Austria

Health Care & Long-Term Care Systems

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Health care systems

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2. HEALTH CARE SYSTEMS

2.1. AUSTRIA

General country statistics: GDP, GDP per capita; population

Austrian GDP per capita has been among the highest in the European Union over the last decades and in 2015 amounted to 34,234 PPS, compared to the EU average of 29,610 PPS. In terms of population, the Austrian population was around 8.6 million in 2015, slowly increasing over the last decade (8.2 million in 2005). It is projected to further increase by 1.5 million from 2016 to 2070, reaching 10.2 million.

Total and public expenditure on health as % of GDP

Total expenditure on health is one of the highest in the EU: 11.1% of GDP in 2015, slightly increasing over the last decade (10.2% in 2005). This is above the EU average of 10.2% in 2015. Public expenditure on health amounted to 8.1% of GDP in 2015, putting Austria in line with the EU average of 8.0%. When measured in per capita terms, in 2015 Austria is above the EU average both in terms of total (4,031 PPS vs. the EU average of 3,305) and public spending (2,965 PPS vs. 2,609 PPS). Looking at health care without long-term care ([10]) reveals a similar picture with spending at the EU average (6.9% vs 6.8% in 2015).

Expenditure projections and fiscal sustainability

As a result of ageing, health care expenditure is projected to increase by 1.3 pps of GDP, which is higher than the EU average of 0.9 pps over the same period. When taking into account the impact of non-demographic drivers on future spending growth ("AWG risk scenario"), health care expenditure is expected to increase by 2.1 pps of GDP by 2070, higher than the average EU level of 1.6 ([11]).

Over the long run, medium sustainability risks appear for Austria. These are primarily related to the strong projected impact of age-related public spending (mainly healthcare and long-term care) ([12]).

Health status

The last decade saw a steady increase in life expectancy, which grew by 3.3 years since 2000 overall. Between 2005 and 2015, it grew by 2.2 years for men and by 1.5 for women. The Austrian population lives slightly longer than the average EU citizens: in 2015, life expectancy was 0.7 years above the EU average ([13]). Broken down by gender, life expectancy at birth of both women (83.7 years) and men (78.8 years) was higher than the EU averages of 83.3 and 77.9 years in 2015 ([14]).

Healthy life years, although with minor fluctuations, have remained quite stable during the past decade ([15]) and in 2015 amounted to 58.1 years for women (compared to 63.3 years in the EU) and 57.9 years for men (compared to 62.6 years in the EU). Infant mortality of 3.1‰ was in 2015 still slightly below the EU average of 3.6‰ ([16]). As in most other European countries, in Austria non-communicable diseases remain the leading causes of morbidity and mortality. The two main causes of death in Austria are circulatory diseases (such as stroke and myocardial infarction) and malignant neoplasms (cancer), accounting for about two thirds of all deaths ([17]). A reduction in the most common causes of death was achieved since 2010, though less marked for malignant neoplasms and especially for lung cancer. Cardiovascular diseases still rank first for both men and women (38% and 47% of the total respectively). Cancer currently ranks as the second

([10]) To derive this figure, the aggregate HC.3 is subtracted from total health spending.

([11]) The 2018 Ageing Report: https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070_en.

([12]) European Commission, Fiscal Sustainability Report (2018) https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf.

([13]) Bachner F, Bobek J, Habimana K, Ladurner J, Lepuschütz L, Ostermann H, Rainer L, Schmidt A E, Zuba M, Quentin W, Winkelmann J. (2018) Austria: Health system review. *Health Systems in Transition*, 2018; 20(3): 1 – 256.

([14]) Data on life expectancy and healthy life years is from the Eurostat database.

([15]) A break in series exists between 2003 and 2004, so the marked decrease in 2004 has likely a strong methodological component.

([16]) Data on infant mortality is from the OECD database.

([17]) Bachner F, Bobek J, Habimana K, Ladurner J, Lepuschütz L, Ostermann H, Rainer L, Schmidt A E, Zuba M, Quentin W, Winkelmann J. (2018) Austria: Health system review. *Health Systems in Transition*, 2018; 20(3): 1 – 256.

cause of death (29% for men and 24% and women respectively). Of particular significance within the group of malignant growths are smoking-related cancers, with lung cancer causing the 5% of total deaths in 2014. Breast cancer also plays a significant role for women, and it caused 2% of overall deaths in 2014 ([18]).

In terms of lifestyle-related risk factors, Austria can be classified as follows. While the percentage of obese adults, 14% in 2014, is below the EU average, this is on an increasing path (12.4% in 2006). Obesity also increased amongst adolescents. Consistently, the mortality rates related to diabetes have increased substantially since 2000, from 17.1 to 28.9 per 100 000 population. The percentage of regular smokers (24% in 2014) lies above the EU average for the same year (21%). Alcohol consumption is growing, with 12.3 litres per capita in 2014 (11.9 litres per capita in 2011) and the value for Austria was, according to the latest figures, the third highest in the EU in that year (around 10 litres). Traditionally, the provisions of social insurance law were strongly oriented towards a curative approach, but a series of legislative initiatives have been set up in the last decade, in order to enhance the approach to health promotion and prevention ([19]). It is estimated that 28% of the overall burden of disease in Austria in 2015 ([20]) could be attributed to behavioural risk factors ([21]). Underlying data - and the projections hereafter - suggest that the authorities could continue their efforts to improve population life-styles.

System characteristics

The Austrian health care system has a complex structure based on the federalist structure of the Austrian state. The regulatory responsibility for the health care sector lies with the federal government, with the exception of the system of hospitals. Concerning the latter, the Federal Republic enacts only basic laws, while their implementation and enforcement is under the responsibility of the states ("*Bundesländer*"). Social insurance providers are supposed to be self-governing bodies, which implies that they have important regulatory functions, especially concerning outpatient health services ([22]).

System financing: taxed-based or insurance-based

The Austrian health system is financed from a mix of sources. In 2015, 73.6% of expenditure was public, while 26.4% came from private sources. As for public spending, about 60% comes from health insurance contributions, while about 40% is financed from taxes, mainly general tax revenue; these proportions have remained rather stable.

Revenue collection mechanism (tax/social security contributions/premium)

Mandatory health insurance is based on mandatory contributions paid by all employed people. The contributions amount to a maximum of 7.65% of the contribution basis (generally wage), and they are mostly equally divided into two parts paid by employer and employee, respectively ([23]). A statutory 'maximum contribution basis' puts a ceiling on the wages used for the calculation of the contributions. In 2018 this ceiling amounted to €5,130. The contributions are collected and administered directly by the health insurance funds.

Social security funds are the main source of financing in the health system, accounting for more than 50% of current health expenditure ([24]). The financing of acute hospital care is partially budgeted and is carried out according to performance-related criteria within the framework of yearly budget. The states, which are owners of the hospitals, not only cover investment and maintenance costs, but also contribute to the

([18]) State of Health in the EU - Austria. Country Health Profile 2017.
([19]) See for instance the Health Promotion Act of 1998, which established the Healthy Austria Fund, and the adoption in 2005 of the "New Preventive Check-up".
([20]) Measured in terms of Disability Adjusted Life Years (DALYs).
([21]) HiT (2018).
([22]) See also Austria - ASISP Annual Report 2009.
([23]) Hauptverband der Sozialversicherungsträger (*Main Association of Austrian Social Security Institutions*) (2018) Beitragsrechtliche Werte in der Sozialversicherung 2018. Stichtag: 1. Jänner 2018 Zahlen - Daten - Fakten --> Aktuelle Werte, Vienna: HVB.
([24]) http://www.euro.who.int/__data/assets/pdf_file/0017/233414/HiT-Austria.pdf, HiT Austria (2013). In the quantification of this share as 50%, expenditure on long-term care is excluded from total current health expenditure.

current expenditure of the hospitals. Hospital debts are also covered at federal level by the states.

Since 2013 Austria imposes a constraint on public spending on health via the budget process ([25]). The reform includes financial targets and the introduction of a budget cap on public expenditure on health (expenditure containment path). Over the period until 2016, the increase in public health expenditure (excluding long-term care) was gradually aligned with the expected average nominal growth of gross domestic product (plus 3.6% per year) ([26]). In total it had been agreed to contain expenditures by €3.43 billion until 2016 by the regional governments (€2.058 billion) and the social insurance institutions (€1.372 billion). Actual containment exceeded this value in the period 2013-2016, also due to somewhat non ambitious targets, considering that in 2011 an expenditure growth of 3.3% was recorded and that the expected growth for 2012 was estimated at 3.4% ([27]).

Administrative organisation: levels of government, levels and types of social security settings involved, Ministries involved, other institutions

As mentioned earlier, the Austrian health system has a complex structure based on the federalist structure of the Austrian state, with a multitude of relevant decision makers ([28]). Nevertheless, the level of expenditure in administering such a complex system remains about the EU average ([29]). Public (0.2%) and total (0.4%) expenditure on health administration and health insurance (HC7) ([30]) as a percentage of GDP is at the same level as the EU average (0.3% and 0.4% respectively in 2015), and so are public and total expenditure on health administration and health insurance as a percentage of current health expenditure 2.8% vs. 3.4 for the EU and 3.8% vs 3.8% for the EU in 2015 ([31]).

