Austria

Health Care & Long-Term Care Systems

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Austria

Health care systems

1. HEALTH CARE SYSTEMS

1.1. 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 2013 amounted to 33,192 PPS, compared to the EU27 average of 27,880 PPS. The global financial and economic crisis has pushed the Austrian economy into a deep recession with economic growth slowing down from 3.4% in 2007 to -4.1% in 2009. Following the swift recovery of the pre-crisis GDP level during 2011, growth has remained sluggish but has recently shown signs of picking up. Correspondingly the more recent numbers indicate a slow but stable GDP growth at 0.9% in 2015, expected to further increase to more than double the rate in 2015 at 1.7% and 1.6% in 2016 and 2017 respectively ([1]).

Fiscal consolidation to bring government revenues and spending into line in the coming years may have some consequences for the health care sector through consolidating current measures to improve its efficiency.

In terms of population, the Austrian population was around 8.5 million in 2013, slowly increasing over the last decade (8.1 million in 2003). It is projected to further increase by 1.2 million from 2013 to 2060, reaching 9.7 million.

Total and public expenditure on health as % of GDP

Total expenditure on health is one of the highest in the EU: 11.0% of GDP in 2013, slightly increasing over the last decade (10.3% in 2003). This is above the EU average of 10.1% in 2013. Public expenditure on health amounted to 8.4% of GDP in 2013, putting Austria on the high end of the European spectrum, above the EU average of 7.8 %. When measured in per capita terms, in 2013 Austria was among the highest in terms of total expenditure (3,821 PPS vs. the EU average of 2,988) and public spending (2,895 PPS vs. 2,208 PPS).

([1]) European Commission (2016), European Economic Forecast Winter 2016.

Expenditure projections and fiscal sustainability

As a result of ageing, health care expenditure is projected to increase by 1.3 pps of GDP (that is higher than the EU average foreseen of 0.9 pps 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 2.0 pps of GDP from now until 2060, higher than the average (EU level: 1.6) ([2]).

Over both the medium and the long run, 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, but pension spending trend is significantly above the EU average as well) ([3]).

Health status

The period 1980–2010 saw a sharp rise in life expectancy, which grew by approximately one year every five years for women, and even more quickly for men ([4]). The Austrian population lives longer than the average EU citizens: life expectancy at birth of both women (83.8 years) and men (78.6 years) was higher than the EU averages of 83.3 and 77.8 years in 2013 ([5]).

Healthy life years, although with minor fluctuations, have remained quite stable during the past decade ([6]) and in 2013 this amounted to 60.2 years for women (compared to 61.5 years in the EU) and 59.7 years for men (compared to 61.4 years in the EU). Infant mortality of 3.1‰ (2013) is still slightly below the EU average of 3.9‰ ([7]). As in most other European countries, in Austria non-communicable diseases remain the leading causes of morbidity and mortality. During the period 1995-2010, diseases of the circulatory system have been the most important cause of

([2]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.
([3]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.
([4]) HiT (2013).
([5]) Data on life expectancy and healthy life years is from the Eurostat database.
([6]) A break in series exists between 2003 and 2004, so the marked decrease in 2004 has likely a strong methodological component.
([7]) Data on infant mortality is from the OECD database.

death, both for men and women. However, a significant reduction in the standardised rates of these conditions was achieved during this period. Although a reduction in the second most common cause of death, malignant neoplasms (cancer), was also achieved, their incidence did not fall as much as diseases of the circulatory systems. Of particular significance within the group of malignant growths are the smoking related cancers. This is the case for both men and women. Breast cancer also plays a significant role for women. Age-standardised cancer incidence rates are just under the average of the EU member states ([8]).

In terms of lifestyle-related risk factors, Austria can be classified in the middle of the EU countries. While percentage of obese population (12.4% in 2006, latest recorded), and percentage of regular smokers (22.9% in 2008) are slightly lower than currently on average in the EU (15.5% and 22% respectively), alcohol consumption (11.9 litres per capita in 2011) is somewhat higher than the corresponding figure for the EU in that year (10 litres). In Austria, 15-year-old males, together with their contemporaries in Poland and Lithuania, show the highest increase in obesity. 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 ([9]). 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 ([10]).

