcomings in coordination, cooperation, and communication at the very beginning of patients' treatment pathways are likely to impede future courses of treatment, leading to an exacerbation of existing barriers. The close interactions between poor communication, uncoordinated care pathways, and, ultimately, poorer health outcomes become particularly visible when addressing chronic conditions and confirm the importance of a holistic and patient-centred approach.

Abbreviations

GP: general practitioner; LBP: low back pain; SHI: social health insurance; VHI voluntary health insurance

Declarations

Ethics approval and consent to participate

The Austrian National Public Health Institute (GOEG) is owned by the Austrian Federal Ministry of Social Affairs, Health, Care and Consumer Protection and regulated by federal law (Bundesgesetz über die Gesundheit Österreich GmbH (GÖGG), [BGBl. I Nr. 132/2006](#)). According to this national legislation, GOEG is entitled to collect, present, analyze and evaluate data relevant to the health status of the population and to fulfil the tasks assigned to it by law. Interview studies and other analyses carried out by GOEG on behalf of the Ministry of Health therefore require no approval from an ethics committee.

This research was commissioned in the course of the Health Reform agreement according to Article 15a of the Federal Constitution on target-based health governance and the agreement according to Article 15a on the organisation and financing of the health care system, the Federal Ministry of Social Affairs, Health, Care and Consumer Protection. A national expert group consisting of representatives of the Federal State of Austria (Ministry of Health), the nine Austrian provinces, and social health insurance institutions who are in charge of driving the healthcare reform commissioned and evaluated this research in compliance with ethical, legal and data protection aspects.

Written informed consent was obtained from all participants before participating in the investigation. They were free to withdraw from the study at any time. The semi-structured interview guide was provided to participants prior to the study. This information was orally reiterated to each participant at the beginning of the interview before the researcher asked the participant to confirm whether he or she was voluntary and consenting to participate, and if he or she agreed to have the interview audio-recorded. The template for the consent form is available on request. Data were properly anonymized, and handling of personal data was in accordance with the EU General Data Protection Regulation GDPR and the Austrian Data Protection Act.

Consent for publication

The written consent form contained information about scientific publication of results of study in anonymous form.

Availability of data and materials

Data generated or analysed during this study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

AS proposed the project idea and supervised the project; AS, JB, and JL undertook literature research; JB, JL and TS conducted and analysed the interviews. TS drafted the manuscript. All authors contributed to and approved of the final manuscript.

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Figures

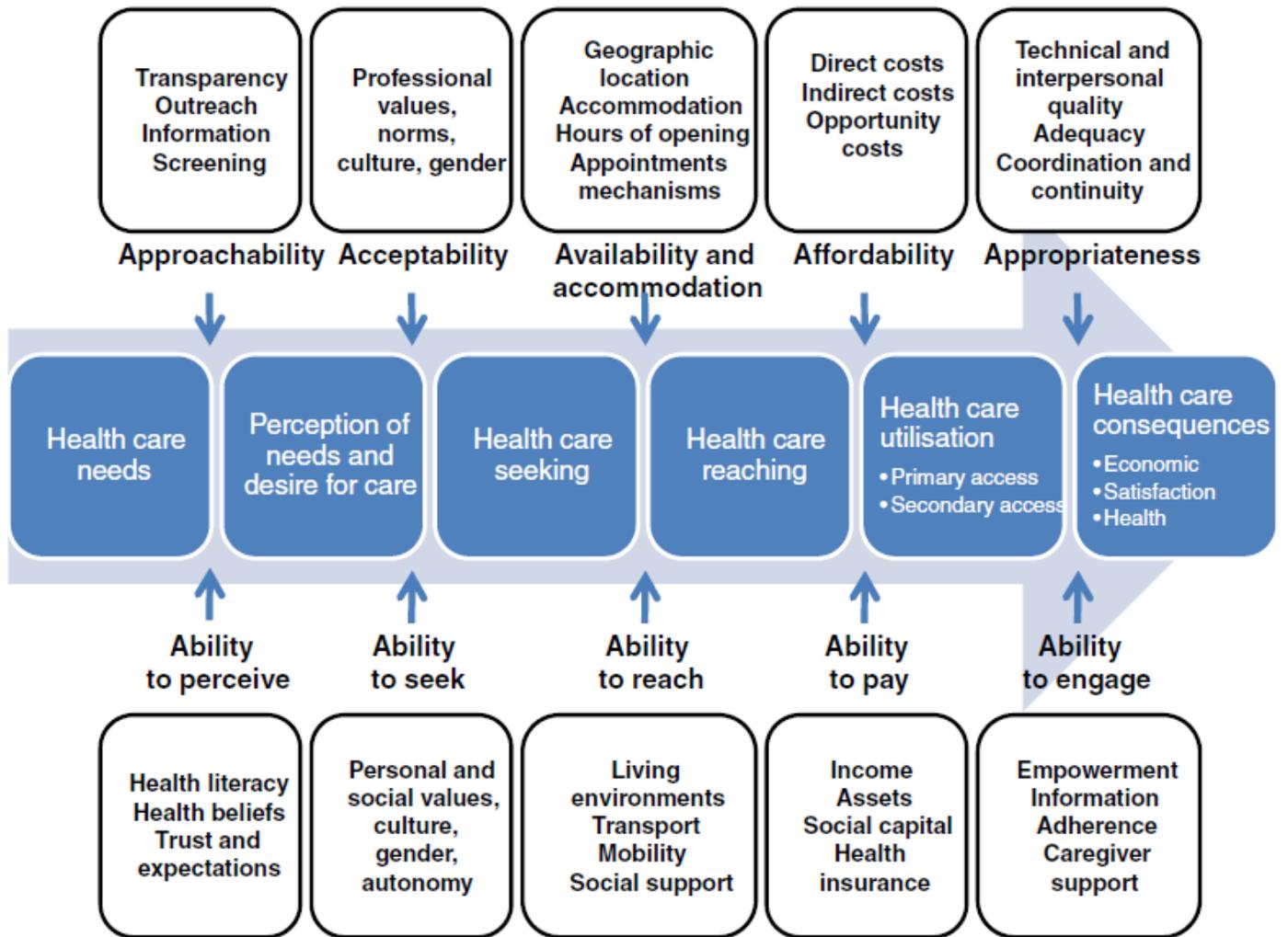


Figure 1

Conceptual framework of access to health care by Levesque et al. [5]

Adapted from Levesque et al. [5]. Permission to use this figure was obtained from Jean-Frederic Levesque.