Health care insurance is provided by a number of health insurance funds. They are decentralised self-administrated institutions. The Central Association of Social-Insurance Institutions coordinates the management of the specific institutions. Insured individuals do not have free choice of health insurance fund. They are assigned a given fund according to the location of their employer or occupational group (e.g. self-employed, farmers, civil servants, specific funds for miners, railway employees, etc.) they belong to. Given that the coverage of individual funds is clearly specified, and the funds cannot choose their members according to risk selection or any other criterion, there is no competition between them. However, individual institutions have a large degree of freedom in establishing their administrative procedures.

Coverage (population)

About 99 % of the Austrian population are covered by the social health insurance, organised as a compulsory insurance for people in gainful employment. The insurance contribution covers also dependent members of the family (their share amounts to about one third of the total number covered by the statutory health insurance), while the persons without insurance may have access to the health care system via means-tested social insurance.

([25]) Austria scored 0 out of 6 in the 2010 OECD scoreboard due to the soft budget constraint.

([26]) Bachner, F., Bobek, J., Lepuschütz, L., Rainer, L., Zuba, M. (2018) Monitoringbericht I/2018, Vienna: GÖG/BMASGK. Available at: https://www.bmgf.gv.at/cms/home/attachments/9/1/9/CH1443/CMS1405074131923/monitoringbericht2018_nachbzk1.pdf.

([27]) Austrian Court of Auditors (2016a). Bericht des Rechnungshofes. Instrumente zur finanziellen Steuerung der Krankenversicherung. Vienna: Austrian Court of Auditors.

([28]) Irrespective of the reforms of 2005 (The 2005 Health Reform), which were aimed at improving integrated planning by the introduction of a Federal Health Agency, a Federal Health Commission and a Structural Healthcare Plan at the national level and of State Health Funds and Health Platforms at the state level (Austria, ASISP Annual Report 2009).

([29]) Of course, we have to take into account the important share of the health expenditure as a % of GDP, and the GDP per capita itself.

([30]) Corresponding to SHA classification HC7 "Governance and health system and financing administration".

([31]) After a data update by Eurostat, AT stands at 2.2% for public expenditure on governance and health system and financing administration (HC7) as a share of current expenditure on health and at 4.1% total expenditure on health administration and health insurance as a percentage of current health expenditure. However this data is not comparable with the figures displayed in this document nor with the EU averages.

Treatment options, covered health services

The benefits guaranteed by the social health insurance system include both in-kind and cash benefits and do not depend on the level of contributions. Further, all health insurance funds are supposed to provide all necessary services. Still, the bundle of "necessary services" is not explicitly defined by law, which may lead to some variations between the funds.

Role of private insurance and out of pocket co-payments

Since an individual person apart from members of selected self-governed professions has no right to opt out from statutory insurance, private health insurance serves predominantly as a supplement to the former and covers additional costs for treatment in private hospitals or serves as an insurance for daily benefits.

Hospitalised patients in standard class accommodation pay a fee of around €11 per day for a maximum of 28 days per year. This fee is collected directly by hospitals. Here again, individuals who already pay a deductible as well as those in need of social protection are exempted from this regulation. Furthermore, since 2017 patients up to the age of 18 years are also exempted. The co-payment for dependants of those insured is slightly higher (between €12 and 19/day depending on the hospital) ([32]).

Private expenditure (e.g. patient co-financing and voluntary private health insurance (5.1% combined) ([33]) represented around 26.4% of the total health expenditure in 2015, and the share increased from the 2005 value of 23.3% throughout the decade. The figure for 2015 is slightly above the EU average of 21.6% for the same year. Out-of-pocket spending accounts for 17.9% of total current health spending (slightly above the EU average of 15.9% in 2015) and, though slightly fluctuating during the past decade it has remained broadly stable since 2005 (17.8%) ([34]). Over the same period, the share of public expenditure out of the total health expenditure has decreased going from 76.7% to 73.6%, but the share of public spending out of total government spending (14.4% in 2015) has remained quite constant over the last decade (14.2% in 2005).

Types of providers, referral systems and patient choice

Patients who are insured in the mandatory social health insurance system, as well as their family members, are provided with electronic health insurance cards (E-Cards) being certificates of entitlement to health services. For each accounting period, which is usually 1 or 3 months – depending on the insurance fund - a patient can choose one general practitioner (GP) and one specialist, for any specialty ([35]), by means of his/her personal E-Card, which has replaced the former health vouchers. For the issue of an E-Card, a lump sum ([36]) deductible is paid. He/she can also switch the contract physician with the agreement of the health insurance fund ([37]).

A large share of primary care is provided by self-employed physicians who predominantly work in individual practices. Patients have also direct access to outpatient clinics which are run by both the social health insurance schemes and by private individuals. Outpatient care is mostly based on contractual relationships between individual private providers and insurance funds, but a large share of patients also opt for outpatient departments of publicly run hospitals.

Hence, private practices are run by self-employed physicians, about half of which are general practitioners and half specialists. The number and regional distribution of self-employed physicians is specified in the "location plan" drawn up by the health insurance funds and the Medical Chamber in order to avoid imbalances in the provision of care. However, there are large differences between rural and urban areas.

Only around 51% of physicians (including dentists) in private practice have a contract with

([32]) Source: HIT 2018 and sozialversicherung.at.
([33]) Note that Non-profit institutions serving households (NPISH) and company schemes (1.8%) are included in the share of 26.4%.
([34]) Note that since 2008, prescription charges are limited to 2% of annual net income.
([35]) For up to 3 specialists by period.
([36]) €10.85 in 2016.
([37]) According to the OECD, the level of choice of provider in Austria had a score of 2.7 out of 6 in 2010.

one or more health insurance fund in December 2015 ([38]). They exercise to some extent a gatekeeper function as they can control patients' flows by referrals. This is the case when several physicians are consulted in one accounting period or when hospital treatment is required. The other 49% private physicians who do not hold a contract with a health insurance fund do not require E-card intervention and mostly apply much higher fees, whereas their services are reimbursed for four fifths of the fee which the health insurance funds would pay for a "contracted physician".

The number of practising physicians per 100,000 inhabitants (510 in 2015) is above the EU average (344 in 2015) and showing a consistent increase since 2005 (432). The number of GPs per 100,000 inhabitants (77 in 2015) is in line with the EU average (78 for the same year), and has remained stable during the past decade (76 in 2005). This figure, paired with the high number of practicing physicians, suggests that the Austrian health care system is currently hospital centred. The number of practicing nurses per 100,000 inhabitants (805 in 2015) is slightly below the EU average (833) having increased throughout the decade, from a level of 718 in 2005 ([39]). Still, there have been concerns about inequalities in the supply structure between the states and also between urban and rural areas. In addition, staff issues may be reinforced by the fact that in 2015 as many as 58% ([40]) of all physicians were more than 45 years old in 2012 and many will retire in less than 10 years. These elements suggest that a comprehensive human resources strategy may be necessary in order to ensure that the skill mix stays in favour of a primary care oriented provision, without excessive recourse to it, and face regional disparities and staff ageing.

Hospital care is, according to the law, the responsibility of the states. The Federal Hospitals Act (KAKuG) stipulates that each state is obliged to ensure the availability of inpatient care for people who require it. The states establish the structure of inpatient acute care in quantitative and qualitative terms according to the specifications set out in health planning ([41]). As such, inpatient care is predominantly provided by the public entities. A minor share is also organised by the private non-profit-making providers, who operate according to the public law and by private profit-making hospitals ([42]). Hospitals which are subject to public law are obliged to admit and provide services to all patients, but are entitled to receive state subsidies for their day-to-day operations. On the contrary, private for-profit providers have the right to refuse patients, but must finance their operations on their own.

The management structure of the hospital sector changed considerably over the first half of the decade of 2000s, as public hospitals have been assigned operating companies which act according to the private law. A similar change has taken place in the case of private non-profit making companies.

Empirical data suggest overutilisation of hospital care in Austria. The number of available acute care beds (566 per 100,000 inhabitants in 2015), although somewhat lower than a decade before (643 per 100,000 in 2005) is more than 40% higher than the respective amount in the EU (402). At the same time, the inpatient average length of stay of 8.5 days is above the EU average for 2015 (7.6), and the number of inpatient discharges per 100 inhabitants (26) is one of the highest in the EU, more than 60% higher than the EU average of (16). Consistently, the number of day-case discharges is lower than average (7,031 in Austria vs. 7,635 in the EU in 2015). Sectoral fragmentation, which also creates the bias towards hospital care, is a long standing weakness of the Austrian health care system. Therefore, it seems essential to improve the cost efficiency of the hospital care, by reducing the number of beds and replacing acute care stays with day-case treatments or outpatient treatment.

The physicians who operate their private outpatient practice are reimbursed by the insurance funds according to a mixed fee system, which combines lump-sum payment for basic services with fee-for-service for more complex treatments. The level and structure of payment is established in regular

([38]) Excluding dentists the corresponding share was 45%.
([39]) Data for density of health personnel is taken from the OECD database. As this figure includes only nurses employed in hospitals, the actual number may be underestimated.
([40]) Source: Austrian Medical Chamber.
([41]) HIT 2013.
([42]) 72.5% of acute care beds are in publicly owned hospitals, 18.8% in not-for-profit privately owned hospitals and 8.7% in for-profit ones.

negotiations between health insurance funds and the Medical Chamber and varies heavily across funds and specialties. In practice, specialists who execute more complicated or technical tasks (in the areas such as radiology or laboratory analysis) are paid almost exclusively according to a fee-for-service scheme, while general practitioners receive proportionately more often flat rate payments per basic case, which are accompanied by basic practice allowances and fees for home visits.