System financing: taxed-based or insurance-based

The Austrian health system is financed from a mix of sources. In 2013, 75.8 % of expenditure was public, while 24.2% 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 pretty 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 ([11]). A statutory 'maximum contribution basis' puts a ceiling on the wages used for the calculation of the contributions. In 2016 this ceiling amounts to EUR 4,860. 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 ([12]). 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 current expenditure of the hospitals. Hospital debts are also covered at federal level by the states.

([8]) HiT (2013).
([9]) 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".
([10]) See also Austria - asisp Annual Report 2009.
([11]) http://www.selbsthilfe-oesterreich.at/fileadmin/upload/doc/aktuelles/SV-aktuell_2013-33_Neue_Betr%C3%A4ge.pdf.
([12]) 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.

Since 2013 Austria imposes a constraint on public spending on health via the budget process ([13]). 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) will be gradually aligned with the expected average nominal growth of gross domestic product (plus 3.6% per year). In total it was agreed to contain expenditures by EUR 3.43 billion until 2016 by the regional governments (EUR 2.058 billion) and the social insurance institutions (EUR 1.372 billion).

The finances for public health expenditure, mainly via the social insurance system, are raised and used in a decentralised manner; they are not subject to any budget-setting process, but rather result from the health insurance funds' obligation to ensure that services are in accordance with the current provisions of social insurance law ([14]). Nevertheless, the health expenditure has remained stable over the last decade, as seen in the in the part covering general country statistics.

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 ([15]). Nevertheless, the level of expenditure in administering such a complex system remains about the EU average ([16]). Public (0.22%) and total (0.38%) expenditure on health administration and health insurance as a percentage of GDP is slightly below or about the EU average (0.27% and 0.47% respectively in 2013), and so are public and total expenditure on health administration and health insurance as a percentage of current health expenditure (2.8% and 3.8% vs. 3.5% and 4.9% in 2013).

Health care insurance is provided by a number of health insurance funds. They are decentralised institutions, based on the self-management model. 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 region in which they live or occupational group (e.g. salary and wage earners, 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.

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 the statutory insurance, private health

([13]) Austria scored 0 out of 6 in the 2010 OECD scoreboard due to the soft budget constraint.
([14]) See HiT 2013.
([15]) 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).
([16]) 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.

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 EUR 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. The co-payment for dependants of those insured is slightly higher (between 12 and EUR 19/day depending on the hospital) ([17]).

Private expenditure (e.g. patient co-financing and voluntary private health insurance) ([18]) represented around 24.2% of the total health expenditure in 2013, ranging between 23.5% and 25.4% throughout the decade. It is slightly above the EU average of 22.6% in 2013. Out-of-pocket spending accounts for 15.8% of total current health spending (slightly above the EU average of 14.1 % in 2013) and has registered a small but steady reduction since 2004 (17.9%) ([19]). The share of private health insurance expenditure amounted to 4.5% in 2012. The respective shares of public and private expenditure in the total health expenditure, as well as the specific out-of-pocket part, have remained quite constant over the last decade ([20]).

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 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 ([21]), 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 ([22]) deductible is paid. He/she can also switch the contract physician with the agreement of the health insurance fund ([23]).

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 47% of physicians (including dentists) in private practice have a contract with one or more health insurance fund. 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 53% 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 (499 in 2013) is above the EU average (344 in 2013) and showing a consistent increase since 2003 (411). The number of GPs per 100,000 inhabitants (77 in 2013) is slightly below the EU

([17]) Source: HIT and sozialversicherung.at.
([18]) This would be excluding Non-profit institutions serving households and corporations other than health insurance, source: OECD; (function: total current expenditure. No possibility to split private sector for the function of total expenditure).
([19]) Note that since 2008, prescription charges are limited to 2% of the income for patients suffering from chronic diseases.
([20]) Austria scored about 6 out of 6 on the breadth, 6 in the scope and around 5.5 on the depth of basic coverage according to the 2010 OECD scoreboard.
([21]) For up to 3 specialists by period.
([22]) EUR 10.85 in 2016.
([23]) According to the OECD, the level of choice of provider in Austria had a score of 2.7 out of 6 in 2010.

average (78.3 the same year), and has remained roughly stable during the past decade (75 in 2003). 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 (787 in 2013) is below the EU average (837) having increased throughout the decade, from a level of 720 in 2003 ([24]). 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 as many as 57.51% 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 (HIT 2013). 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 ([25]). 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.