The level of the flat rate fees for basic services varies according to specialty and state. In some states, in order to distribute the general budget more equally among the physicians, it is calculated on a decreasing scale, depending on the number of E-Card certificates invoiced per provider and per accounting period.

About 50% ([43]) of specialists work exclusively in hospitals and are paid salaries, which vary across states. They can also treat private patients in public hospitals and earn additional incomes from these practices.

Hospitals are paid differently depending on the type of expenditure. Investment and capital costs are borne by the owners and operating companies. The ongoing operating costs are estimated prospectively based on the modified, activity-oriented diagnosis-related groups (DRGs). The units of calculation are points, whose value is established retrospectively at the level of the state by dividing the fixed budget by the number of points performed during the accounting period. In the DRG system two types of payments exist: the nationally uniform DRG core area and the DRG fund control area, which can vary according to the state. Health insurance funds also participate in the funding of hospitals by transferring a fixed share of their resources (about 35%) to the states' hospital funds.

In the core area, procedure- and diagnosis-oriented case groups form the basis for awarding points for an inpatient stay. A nationally uniform number of points is allocated for stays in a number of selected specialised units (intensive care, geriatric care, psychiatric day care, etc.), while special rules apply for stays which are longer or shorter than the predefined bounds. Financing in the fund control area can be modified by the individual states, which gives them an opportunity to take into account different structural criteria (e.g. hospital type, staff, equipment, state of hospital buildings, utilisation of capacities, quality of accommodation, etc.) when distributing financial resources among the hospitals.

The activity-related hospital financing DRG system was introduced in 1997. The main effect of this measure was a shortening of the average length of stay, but also increased hospitalisations and a shift towards high scoring diagnoses ([44]).

In 2017 it was agreed to introduce the diagnosis-related groups reimbursement system also for ambulatory departments in hospitals. This has the aim to promote a shift of excess capacity from the inpatient to the outpatient sector and a consequent reduction in acute care beds.

The market for pharmaceutical products

Public expenditure on pharmaceuticals ([45]) is just below the EU average when measured as % of GDP (0.9% vs. 1.0% in 2015), and it is also lower when calculated as percentage of public current health expenditure (11.3% vs. 12.7% in 2015).

Austria applies external price referencing when establishing maximum price for reimbursed pharmaceuticals. The price of drugs, taking into account ex-factory and wholesale price level, is included in the Reimbursement Code - or "EKO" ("*Erstattungskodex*"), in place since 2005 - and cannot be higher than the EU average price, as established by the Pricing Committee.

All reimbursable pharmaceuticals are explicitly listed in a list annexed to the Austrian Social Insurance Law. The cost-sharing mechanism takes the form of a flat rate fee paid for each prescription

([43]) Bachner F, Bobek J, Habimana K, Ladurner J, Lepuschütz L, Ostermann H, Rainer L, Schmidt A E, Zuba M, Quentin W, Winkelmann J. (2018) Austria: Health system review. *Health Systems in Transition*, 2018; 20(3): 1 – 256.

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([44]) As a result, the OECD score for remuneration incentives to raise the volume of care in Austria is 3 out of 6.

([45]) Expenditure on pharmaceuticals used here corresponds to category HC.5.1 (pharmaceuticals and other medical non-durables) in the OECD System of Health Accounts. Note that this SHA-based estimate only records pharmaceuticals in ambulatory care (pharmacies), not in hospitals. Data is taken from Eurostat.

by all patients, apart from socially disadvantaged people (in particular elderly pensioners with an income below a certain threshold and persons with communicable diseases) who are exempted. Moreover, a ceiling on prescription fees (*Rezeptgebührenobergrenze*) was introduced in 2008. Patients have to pay the flat rate prescription fee until it exceeds the threshold of 2% of their annual net income. Patients pay out-of-pocket for over-the-counter and non-reimbursable pharmaceuticals, but in some precisely determined circumstances, they can apply for individual reimbursement, which requires an ex-ante approval of the head physician.

Rational prescribing is ensured through the Economic Prescription Guidelines published by the Main Association of Social Security Institutions (MASSI) in 2004. These guidelines encourage doctors to prescribe the most economical pharmaceutical out of several therapeutically similar alternatives ([46]). Regional health funds also monitor the prescribing patterns of GPs and specialists who are under contract with them, and provide them with information leaflets and newsletters ([47]).

Use of Health Technology Assessments and cost-benefit analysis

A national Health Technology Assessment (HTA) strategy was published in 2010, establishing common goals of the major decision-makers in the health-care sector and creating a framework for expanding the use of HTA. The importance of an evaluation of health technologies as an instrument to support or to control their dissemination and use or to help define policies is increasingly referred to by the public health insurances and hospitals. Several academic institutions ([48]) are carrying out Health Technology Assessments. Preselected medical devices undergo HTA assessment through the annual evaluation of their uptake into the Austrian DRG system. For pharmaceuticals, up until now, there has been no uniform and formal HTA process in place. However, in the outpatient sector pharmaceuticals are evaluated in an HTA related process to establish a positive list of the pharmaceuticals that are covered by the public health insurance scheme.

eHealth, Electronic Health Record

In 2012 the Austrian parliament passed a law to strengthen eHealth in the Austrian health care system by introducing the Electronic Health Record (ELGA). Its implementation is making significant progress together with its e-medication and e-report applications.

The Electronic Health Record (ELGA) is an information system that offers personalised health data to the individual citizens and to their health service providers (hospitals, pharmacies, general practitioners, specialists, etc.). Doctors can access individual medical exams, prescriptions and other relevant health information independently from location and time in order to support their decisions and diagnoses.

ELGA aims to raise quality of care and thus patient safety. It also helps to reduce organisational barriers, avoid duplication of medical exams by improving coordination and ensuring the information flow between health care providers' crosslinking interfaces.

Patients are generally free to opt out of ELGA, but also have the right to ban only certain information within the portal or even a single health care provider from usage. Patients will also be able to check who is accessing their individual record.

Access to ELGA is limited to health care providers. Private companies, health insurers or employers are strictly banned from accessing the health records. The functionalities of ELGA will be implemented stepwise.

([46]) Vogler, S., Schmickl, B., Zimmermann, N., Short PPRI / PHIS Pharma Profile Austria 2013. Vienna: Pharmaceutical Pricing and Reimbursement Information (PPRI) / Pharmaceutical Health Information System (PHIS). http://whocc.goeg.at/Literaturliste/Dokumente/CountryInformationReports/Short_PPRI_PHIS_Pharma_Profile_Austria_2013_final.pdf.

([47]) Vogler, S.; Zimmermann, N., (2013), 'How do regional sickness funds encourage more rational use of medicines, including the increase of generic uptake? A case study from Austria', Generics and Biosimilars Initiative Journal (GaBI Journal) 2/2:65-75.

([48]) Currently: LBI-HTA, GÖG, Donau-Uni Krems, Med-Uni Graz, UMIT.

Health and health-system information and reporting mechanisms

In the past few years, great efforts have been made to build and expand information systems in the health care system with the principal aim of increasing transparency. A series of national guidelines on the systematic documentation of services and costs, particularly in inpatient care, were recently issued or refined.

Health promotion and disease prevention policies

As introduced, some socio-economic risk factors could translate into an important burden of disease and financial costs. This is why the authorities have emphasised somewhat health promotion and disease prevention measures in very recent years. Currently, public and total expenditure on prevention and public health services as a share of GDP (0.2% and 0.2% in 2015) are close, though slightly below, the EU average (0.3% and 0.3% in the same year). The figures are below average when measured, as a % of total current health expenditure, with 2.1% vs. 3.1% for total and 2.1% vs. 3.2% for public expenditure in 2015 ([49]).

Transparency and corruption

Since 2008, anti-corruption legislation has aimed to increase transparency in the formation of waiting lists and to minimise the incentive to make and solicit informal payments but were relaxed slightly again in 2009 ([50]). Doctors have to abide by the medical association's code of conduct ([51]), which regulates in this context the cooperation between doctors and pharmaceutical industry regarding attendance at conferences, acceptation of gifts or professional samples. Patients have the possibility of complaint; there are ombudspersons and patients advocates in charge.

Improving transparency within the health care system is also a major target of the health reforms launched in 2013. The target includes improvement of information systems on the organisation of the system, on providers and services, on the "best point of service" for patients according to their needs, and on the quality of treatments. Equal attention is paid to measures that contribute to the improvement of health literacy of the population and of communication skills of health care providers. Transparency is also improved by the obligation to publish major reform documents and evaluation reports.

Recently legislated and/or planned policy reforms

In order to address the major challenge (fragmentation) of the Austrian health system the Federal Ministry of Health started a reform process in December 2010 by drawing the roadmap for a health reform in the next years. The key element of the reform is a cooperative "governance by objectives" approach for achieving targets which will guarantee better coordination within the system.

The first period of the health care reform ("target-based health governance") covered the years 2013 to 2016. At the end of the year 2016 the federal government, the regional governments and the social insurance institutions agreed on the continuation of the health reform for the years 2017 to 2021.

First period of the health reform (2013 to 2016)

With the reform of the Austrian Internal Stability Pact, agreement was reached to limit health expenditure growth. In the context of the health system reform plan (2013-2016) the different layers of government agreed to limit public health expenditure growth from 2016 onwards so that it remains in line with expected average nominal GDP growth.