The empirical data suggest the overutilisation of the hospital care in Austria. The number of available acute care beds (535 per 100,000 inhabitants in 2013), although somewhat lower than a decade before (604 per 100,000 in 2003) is 50% higher than the respective amount in the European Union (356). At the same time, even if the curative care average length of stay of 6.5 days is about the EU average in 2013, the number of inpatient discharges per 100 inhabitants (26.6) is the highest in the EU, more than 50% higher than the EU average of (16.5). Consistently, the number of day-case discharges is lower than average (6,595 in Austria vs. 7,031 in the EU in 2013). 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 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.

([24]) 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.

([25]) 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.

About 50% ([26]) 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 ([27]).

([26]) Hofmarche, M., Quentin, W. Austria: Health system review. Health Systems in Transition, 2013; 15(7): 1– 291.

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

The market for pharmaceutical products

Expenditure on pharmaceuticals ([28]) is below the EU average both when measured as % of GDP (1.2% vs. 1.44% in 2013), and when calculated as percentage of total current health expenditure (11.9% vs. 14.9% in 2013).

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 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 ([29]). Health

([28]) 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 the OECD database.

([29]) 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/CountryInfo

funds also monitor the prescribing patterns of GPs and specialists who are under contract with them, and provide them with information leaflets and newsletters ([30]).

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 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 ([31]) are carrying out full Health Technology Assessments. At the same time, within the reimbursement institutions (health insurances, hospitals) some form of evaluation reflecting the institution's perspective is increasingly implemented. Health Technology Assessment as an instrument for health technology regulation is nowadays often being used: for coverage and fee-setting in the private practices of the outpatient sector; to establish a positive list of the pharmaceuticals that are covered by the public health insurance scheme; as a controlling instrument in hospitals for obvious inefficient practice styles; as planning or reimbursement tool for new surgical interventions; by the medical community for professional training and education.

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).

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 avoid duplication of medical exams and ensures 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.

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 (0.15% and 0.19% in 2013) are close, though slightly below, to EU average (0.19% and 0.24% in 2013). The figures are below average when measured, as a % of total current health

rmationReports/Short_PPRI_PHIS_Pharma_Profile_Austria_2013_final.pdf.

([30]) 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.

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

expenditure (2.0% vs. 2.5% and 1.9% vs. 2.5% in 2013) ([32]).

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 (HiT). Doctors have to abide by the medical association's code of conduct ([33]), 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 reform 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 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.

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 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 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) will be gradually aligned with the expected average nominal growth of gross domestic product (plus 3.6% per year). In total, it was agreed by the regional governments (EUR 2.058 billion) and the social insurance institutions (EUR 1.372 billion) to contain expenditures by EUR 3.43 billion until 2016.

Thus, a contract between the federal government, social insurance and the states was signed to formalise both health and financial targets ("Bundes-Zielsteuerungsvertrag"). The contract 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. The key areas define 26 operative objectives together with actions and target measures. The contract will be updated in 2016 including adapted financial targets and a new budget cap.

In order to raise institutional capacity the "Federal Target-Based Governance Commission" has been established in 2013 as a new cooperative decision-making body. Since 2013 the "Federal Health Commission" together with 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". Based on the standards of the federal contract, also the "Provincial Target-Based Governance

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

Commissions" set up contracts between states and the social insurance funds to concretise the federal targets at the state level.

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. According to the monitoring reports, most of the federal states reached their financial targets in recent years.

Nevertheless, given that the estimated average nominal GDP growth of 3.6 % proved to be optimistic compared with the growth observed since 2013, expenditure caps will have to be revised downwards. As a consequence, compliance may turn out to be more difficult in the future, not least against the background of the full effects of an ageing population.

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 financial 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 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;

- 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).

Table 1.1.1: **Statistical Annex – Austria**

General context												EU- latest national data		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	231	242	253	266	282	292	286	295	309	317	323	9289	9800	9934
GDP per capita PPS (thousands)	31.0	31.9	31.7	32.8	33.4	33.1	30.9	32.0	32.6	33.4	33.2	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	0.4	1.9	1.7	3.1	3.4	1.1	-4.1	1.5	2.5	0.4	-0.2	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	2.4	3.2	1.6	1.1	3.8	3.4	2.1	1.1	0.1	2.5	-0.8	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	10.3	10.4	10.4	10.2	10.3	10.5	11.2	11.1	10.9	11.1	11.0	10.4	10.1	10.1
Total current as % of GDP	9.8	9.9	9.9	9.7	9.7	10.0	10.5	10.5	10.2	10.4	10.1	9.8	9.6	9.7
Total capital investment as % of GDP	0.5	0.5	0.6	0.5	0.5	0.5	0.6	0.7	0.6	0.7	0.9	0.6	0.5	0.5
Total per capita PPS	2650	2805	2915	2992	3172	3343	3478	3561	3633	3796	3821	2828	2911	2995
Public as % of GDP	7.7	7.8	7.9	7.7	7.8	8.0	8.5	8.4	8.3	8.4	8.4	8.1	7.8	7.8
Public current as % of GDP	7.4	7.5	7.5	7.5	7.5	7.7	8.1	8.1	7.9	8.0	7.7	7.9	7.7	7.7
Public per capita PPS	1848	1953	2033	2120	2238	2374	2444	2499	2780	2879	2895	2079	2218	2208
Public capital investment as % of GDP	0.3	0.3	0.4	0.3	0.3	0.3	0.4	0.3	0.4	0.4	0.7	0.2	0.2	0.1
Public as % total expenditure on health	74.6	74.7	75.3	75.6	75.8	76.4	76.2	75.5	76.5	75.9	75.8	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	14.8	14.1	15.2	15.5	15.4	15.8	15.6	15.5	15.4	15.3	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	98.0	98.0	98.0	98.5	98.7	98.8	98.8	98.8	99.9	99.9	99.9	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	16.3	17.9	17.8	17.4	17.3	16.9	17.0	17.2	16.9	16.7	15.8	14.1	14.4	14.1

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												**2009**	**2011**	**2013**
Population, current (millions)	8.1	8.1	8.2	8.3	8.3	8.3	8.3	8.4	8.4	8.4	8.5	502.1	504.5	506.6
Life expectancy at birth for females	81.5	82.1	82.2	82.8	83.1	83.3	83.2	83.5	83.8	83.6	83.8	82.6	83.1	83.3
Life expectancy at birth for males	75.9	76.4	76.6	77.1	77.4	77.7	77.6	77.8	78.3	78.4	78.6	76.6	77.3	77.8
Healthy life years at birth females	69.6	60.4	60.1	61.0	61.4	59.9	60.8	60.8	60.1	62.5	60.2	:	62.1	61.5
Healthy life years at birth males	66.2	58.3	58.2	58.7	58.7	58.5	59.5	59.4	59.5	60.2	59.7	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	71	56	54	52	48	47	45	43	96	97	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	4.5	4.5	4.2	3.6	3.7	3.7	3.8	3.9	3.6	3.2	3.1	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	3.44	3.45	3.46	3.42	3.38	3.48	3.66	3.65	3.57	3.66	3.44	3.13	2.99	3.01
Day cases curative and rehabilitative care	:	0.03	0.03	0.04	0.04	0.05	0.05	0.05	0.05	0.07	0.07	0.18	0.18	0.19
Out-patient curative and rehabilitative care	2.49	2.43	2.47	2.41	2.44	2.43	2.63	2.59	2.53	2.55	2.55	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.35	1.34	1.33	1.32	1.34	1.38	1.33	1.31	1.27	1.27	1.20	1.60	1.55	1.44
Therapeutic appliances and other medical durables	0.44	0.45	0.41	0.41	0.41	0.42	0.45	0.44	0.44	0.44	0.43	0.31	0.31	0.32
Prevention and public health services	0.17	0.20	0.20	0.19	0.19	0.19	0.19	0.19	0.18	0.18	0.19	0.25	0.25	0.24
Health administration and health insurance	:	0.43	0.41	0.39	0.39	0.41	0.43	0.42	0.41	0.42	0.38	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	2.94	2.97	3.00	2.98	2.96	3.06	3.24	3.24	3.17	3.27	3.01	2.73	2.61	2.62
Day cases curative and rehabilitative care	:	0.03	0.03	0.04	0.04	0.05	0.05	0.05	0.05	0.07	0.07	0.16	0.16	0.18
Out-patient curative and rehabilitative care	1.69	1.69	1.72	1.69	1.71	1.72	1.85	1.81	1.77	1.78	1.80	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	0.91	0.91	0.89	0.88	0.91	0.94	0.90	0.88	0.87	0.86	0.83	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.19	0.20	0.18	0.18	0.18	0.19	0.20	0.19	0.19	0.19	0.20	0.13	0.12	0.13
Prevention and public health services	0.15	0.17	0.17	0.17	0.17	0.16	0.16	0.16	0.16	0.15	0.15	0.25	0.20	0.19
Health administration and health insurance	0.22	0.24	0.25	0.22	0.23	0.24	0.25	0.25	0.24	0.23	0.22	0.11	0.27	0.27