Major elements of the health reform are: 1) the creation of institutional capacity for the effective realisation of the "governance by objectives" approach, 2) enhanced primary health care capacity, 3) standardisation of care processes, 4) monitoring of health indicators and 5) the definition of accounting standards to better enable adherence to the budget cap.

The reform also included financial targets and the introduction of a budget cap on public expenditure

([49]) Data on expenditure on prevention and public health services was taken from OECD.
([50]) HiT 2018.
([51]) http://www.aerztekammer.at/.documents/10431/19066/%C3%84rztlicher+Verhaltenskodex+konsolidierte+Fassung/4ce3afe0-57d0-4cc4-923a-0dab81fe045f?version=1.0&t=1387379387000.

on health (expenditure containment path). The aim was to gradually align the increase in public health expenditure (excluding long-term care) with the expected average nominal growth of gross domestic product (plus 3.6 % per year) over the period until 2016. According to the financial monitoring reports, the states and the social insurance institutions reached their financial targets in the first reform period, though the targets were criticised for their lack of ambition ([52]).

Already in the first reform period (2013-2016), a contract between the federal government, social insurance institutions and the states had been signed to formalise both health and financial targets. It is divided into four key areas (1) the structure of provision, (2) the process of care, (3) outcome and health targets and (4) financial targets.

In order to raise institutional capacity the "Federal Target-Based Governance Commission" was established in 2013 as a new cooperative decision-making body. The "Federal Target-Based Governance Commission" is responsible for steering and controlling the Austrian health care system. At the state level, nine "Provincial Target-Based Governance Commissions" were established in order to ensure "governance by objectives".

Second period of the health reform (2017 to 2021)

In the course of the reform of the Austrian Internal Stability Pact an agreement was reached on the legal basis for the health care reform from 2017 onwards.

The priorities for the second period are strengthening of the primary health care sector, fostering of day clinic service provision, increased health promotion and prevention, joint provision and procurement of pharmaceuticals, further strengthening of the public health care system (e.g. focusing on the extension of in-kind benefits), measurement of outcome quality, improvements for health professionals (e.g. skill mix) and e-health.

Stakeholders also reached an agreement on the continuation of target-based financial governance mechanisms with the aim of reducing annual growth of public health expenditure (excluding long-term care) stepwise from 3.6 percentage points to 3.2 percentage points in 2021, based on GDP growth.

In April 2017 the federal government, the states and the social insurance institutions agreed on the federal target-based governance contract ("Zielsteuerungsvertrag") for the years 2017 to 2021, where the agreed measures and financial targets are operationalised. The fragmentation of financing responsibilities between inpatient and ambulatory sector contributes to inefficiencies, especially in the hospital sector. While many reform waves have attempted to improve the coordination and cooperation in the health system, promoting joint planning, governance and financing by putting the Federal Target-Based Commission in charge of implementing the new governance, fragmentation in the organisational and financial structure is still a challenge.

It is promising that the states' healthcare expenditure, having for many years exhibited a rate of growth above that of other levels of government and above nominal GDP growth, has been much better controlled in recent years. However, the target to converge to 3.2% in 2021 could make compliance more challenging in this second phase.

Following general elections in October 2017, new coalition government decided to merge the Federal Ministry of Health with the Federal Ministry of Labour, Social Affairs and Consumer Protection, forming the new Federal Ministry of Labour, Social Affairs, Health and Consumer Protection (BMASGK). While there are substantial overlaps with the previous reform agenda, such as strengthening primary health care, reallocation of resources and focus on public health, the new programme also envisages an overhaul of the social security system, with mergers of existing social security funds bringing the number from 21 down to 5. This reform aims to improve the cost-efficiency, transparency and equity of the system ([53]). A recent comprehensive study of the

([52]) Austrian Court of Auditors (2016a). Bericht des Rechnungshofes. Instrumente zur finanziellen Steuerung der Krankenversicherung. Vienna: Austrian Court of Auditors.

([53]) Country Report Austria 2018 {COM(2018) 120 final}.

Austrian system ([54]) concludes that an effective risk adjustment mechanism and reducing the fragmentation in procurement could increase efficiency. While expected benefits are assumed to materialise in the medium/long term, costs from mergers will necessarily materialise in the short term. The new reform is expected to be implemented in the course of 2019.

Challenges

A range of reforms have been implemented in recent years – or are still in the process of gradual implementation – implying substantial structural changes, with a focus on more integrated nation-wide planning, assuring and improving the quality of the health system, and ensuring fiscal sustainability of the health care system. As the analysis above has shown, the main challenges for the Austrian health system currently are as follows:

- To continue increasing the efficiency of health care spending in order to adequately respond to the rising expenditure pressures over the coming decades, which is a risk to the medium and long-term sustainability of public finances.

- To explore if current cost-sharing could be adjusted to discourage overuse/ encourage better use of more effective and cost-effective services – e.g. use of primary care rather than specialist care, and notably more health promotion and disease prevention activities (e.g. vaccination).

- To correct the misalignment between revenue generation and spending, currently characterised by a high level of decentralisation, to improve coordination at sub-federal level and increase efficiency in the provision of health care and reduce unnecessary costs.

- To continue to develop a comprehensive human resources strategy that tackles spatial/regional disparities – inequalities between the states and between urban and rural areas – and that ensures sufficient numbers of staff in general and in the future in view of population ageing.

- To tackle the excessive degree of hospitalisation, one of the major drivers of the high spending, deriving from the fragmentation of competencies between different government levels, where states and local governments are both involved in providing hospital services, while out-patient care is provided by social security services, and the consequent weak incentives to shift care from hospitals to outpatient settings.

- To control more effectively the use of specialist and hospital care, by strengthening primary health care as a gatekeeper and fostering the coordination of care between primary, secondary and hospital care. To this end, to strengthen/improve the referral system and ensure reimbursement of health care providers delivers the incentives to pursue efficiency goals.

- To improve the cost-efficiency within hospitals, ensuring that care is provided in the most clinically appropriate and cost-effective way, for example by maximising the proportion of elective care provided on a day case basis, day-of-surgery admission and containing unnecessary hospitalisation.

- To monitor and adapt, as necessary, the functioning and competences of the "Federal Target-Based Governance Commission" and the "Federal Health Commission" with a view to give room to further improve, cost control, quality management and efficiency. To monitor how the work of these governing bodies is aligned with fiscal targets established for health care spending, as well as with national public health goals.

- To improve data collection, especially in some crucial areas such as resources and care utilisation; to improve the patient information system.

([54]) LSE Consulting (2017). Efficiency review of Austria's social insurance and healthcare system. Volume 1 – International Comparisons and Policy Options. London: London School of Economics and Political Science (LSE Health).

- To foster the wide use of Health Technology Assessment and information and communication technologies in health care.

- To further enhance health promotion and disease prevention activities, promoting healthy life styles and disease screening given the most recent pattern of risk factors (smoking, alcohol, cardiovascular diseases).

- To further strengthen the health literacy of the population by improving health information systems and monitoring of health literacy.

Table 2.1.1: **Statistical Annex – Austria**

General context												EU- latest national data			
GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
GDP, in billion Euro, current prices	254	268	284	294	288	296	310	319	324	333	344	12,451	13,213	13,559	14,447
GDP per capita PPS (thousands)	32.5	33.4	34.0	33.6	31.4	32.2	32.9	33.8	33.3	33.4	34.2	26.8	28.1	28.0	29.6
Real GDP growth (% year-on-year) per capita	1.5	2.9	3.4	1.1	-4.0	1.6	2.6	0.2	-0.6	0.0	0.1	-4.7	1.5	0.1	2.0
Real total health expenditure growth (% year-on-year) per capita	:	1.4	3.7	2.9	1.0	1.6	0.8	2.9	-0.3	1.0	0.2	3.7	0.2	0.2	4.1

Expenditure on health*	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Total as % of GDP	10.2	10.1	10.1	10.3	10.8	10.8	10.6	10.9	10.9	11.0	11.1	10.2	10.1	10.1	10.2
Total current as % of GDP	9.4	9.6	9.6	9.6	9.5	9.5	9.9	10.1	10.2	10.3	10.3	9.3	9.4	9.9	9.9
Total capital investment as % of GDP	0.8	0.5	0.4	0.7	1.3	1.3	0.7	0.8	0.7	0.8	0.7	0.9	0.6	0.2	0.3
Total per capita PPS	2,873	2,966	3,145	3,299	3,393	3,479	3,572	3,754	3,806	3,928	4,031	2,745	2,895	2,975	3,305
Public total as % of GDP	7.8	7.7	7.8	8.0	8.5	8.4	7.9	8.1	8.0	8.1	8.1	8.0	7.8	7.8	8.0
Public current as % of GDP	7.5	7.5	7.5	7.7	8.1	8.1	7.5	7.7	7.7	7.8	7.8	7.7	7.6	7.6	7.8
Public total per capita PPS	2,204	2,277	2,421	2,571	2,661	2,714	2,650	2,774	2,800	2,889	2,965	2,153	2,263	2,324	2,609
Public capital investment as % of GDP	0.33	0.28	0.31	0.31	0.35	0.36	0.35	0.37	0.36	0.36	0.33	0.2	0.2	0.2	0.2
Public as % total expenditure on health	76.7	76.8	77.0	77.9	78.4	78.0	74.2	73.9	73.6	73.6	73.6	78.1	77.5	79.4	78.4
Public expenditure on health in % of total government expenditure	14.2	14.6	14.8	14.5	14.0	14.3	14.6	14.5	14.8	14.0	14.4	14.8	14.8	15.2	15.0
Proportion of the population covered by public or primary private health insurance	98.0	98.5	98.7	98.8	98.8	98.8	99.9	99.9	99.9	99.9	99.9	99.6	99.1	98.9	98.0
Out-of-pocket expenditure on health as % of total current expenditure on health	17.8	17.4	17.3	16.9	17.0	17.2	17.8	17.8	18.2	18.1	17.9	14.6	14.9	15.9	15.9

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Population, current (millions)	8.2	8.3	8.3	8.3	8.3	8.4	8.4	8.4	8.5	8.5	8.6	502.1	503.0	505.2	508.5
Life expectancy at birth for females	82.2	82.8	83.1	83.3	83.2	83.5	83.8	83.6	83.8	84.0	83.7	82.6	83.1	83.3	83.3
Life expectancy at birth for males	76.6	77.1	77.4	77.7	77.6	77.8	78.3	78.4	78.6	79.1	78.8	76.6	77.3	77.7	77.9
Healthy life years at birth females	60.1	61.0	61.4	59.9	60.8	60.8	60.1	62.5	60.2	57.8	58.1	62.0	62.1	61.5	63.3
Healthy life years at birth males	58.2	58.7	58.7	58.5	59.5	59.4	59.5	60.2	59.7	57.6	57.9	61.3	61.7	61.4	62.6
Amenable mortality rates per 100 000 inhabitants*	54	52	48	47	45	43	114	112	112	109	109	64	138	131	127
Infant mortality rate per 1 000 live births	4.2	3.6	3.7	3.7	3.8	3.9	3.6	3.2	3.1	3.0	3.1	4.2	3.9	3.7	3.6

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data			
Composition of total current expenditure as % of GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	3.5	3.4	3.4	3.5	3.7	3.7	3.4	3.5	3.4	3.5	3.4	2.7	2.6	2.7	2.7
Day cases curative and rehabilitative care	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.3
Out-patient curative and rehabilitative care	2.5	2.4	2.4	2.4	2.6	2.6	2.5	2.5	2.5	2.6	2.6	2.5	2.5	2.4	2.4
Pharmaceuticals and other medical non-durables	1.3	1.3	1.3	1.4	1.3	1.3	1.2	1.2	1.2	1.3	1.3	1.2	1.2	1.5	1.4
Therapeutic appliances and other medical durables	0.4	0.4	0.4	0.4	0.5	0.4	0.4	0.4	0.5	0.5	0.5	0.3	0.3	0.4	0.4
Prevention and public health services	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.2	0.3	0.3
Health administration and health insurance	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Composition of public current expenditure as % of GDP															
Inpatient curative and rehabilitative care	3.0	3.0	3.0	3.1	3.2	3.2	3.0	3.0	3.0	3.0	3.0	2.6	2.5	2.5	2.5
Day cases curative and rehabilitative care	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.3	0.3
Out-patient curative and rehabilitative care	1.7	1.7	1.7	1.7	1.8	1.8	1.7	1.8	1.8	1.8	1.9	1.8	1.8	1.7	1.8
Pharmaceuticals and other medical non-durables	0.9	0.9	0.9	0.9	0.9	0.9	0.8	0.8	0.8	0.9	0.9	0.9	0.9	1.0	1.0
Therapeutic appliances and other medical durables	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.2	0.2
Prevention and public health services	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3
Health administration and health insurance	0.3	0.2	0.2	0.3	0.3	0.3	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3

Source: EUROSTAT, OECD and WHO.

Table 2.1.2: **Statistical Annex - continued – Austria**

												EU- latest national data			
Composition of total as % of total current health expenditure	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	36.8%	35.7%	35.0%	36.3%	38.6%	38.5%	34.4%	34.5%	33.7%	33.5%	33.2%	29.1%	27.9%	27.1%	27.0%
Day cases curative and rehabilitative care	0.4%	0.4%	0.4%	0.5%	0.5%	0.5%	0.5%	0.7%	0.8%	0.9%	0.9%	1.7%	1.7%	3.0%	3.1%
Out-patient curative and rehabilitative care	26.2%	25.1%	25.3%	25.4%	27.7%	27.3%	24.7%	24.5%	24.9%	25.0%	25.1%	26.8%	26.3%	23.7%	24.0%
Pharmaceuticals and other medical non-durables	14.1%	13.8%	13.9%	14.4%	14.0%	13.8%	12.5%	12.1%	12.2%	12.3%	12.4%	13.1%	12.8%	14.7%	14.6%
Therapeutic appliances and other medical durables	4.4%	4.3%	4.3%	4.3%	4.7%	4.6%	4.3%	4.3%	4.4%	4.5%	4.5%	3.6%	3.6%	4.1%	4.1%
Prevention and public health services	2.1%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.1%	2.1%	2.1%	2.8%	2.5%	3.0%	3.1%
Health administration and health insurance	4.4%	4.1%	4.0%	4.3%	4.5%	4.4%	3.5%	3.6%	3.7%	3.7%	3.8%	4.5%	4.3%	3.9%	3.8%
Composition of public as % of public current health expenditure															
Inpatient curative and rehabilitative care	40.0%	40.0%	39.7%	39.8%	39.9%	40.1%	39.3%	39.4%	38.7%	38.4%	38.2%	33.9%	33.6%	32.1%	31.9%
Day cases curative and rehabilitative care	0.4%	0.5%	0.5%	0.6%	0.6%	0.6%	0.7%	0.9%	1.0%	1.0%	1.2%	1.9%	2.0%	3.4%	3.5%
Out-patient curative and rehabilitative care	22.9%	22.8%	22.9%	22.4%	22.6%	22.3%	23.0%	23.0%	23.4%	23.6%	23.7%	22.9%	23.5%	22.2%	22.5%
Pharmaceuticals and other medical non-durables	11.9%	11.8%	12.2%	12.2%	11.1%	10.9%	11.2%	10.9%	10.8%	11.1%	11.3%	11.8%	11.9%	12.6%	12.7%
Therapeutic appliances and other medical durables	2.7%	2.7%	2.5%	2.6%	2.6%	2.6%	2.5%	2.6%	2.6%	2.6%	2.6%	1.8%	1.9%	2.0%	2.1%
Prevention and public health services	2.3%	2.3%	2.3%	2.1%	2.0%	2.0%	2.0%	2.0%	2.0%	2.1%	2.1%	2.9%	2.5%	3.2%	3.2%
Health administration and health insurance	3.5%	3.1%	3.2%	3.3%	3.2%	3.1%	2.8%	2.9%	2.9%	2.8%	2.8%	4.1%	4.0%	3.6%	3.4%

												EU- latest national data			
Expenditure drivers (technology, life style)	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
MRI units per 100 000 inhabitants	1.62	1.68	1.77	1.80	1.84	1.86	1.86	1.91	1.92	1.97	2.07	1.0	1.4	1.5	1.9
Angiography units per 100 000 inhabitants	0.9	0.9	0.9	:	:	:	:	:	:	:	:	0.9	0.9	0.9	1.0
CTS per 100 000 inhabitants	3.0	3.0	3.0	3.0	2.9	3.0	2.9	3.0	3.0	2.9	2.9	2.1	1.9	2.1	2.3
PET scanners per 100 000 inhabitants	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.2	0.2
Proportion of the population that is obese	:	12.4	:	12.8	:	:	:	:	:	14.3	:	15.0	15.1	15.5	15.4
Proportion of the population that is a regular smoker	:	23.2	:	22.9	:	:	:	:	:	24.3	:	23.2	22.3	21.8	20.9
Alcohol consumption litres per capita	12.4	12.4	12.5	12.0	11.3	12.1	12.0	12.3	11.8	12.3	:	10.4	10.3	10.1	10.2

Providers	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Practising physicians per 100 000 inhabitants	432	445	453	460	468	478	482	490	499	505	510	324	330	338	344
Practising nurses per 100 000 inhabitants	718	727	738	752	761	767	775	783	787	800	805	837	835	825	833
General practitioners per 100 000 inhabitants	76	77	77	77	77	78	78	78	77	77	77	77	78	78	78
Acute hospital beds per 100 000 inhabitants	690	617	608	559	553	546	535	528	523	524	518	416	408	407	402

Outputs	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Doctors consultations per capita	6.7	6.7	6.8	6.9	6.9	6.9	6.9	6.8	6.8	6.8	6.6	6.2	6.2	6.2	6.3
Hospital inpatient discharges per 100 inhabitants	27	28	28	28	28	28	27	27	27	26	26	17	16	16	16
Day cases discharges per 100 000 inhabitants	4,487	4,834	5,113	5,457	5,501	5,690	6,018	6,348	6,595	6,911	7,031	6,362	6,584	7,143	7,635
Acute care bed occupancy rates	86.0	87.0	77.7	78.5	77.9	77.0	76.3	75.2	75.4	75.0	74.3	77.1	76.4	76.5	76.8
Hospital average length of stay	7.0	6.9	7.9	7.9	7.8	7.9	7.8	7.9	8.1	8.2	8.5	8.0	7.8	7.7	7.6
Day cases as % of all hospital discharges	14.0	14.8	:	16.2	16.5	17.1	18.0	19.0	19.9	20.8	21.3	28.0	29.1	30.9	32.3

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	**2016**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**	**2065**	**2070**
AWG reference scenario	7.0	7.0	7.2	7.3	7.5	7.7	7.9	8.0	8.1	8.2	8.2	8.3
AWG risk scenario	7.0	7.1	7.3	7.6	7.9	8.2	8.4	8.6	8.8	8.9	9.0	9.1

Change 2016-2070, in pps.	
Austria	**EU**
1.3	0.9
2.1	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	**2016**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**	**2065**	**2070**
Population projections until 2070 (millions)	8.7	9.0	9.4	9.7	9.9	10.1	10.2	10.2	10.2	10.2	10.2	10.2

Change 2016-2070, in %	
Austria	**EU**
17.0	2.0

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).