Source: EUROSTAT, OECD and WHO

Table 1.1.2: **Statistical Annex - continued – Austria**

Composition of total as % of total current health expenditure	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	35.1%	34.8%	35.1%	35.1%	34.7%	35.0%	34.7%	34.8%	34.9%	35.2%	34.1%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	:	0.3%	0.3%	0.4%	0.4%	0.5%	0.5%	0.5%	0.5%	0.7%	0.7%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	25.4%	24.5%	25.0%	24.7%	25.1%	24.4%	25.0%	24.7%	24.7%	24.5%	25.3%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	13.8%	13.5%	13.5%	13.6%	13.8%	13.9%	12.6%	12.5%	12.4%	12.2%	11.9%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	4.5%	4.5%	4.1%	4.2%	4.3%	4.2%	4.2%	4.2%	4.3%	4.2%	4.3%	3.2%	3.3%	3.3%
Prevention and public health services	1.7%	2.0%	2.0%	2.0%	2.0%	1.9%	1.8%	1.8%	1.8%	1.7%	1.9%	2.6%	2.6%	2.5%
Health administration and health insurance	:	4.3%	4.2%	4.0%	4.0%	4.1%	4.1%	4.0%	4.0%	4.0%	3.8%	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	39.9%	39.8%	40.0%	40.0%	39.7%	39.8%	39.9%	40.1%	40.1%	40.7%	39.1%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	:	0.4%	0.4%	0.5%	0.5%	0.6%	0.6%	0.6%	0.7%	0.9%	0.9%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	22.9%	22.6%	22.9%	22.7%	22.9%	22.4%	22.8%	22.4%	22.4%	22.1%	23.3%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	12.3%	12.2%	11.9%	11.8%	12.2%	12.2%	11.1%	10.9%	11.0%	10.7%	10.7%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	2.6%	2.7%	2.5%	2.5%	2.4%	2.5%	2.5%	2.4%	2.4%	2.4%	2.6%	1.6%	1.6%	1.6%
Prevention and public health services	2.0%	2.3%	2.3%	2.3%	2.3%	2.1%	2.0%	2.0%	2.0%	1.9%	2.0%	3.2%	2.7%	2.5%
Health administration and health insurance	3.0%	3.2%	3.3%	3.0%	3.1%	3.2%	3.1%	3.1%	3.0%	2.9%	2.8%	1.4%	3.5%	3.5%

												EU- latest national data		
Expenditure drivers (technology, life style)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
MRI units per 100 000 inhabitants	1.35	1.59	1.62	1.68	1.77	1.80	1.84	1.86	1.86	1.91	1.92	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	0.9	0.9	0.9	0.9	0.9	:	:	:	:	:	:	0.9	0.9	0.8
CTS per 100 000 inhabitants	2.7	2.9	3.0	3.0	3.0	3.0	2.9	3.0	2.9	3.0	3.0	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.1
Proportion of the population that is obese	:	:	:	12.4	:	:	:	:	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	:	:	:	23.2	:	22.9	:	:	:	:	:	23.2	22.4	22.0
Alcohol consumption litres per capita	12.4	12.1	12.2	12.5	12.5	12.0	11.7	12.1	11.9	:	:	10.3	10.0	9.8

Providers	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Practising physicians per 100 000 inhabitants	411	420	432	445	454	460	469	480	484	490	499	329	335	344
Practising nurses per 100 000 inhabitants	720	713	718	727	738	752	761	767	775	783	787	840	812	837
General practitioners per 100 000 inhabitants	75	76	76	77	77	77	77	78	78	78	77	:	78	78.3
Acute hospital beds per 100 000 inhabitants	604	596	588	583	581	575	568	560	554	546	535	373	360	356