Austria

Long-term care systems

3. LONG-TERM CARE SYSTEMS

3.1. AUSTRIA

General context: Expenditure, fiscal sustainability and demographic trends

Austria, federal republic consisting of nine states ("*Bundesländer*") has a population of about 8.6 million inhabitants, which accounts for slightly more than 1.7% of the EU population in 2016, which is projected to reach 10.2 million by 2070 ([427]). With a GDP of about €340 billion (2015), or 34,230 PPS per capita, it is also among the richest EU member states (EU average 29,610). Based on the Ageing Report 2018, total public expenditure on long-term care (health and social part) ([1]) is with 1.9% of GDP in 2016 above the EU average in the same year (1.6%).

Health status

Life expectancy at birth for both women and men in 2015 was 83.7 and 78.8 years and lies above the EU average values (83.3 and 77.9 years respectively in 2015). Nevertheless, the healthy life years at birth, 58.1 years for women and 57.9 years for men, are well below the EU-average (63.3 and 62.6 respectively) ([428]).The percentage of the Austrian population having a long-standing illness or health problem is slightly above, though broadly in line with the figures for the EU as a whole (34.8% vs EU 34.2% respectively). The percentage of the population indicating a self-perceived severe limitation in their activities of daily living has been slightly decreasing in the last few years, from 10.2 in 2007 to 9.2 in 2015, but is still higher than the EU-average of 8.1%.

Dependency trends

The number of people depending on others to carry out activities of daily life is projected to increase significantly over the coming 50 years. From 0.81 million residents living with strong limitations due to health problems in 2016, an increase of 49% is envisaged by 2070 to reach around 1.22 million. That is a steeper increase than in the EU as a whole (25% on average across the EU). Also as a share of the population the dependents are becoming a bigger group, going from 9.3% to 12.0%, an increase of 28%, slightly higher than the EU average (EU: 21%).

([427]) Based on Eurostat projections.
([428]) Figures in this section have been extracted from Eurostat.

Expenditure projections and fiscal sustainability

With the demographic changes, public expenditure on long-term care as a percentage of GDP is projected to steadily increase. In the "AWG reference scenario", public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 1.9 pps of GDP by 2070 (going from 1.9% to 3.8%), an increase of 100% well above the EU average of 73% ([429]). The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 3.4 pps of GDP by 2070, an increase of almost 180%, slightly higher than the EU average of 170%. Overall, the projected long-term care expenditure increase is expected to add to budgetary pressure. Over the long run, medium sustainability risks appear for Austria. These are primarily related to the strong projected impact of age-related public spending (mainly healthcare and long-term care) ([430]).

System Characteristics

The Austrian federal constitution attributes public responsibilities in social care to both the federal republic and to the nine states. According to the constitution, the federal republic is responsible for developing the framework legislation relating to social welfare and nursing homes, whereas defining the specific measures within the broader framework, implementing and executing laws is defined as a competence of the states (art. 12 B-VG).

According to the Agreement between the Federal Government and the states, in accordance with Art. 15a B-VG on common measures of the Federal Government and the states for dependent persons, BGBl. No 866/1993, the Parties agree, on the basis

([429]) The 2018 Ageing Report: https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070_en.
([430]) European Commission, Fiscal Sustainability Report (2018) https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf.

of Austria's federal structure, that provision for persons reliant on care throughout Austria should follow identical aims and principles. This agreement obliges the states to provide a minimum standard of long-term care services such as mobile care services, residential care facilities, part-time care services, short-term care services in residential care facilities and case & care management.

Types of care

The system of care provision is mainly based on three pillars. The first pillar provides the care allowances, the second pillar consists of the care services and the third pillar consists of measures to support carers.

Cash benefits As from the beginning of 2012 long-term care cash benefits ("*Pflegegeld*"), originally introduced in 1993, fall within the sole competency of the federal republic. The benefit currently amounts to €157.30 per month in level 1 (the lowest level), but it may be as high as €1,688.90 in level 7 (the highest level) ([431]). These cash benefits are intended to be used to buy formal care services from public or private providers or to reimburse informal care provision. However, it is not being controlled for what purposes long-term care benefits are actually used by the benefit recipients.

In-kind care The types of in-kind care provided range from proper institutional care to hybrid forms of short-term institutional care and semi-institutional care. Institutional care is typically provided in ad-hoc institutions such as nursing care homes and supervised residential communities for the elderly. There are forms of short-term institutional care, within the same settings but for a maximum time of three months, conceived to offer support or a back-up to family carers who provide care at home. For patients who are not based in residential facilities, semi-inpatient care offers half-day or full day support (care and social care) including transportation to the care facility. Lastly, there are forms of long-term care delivery, outpatient/mobile care, offering home help and or nursing depending on the individual need ([432]).

As far as expenditure is concerned, based on available figures, the focus on in-kind services seems to be slightly above the average, with 89.8% of total long-term care spending against 84.4% for the EU in 2016. Conversely, the proportion of the long-term care budget spent on cash benefits seems to be below average for the same year, with 10.2% against 15.6% for the EU. Combined with the relatively low unit costs per capita as a share of GDP per capita, this suggests that shifting more resources to cash allowances, where appropriate, may increase cost-efficiency.

Measures to support family carers Currently, there are a large number of options to support family carers, including by improving compatibility between care and work, such as:

- carer's leave and part-time working arrangements, the entitlement to a carer's leave allowance;
- financial contributions towards the cost of substitute care in case of unavailability of the primary caregiver;
- social insurance for family carers;
- advisory services to citizens provided by the Ministry of Social Affairs;
- counselling for family members;
- measures under the strategy for dementia;
- young carers;
- visits within the framework of quality assurance in home care.

24-hour care Under the initiative of the Ministry of Social Affairs, a legal framework for quality-assured 24-hour care was established and a corresponding subsidy scheme was developed in 2007. According to this scheme, caring in private

([431]) Source: https://www.sozialministerium.at/site/Pension_Pflege/Pflege_und_Betreuung/Hilfe_Finanzielle_Unterstuetzung/Pflegegeld/#intertitle-3 (accessed on 19/03/2019).

([432]) Fink, M. (2018). ESPN Thematic Report on challenges in long-term care, Austria, 2018, Report to the European Commission, DG EMPL, via the European Social Policy Network (ESPN).

homes can be regulated as self-employed or employed work. 24-hour home-care is an essential tool for people in need of care and their families to ensure a legitimate, quality-assured home care. In accordance with Section 21b of the Federal Long-Term Care Act, the Ministry of Social Affairs has developed a model that finances benefits for dependents and their family members. Provided the conditions for funding are met ([433]) in accordance with the Home Care Act *(Hausbetreuungsgesetz)*, a maximum amount of €550 per month (when two self-employed carers are deployed) or €1,100 per month (when two employed carers are deployed). The responsibilities in the financing of this scheme are split between the federal government, financing 60%, and the states, responsible for 40%.

Long-term care fund In the field of long-term care the Federal Government plays a major role in securing funding to support regional governments to cover expenditure for long-term services and facilities, alongside supporting the provision of benefits.

In 2011, the long-term care fund was introduced by the Ministry of Social Affairs and was followed by an amendment of the care-fund in August 2013. The purpose of grants from the fund is to ensure the provision and sustainability of long-term care services, which are provided by states and municipalities in cooperation with non-profit organisations. The long-term care-fund sets priorities for nationwide expansion of mobile services and is primarily used for non-stationary ([434]) services. The majority, i.e. two thirds, of the long-term care-fund is financed by the federal republic and one third by the states and the municipalities. Between 2011 and 2016 a total amount of €1.335 billion had been transferred to this purpose.

In January 2017 the long-term care-fund was extended from 2017 to 2021 and increased up to a total of €1,914 million. The amendment introduced an expenditure path following the model of the health reform, which sets a maximum of 4.6% for the annual percentage increases in the total gross expenditures of all states in the area of long term care provision. Additionally €18 million per year is dedicated to the expansion of hospice and palliative care for 2017-2021.

Role of the private sector

Provision of social care is not exclusively managed by public entities and social care services can be offered by other organisations as long as they are suitable to the needs of dependent people and they are cost-effective. Hence, Austria has a mix of public and private providers, with services provided by municipalities and both for-profit and non-profit organisations of the so-called intermediary sector, i.e. social NGOs of different types. The role of the private sector is non-negligible, with more than 50% of residential care and nursing homes run by private organisations back in 2008. Accordingly, cash benefits can be used to buy formal care services from public or private providers or to reimburse informal care giving.

Eligibility criteria and user choices: dependency, care needs, income

In the Austrian long-term care system no definition of "need of care" exists, but eligibility requirements for cash allowances could be seen as a partial substitute for such a definition. The assessment of the need for long-term care is rather based on individual requirements for personal services and assistance. The need for both personal services and assistance is necessary in order to

([433]) In order to obtain financial support for 24 hour care, the following conditions have to be fulfilled:

•A need for (up to) 24-hour care

•Receipt of long-term care benefit at Stage 3 or higher

•Existence of a care relationship (i.e. a formal or informal contract) between a carer and the person in need of care or a family member, or a contract between either of these persons and a non-profit organisation offering care services

•Carers need to be able to prove that they have either completed a theoretical training course (which is essentially the same as that for a home help), or have cared for the person applying for the subsidy in a proper manner for at least six months. Alternatively, the carer must possess official authorisation for carrying out care work or nursing work. There are also income thresholds for entitlement set at €2,500 net per month, excluding benefits. Assets are not taken into account. Increases of €400 for every family member who is dependent or entitled to maintenance, and by €600 for family members who are disabled and entitled to maintenance are established. https://www.sozialministerium.at/siteEN/Pension_Nursing/Long_term_Care_Benefit/24_hour_care.

([434]) Non-inpatient.

qualify for federal or provincial long-term care allowances.

Needs assessment is based on a doctors' expert opinion. Representatives of other fields (e.g. nursing) are also involved for an extensive assessment of the situation. The expert opinion is usually drawn up after an examination at home. It is possible for a trusted third party to be present during the examination, if desired by the person applying for long-term care allowance. The eligibility decision is made by means of an official notification with the possibility to appeal against this decision at the appropriate Labour and Social Court. The examination, the classification, as well as the payment of the long-term care allowance, are carried out by social insurance institutions, specifically pension insurance and accident insurance.

The specific provisions regarding the assessment of need of care are laid down in an ordinance. This ordinance defines care and assistance and the time allotted to individual tasks, e.g. dressing and undressing, care of the body, preparation of food, feeding as well as mobility assistance. In addition to that, the Main Association of Austrian Social Security Institutions ([435]) has the right to define national guidelines for assessing needs of care. Such guidelines were issued and updated several times in order to assure the uniform interpretation of the respective laws also in practice and over different decision makers.

Co-payments, out of the pocket expenses and private insurance

Access to long-term care benefits in-kind and services is in principle not free of charge and users need to pay a co-payment. Where own resources and cash benefits were not sufficient to cover the expenses, the cost difference is compensated by states and municipalities. Here, means-testing applies, whereby all kinds of personal income are taken into account, including long-term care cash benefits and except for assets, due to the recent abolition of recourse to personal and family assets to finance inpatient long term care (Pflegeregress).

Long-term care cash benefits are granted without means-testing (against income or assets) and based on care needs categorised in seven different levels of need.

Social services can be provided by entities under private law. Persons in need of care may be requested to make contributions to the costs of social services but the social aspects have to be taken into consideration in assessing the share to be borne by them. Thus, there is in general some kind of means testing regarding social services, but the concrete form differs by state.

eHealth

The Federal Ministry for Labour, Social Affairs and Consumer Protection, has commissioned the computer application *"PFIF Pflegegeldinformation"* used by the Main Association of Austrian social insurance institutions. With the introduction of PFIF the existing system has been strengthened and upgraded. This application provides a valuable tool to improve the situation for dependent people and their families, by monitoring the overall process of all care allowances in Austria, including application and payment, as well as by providing comprehensive statistical evaluation of available options. In addition, this database is constantly updated to account for changes to the existing legal framework.

In order to enhance the transparency, validity and comparability of the data in terms of care and long-term care and to increase the quality of care supply, a national long-term care database *"Pflegedienstleistungsdatenbank"* was launched at the beginning of July 2012 by the Austrian Federal Statistics Office, on behalf of the Ministry of Social Affairs. This is based on the 2012 legislation on care-services related statistics (BGBl. II No 302/2012). This database covers all long-term care services including mobile, semi-residential and residential care services for elderly and dependent population.

Formal/informal caregiving

Most persons in need of care prefer staying in the private environment and receiving informal care from relatives or family members over formal care. Consequently, roughly 80% of persons in need of

([435]) http://www.hauptverband.at/cdscontent/?contentid=10007.754040.

care do receive informal care. By providing the cash allowance irrespective of the chosen care setting (formal/informal, institution/home based), the philosophy of the system again is one of supporting the possibility of individual choice.

Recently legislated and/or planned policy reforms The Working Group on Long-term Care Reform, established by the government to deal with respective problems and to develop a strategy for the future, suggested inter alia introducing a care leave or part-time care leave for care-giving close relatives. This care leave has the aim to support working relatives during the first stage of care to better coordinate work and care.

The care leave and part-time care leave was implemented in 2014, the provisions in the Federal Long-term Care Allowance Act ("*Bundespflegegeldgesetz*") entered into force on January 1, 2014. Since then workers can take care leave or part-time care leave waiving income from employment in order to care and nurse family members in need of care. Persons can also take family hospice leave or part-time family hospice leave for the purpose of nursing a dying close family member or a seriously ill child.

These family members can, under certain conditions, claim care leave benefits (certain level of long-term care benefit of the family member in need of care, employment contract in place since at least three months - comprehensive insurance). A close family member may receive care leave benefits for one to three months during care leave or part-time care leave, depending on the period of leave agreed with the employer. If the level of the long-term care benefit is raised, employer and employee may agree on one single additional period of care leave or part-time care leave. In case of family hospice leave for the purpose of nursing a dying close family member (a long-term care benefit is not required in this case) the care leave benefits can be drawn for up to six months (typically three months with the possibility of prolongation up to six months). In case of family hospice leave for the purpose of nursing a seriously ill child (a long-term care benefit is not required in this case), the care leave benefits can be drawn for up to nine months (typically five months with the possibility of prolongation up to nine months).

The rate of care leave benefits is income-related and approximately equal to the rate of unemployment benefits (55 % of the daily net income) plus children's allowance.

The situation of care-giving relatives has been evaluated in the context of the quality assurance of home care and the results show that relatives often indicate emotional stress because of their caring responsibilities and should therefore be supported as much as possible. After pilot testing, the initiative "dialogue with relatives" has been established. To support family carers, psychologists or professional social workers provide free counselling services, offering advice and psychological support to prevent any health consequence due to mental stress.

It is estimated that between 115,000 and 130,000 people in Austria are currently living with some form of dementia. Due to population ageing and increasing life-expectancy the number of people suffering from dementia is expected to increase. Accordingly, the Federal Government assigned a high priority to the development of a dementia strategy *"Demenzstrategie"*.

The first step towards the strategy was the 2014 report on dementia, *"Österreichischer Demenz-bericht 2014*", based on research carried out by the Austrian Public Health Institute (Gesundheit Österreich GmbH), on behalf of the Ministry of Social Affairs and the Ministry of Health. The report covers the status quo as regards the situation of people with dementia impairments and contains epidemiological key messages on the prevalence of dementia in Austria.

The technical work has been carried out by six working groups in a participative process, emphasising the importance of a common cross-policy approach in long-term care. Representatives of the provincial, municipal and local federations, social security institutions, scientific community, key stakeholders, developed recommendations targeting those seen as key issues.

A total of twenty one recommendations reflect seven main targets:

- involvement and empowerment of those affected;

- developing wide and target-group specific information;
- developing knowledge and enhancing skills;
- uniforming conditions;
- ensuring availability of dementia care;
- developing coordination and cooperation;
- quality assurance and improvement through research.

In 2015 the report by the experts *"Demenzstrategie — Living well with dementia"* was presented to the public and the implementation has started.

The future of long-term care has gained increased political attention in Austria over the last few years. To deal with respective problems and to develop a strategy for the future, the above-mentioned Working Group on Long-term Care Reform suggested taking into account an amendment of the Act on Long-term Care Funds, which was adopted in 2013.

Overall, these developments do not point towards a structural change of the main features of the Austrian long-term care system. The aim appears to be to safeguard financial sustainability in view of rising demand (and without reduced accessibility). Within this context, the Reform Working Group rejected the idea of a separate contribution-financed long-term care insurance and clearly stated that long-term care services should remain tax-financed. Furthermore, the currently existing model of a combination of universal cash benefits and (means-tested) long-term care services administered by the states and municipalities has not been put into question. It is, however, the declared aim to do more to harmonise the access to available services, to focus on the further development of mobile/outpatient services (also for reasons of cost containment) and to promote innovative approaches.

Negotiations on the budget redistribution between the federal government and the states, including in the area of long-term care, led to the extension of the long-term care-fund from 2017 to 2021, to reach a total of €1,914 million (with an increase of 4.5% per year starting from 2018).

On 29 June 2017 the Austrian Parliament passed a Constitutional Provision (Verfassungsbestimmung), prohibiting recourse to the assets of people in inpatient long-term care (so-called Pflegeregress) ([436]). The recently voted Constitutional Provision (amending sections §§ 330a, 330b and 707a of the General Law on Social Insurance/ASVG) prohibits recourse to the assets of persons living in inpatient long-term care facilities, as well as recourse to the assets of their relatives, heirs or gift-recipients, to cover costs for long-term care otherwise to be borne by Social Assistance.

Since then, compensation claims may no longer be asserted; ongoing proceedings are or were to be discontinued. Insofar as provincial laws precluded this, the relevant provisions expired on 1 January 2018. In order to cover the revenues which the states are now facing because of the new regulations, the Federal Minister of Finance has to provide at least 100 million euros from the general federal budget annually. Due to the "Verbot des Pflegeregresses", the special subsidy law (Zweckzuschussgesetz) has been adopted on 21 December 2018 ([437]). This is intended to create a legal basis that will enable the federal government to provide the states with further 240 million euros for the year 2018 as compensation for the effects of the ban of the Pflegeregress in accordance with § 330a ASVG. The maximum sum of 340 million Euros will be evaluated in the first half of 2019, to get a baseline for a settlement for the following years.

([436]) In Austria, up to now, it had been in principle the individual in need of long-term care who was responsible for financing his/her stay in a residential or nursing home. Personal income used for this purpose typically consisted of a retirement pension plus "long-term care cash benefit" (Pflegegeld). Furthermore, personal assets (such as savings or real estate) had to be used for financing inpatient long-term care before the respective provider of Social Assistance (Sozialhilfe) steps in to bear uncovered costs. This long-term care recourse-to-assets was then subject to specific regulations in each of the nine states (Bundesländer), which are responsible both for long-term care services and for Social Assistance.

([437]) https://www.parlament.gv.at/PAKT/VHG/XXVI/I/I_00327/index.shtml.

Another possible future policy challenge are care-giving children and adolescents ('young carers'). Care-giving children are a social phenomenon, which was given little credit so far. In December 2012 the results of a study, which was financed by the Federal Ministry of Labour, Social Affairs and Consumer Protection, were published under the title "Children and Adolescents as informal caregivers; an inside look into the past and present situation of young carers in Austria". This study, which was carried out by the Institute for Nursing Science, shows for the first time figures about how many care-giving children exist in Austria and on the other hand also shows the way and frequency of assistance by these children. According to this study there are 42,700 care-giving children and adolescents between the age of 5 and 18 in Austria.

Building on the results of the previous study, raising awareness on young carers, a follow-up study "Children and young people as family carers: insight on the condition and possible support measures" was carried out in 2014 ([438]). This study developed a basic framework focused on young carers (e.g. the need to support young carers, information and advice, expert views, resources) as well as with focus on their family (coordination of assistance within the family.). This study provides evidence on which particular programmes can be applied to support young carers and their families and it serves as guidance for those institutions intending to implement support programmes in this area.

In the years 2017 and 2018 a study on Family care in Austria was carried out by the Department of Nursing Science in cooperation with the Department of Sociology (University of Vienna) commissioned by the Ministry of Labour, Social Affairs, Health and Consumer Protection. The study examines the situation of caregiving relatives and the development of informal care networks.

With the long-term care Master Plan adopted by the Council of Ministers on 5 December 2018, another step was taken to tackle this important future challenge. Ensuring adequate and high-quality care according to the state of nursing science and medicine as well as the support of people in need of care and their relatives have the highest priority in Austria. By the end of the year 2019 a comprehensive concept based on the masterplan will be developed. The master plan addresses the following topics:

– control/organisation;

– caring relatives;

– caregivers;

– digitalisation;

– financing.

Challenges

Austria has a relatively fragmented system of long-term care, with unequal coverage across regions and a large provision of informal care that is privately financed. The main challenges of the system appear to be:

- **Improving the governance framework and increase administrative efficiency**: to strengthen the existing legal and governance framework for a clearer delineation of responsibilities of states with respect to the provision of long-term care services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and providers**;** to share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes.

- **Improving financing arrangements:** to foster pre-funding elements, which implies setting aside some funds to pay for future obligations.

- **Providing adequate levels of care to those in need of care:** to adapt and improve LTC

([438]) http://www.studienreihe.at/cs/Satellite?pagename=Z02/index&n=Z02_0.

coverage schemes, setting a homogenous need-level triggering entitlement to coverage and the depth of coverage, that is, setting the extent of user cost-sharing on LTC benefits; and the scope of coverage, that is, setting the types of services included into the coverage.

- **Continue to encourage home care and to support family carers** to continue to monitor and evaluate alternative services, including incentives for use of alternative settings; to strengthen policies for supporting informal carers, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- **Ensuring availability of formal carers:** to determine current and future needs for qualified human resources and facilities for long-term care; to improve recruitment efforts, including through the migration of LTC workers and the extension of recruitment pools of workers; to increase the retention of successfully recruited LTC workers, by improving the pay and working conditions of the LTC workforce, training opportunities, more responsibilities on-the-job, feedback support and supervision.

- **To facilitate appropriate utilisation across health and long-term care:** to arrange for adequate supply of services and support outside hospitals, changing payment systems and financial incentives to discourage acute care use for LTC.

- **Changing payment incentives for providers:** to consider a focused use of budgets negotiated ex-ante or based on a pre-fixed share of high-need users.

- **Improving value for money:** to invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services; to invest in ICT as an important source of information, care management and coordination.

- **Prevention:** To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 3.1.1: **Statistical Annex –Austria**

GENERAL CONTEXT

GDP and Population	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2011	EU 2013	EU 2015
GDP, in billion euro, current prices	254	268	284	294	288	296	310	319	324	333	344	13,213	13,559	14,447
GDP per capita, PPS	32.5	33.4	34.0	33.6	31.4	32.2	32.9	33.8	33.3	33.4	34.2	28.1	28.0	29.6
Population, in millions	8.2	8.3	8.3	8.3	8.3	8.4	8.4	8.4	8.5	8.5	8.6	503	505	509
Public expenditure on long-term care (health)														
As % of GDP	1.0	1.0	1.0	1.1	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2
Per capita PPS	:	:	:	:	:	:	394.5	417.5	420.7	430.6	438.8	283.2	352.1	373.6
As % of total government expenditure	2.0	2.1	2.1	2.2	2.3	2.3	2.3	2.3	2.4	2.3	2.3	1.8	2.5	2.5
Note: Based on OECD, Eurostat - System of Health Accounts														
Health status														
Life expectancy at birth for females	82.2	82.8	83.1	83.3	83.2	83.5	83.8	83.6	83.8	84.0	83.7	83.1	83.3	83.3
Life expectancy at birth for males	76.6	77.1	77.4	77.7	77.6	77.8	78.3	78.4	78.6	79.1	78.8	77.3	77.7	77.9
Healthy life years at birth for females	60.1	61.0	61.4	59.9	60.8	60.8	60.1	62.5	60.2	57.8	58.1	62.1	61.5	63.3
Healthy life years at birth for males	58.2	58.7	58.7	58.5	59.5	59.4	59.5	60.2	59.7	57.6	57.9	61.7	61.4	62.6
People having a long-standing illness or health problem, in % of pop.	:	21.9	23.9	32.3	31.8	34.8	34.1	33.1	34.5	35.8	34.8	31.7	32.5	34.2
People having self-perceived severe limitations in daily activities (% of pop.)	:	9.4	10.2	10.3	9.7	9.5	9.7	9.6	9.7	9.8	9.2	8.3	8.7	8.1

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2011	EU 2013	EU 2015
Number of people receiving care in an institution, in thousands	:	:	19	42	66	89	91	93	74	75	77	3,851	4,183	4,313
Number of people receiving care at home, in thousands	:	:	87	116	145	174	177	179	166	168	171	7,444	6,700	6,905
% of pop. receiving formal LTC in-kind	:	:	1.3	1.9	2.5	3.2	3.2	3.2	2.8	2.9	2.9	2.2	2.2	2.2
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients														
Providers														
Number of informal carers, in thousands	:	290	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	58	61	66	67	64	64	:	:	:	:

Source: EUROSTAT, OECD and WHO.

Table 3.1.2: **Statistical Annex - continued – Austria**

PROJECTIONS

Population	**2016**	**2020**	**2030**	**2040**	**2050**	**2060**	**2070**	**MS Change 2016-2070**	**EU Change 2016-2070**
Population projection in millions	8.7	9.0	9.7	10.1	10.2	10.2	10.2	16%	2%
Dependency									
Number of dependents in millions	0.81	0.85	0.97	1.07	1.17	1.19	1.22	49%	25%
Share of dependents, in %	9.3	9.4	10.0	10.6	11.4	11.7	12.0	28%	21%
Projected public expenditure on LTC as % of GDP									
AWG reference scenario	1.9	2.0	2.3	2.6	3.2	3.6	3.8	101%	73%
AWG risk scenario	1.9	2.0	2.5	3.0	3.9	4.6	5.3	178%	170%
Coverage									
Number of people receiving care in an institution	90,721	96,029	117,209	138,489	171,718	186,788	194,537	114%	72%
Number of people receiving care at home	174,506	185,519	222,102	260,109	308,505	326,460	340,764	95%	86%
Number of people receiving cash benefits	465,342	498,105	605,641	719,119	866,740	925,118	968,725	108%	52%
% of pop. receiving formal LTC in-kind and/or cash benefits	8.4	8.6	9.7	11.1	13.1	14.1	14.8	77%	61%
% of dependents receiving formal LTC in-kind and/or cash benefits	89.8	91.2	97.9	100.0	100.0	100.0	100.0	11%	33%
Composition of public expenditure and unit costs									
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	89.8	89.8	90.0	90.0	90.3	90.6	90.8	1%	5%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	10.2	10.2	10.0	10.0	9.7	9.4	9.2	-10%	-27%
Public spending on institutional care (% of tot. publ. spending LTC in-kind)	70.6	70.6	70.9	71.1	71.8	72.4	72.3	2%	0%
Public spending on home care (% of tot. publ. spending LTC in-kind)	29.4	29.4	29.1	28.9	28.2	27.6	27.7	-6%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	115.8	117.3	120.3	122.1	124.0	128.3	131.0	13%	10%
Unit costs of home care per recipient, as % of GDP per capita	25.0	25.3	26.1	26.4	27.0	28.0	28.6	14%	1%
Unit costs of cash benefits per recipient, as % of GDP per capita	3.6	3.6	3.7	3.7	3.7	3.7	3.7	1%	-14%

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).