Outputs	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Doctors consultations per capita	6.7	6.7	6.7	6.7	6.8	6.9	6.9	6.9	6.9	6.8	6.8	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	26.6	27.4	27.3	27.7	27.9	28.1	27.8	27.6	27.3	27.0	26.6	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	4,132	4,294	4,487	4,834	5,113	5,457	5,501	5,690	6,018	6,348	6,595	6368	6530	7031
Acute care bed occupancy rates	85.0	88.0	86.0	87.0	87.0	87.7	86.9	86.2	85.5	82.7	80.2	72.0	73.1	70.2
Hospital curative average length of stay	7.2	7.2	7.0	6.9	6.8	6.8	6.7	6.6	6.6	6.5	6.5	6.5	6.3	6.3
Day cases as % of all hospital discharges	13.5	13.5	14.0	14.8	:	16.2	16.5	17.1	18.0	19.0	19.9	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060**	**EU Change 2013 - 2060**
AWG reference scenario	6.9	7.2	7.6	7.9	8.2	8.2	1.3	0.9
AWG risk scenario	6.9	7.4	7.9	8.5	8.8	8.9	2.0	1.6

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

Population projections	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060, in %**	**EU - Change 2013 - 2060, in %**
Population projections until 2060 (millions)	8.5	8.8	9.3	9.6	9.7	9.7	14.3	3.1

Source: EUROSTAT, OECD and WHO

Austria

Long-term care systems

2. LONG-TERM CARE SYSTEMS

2.1. AUSTRIA

General context: expenditure, fiscal sustainability and demographic trends

Austria, federal republic consisting of nine states ("*Bundesländer*"), and member of the European Union since 1995, has a population of about 8.5 million inhabitants, which accounts for slightly less than 1.7% of the EU population in 2013. With a GDP of more than EUR 300 billion (323 in 2013), or 33,200 PPS per capita it is also among the richest EU member states. Public expenditure on LTC was with 1.3% of GDP in 2012 low compared to other rich member states, but above average compared to the overall EU average of 1.0% of GDP.

Health status

Life expectancy at birth for both men and women in 2013 was 78.6 years and 83.8 years and lies above the EU average values (77.8 and 83.3 years respectively in 2013). Nevertheless, the healthy life years at birth are with 60.2 years (women) and 59.7 years (men) below the EU-average (61.5 and 61.4 respectively). At the same time the percentage of the Austrian population having a long-standing illness or health problem is slightly higher than in the Union as a whole (34.5% vs EU 32.5% respectively). The percentage of the population indicating a self-perceived severe limitation in its daily activities has been slightly decreasing in the last few years, going from 10.2 in 2004 to 9.7 in 2013, but is still higher than the EU-average of 8.7%.

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 0.78 million residents living with strong limitations due to health problems in 2013, an increase of 57% is envisaged until 2060 to around 1.22 million. That is a steeper increase than in the EU as a whole (57% vs. 40%). Also as a share of the population, the dependents are becoming a bigger group, from 9.2% to 12.6%, an increase of 38%, slightly higher than the EU average (EU: 36%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. 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 1.3 pps of GDP by 2060 (from 1.4% to 2.7%) ([343]). 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 2.8 pps of GDP by 2060, higher, with almost 200% than the EU average of 149%. Overall, projected long-term care expenditure increase is expected to add to budgetary pressure. Sustainability risks appear over the long run due to the projected increase in age-related public spending, notably deriving from long-term care and healthcare ([344]).

System Characteristics

Owing to the internal division of powers is the rule that all matters falling within the independent remit of countries which does not expressly refer to the Federal Constitution, legislation or by the implementation have been transferred to the Federal Government. Therefore, the field of social services was the responsibility of the states.

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 of Austria's federal structure, that provision for persons reliant on care throughout Austria should follow identical aims and principles. In this agreement the states are obliged for a minimum standard of long-term care services such as mobile care services, residential care

([343]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

([344]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.

facilities, part-time care services, short-term care services in residential care facilities, a case & care management.

Types of care

The Austrian system of LTC has a twofold design, consisting of cash benefits on the one hand, and publicly organised LTC services in kind on the other hand. The system of care provision is mainly based on three pillars. The first pillar provides the care allowances, the second pillar consists of measures to support carers and the third pillar consists of the care services.

Cash benefits As from the beginning of 2012 LTC cash benefits ("*Pflegegeld*"), originally introduced in 1993, fall within the sole competency of the federal state.

The benefit currently amounts to EUR 157.30 per month in level 1 (the lowest level), but may be as high as EUR 1,688.90 in level 7 (the highest level). ([345]) These cash benefits are intended to be used to buy formal care services from public or private providers or to reimburse informal care giving. However, it is not being controlled for what purposes LTC benefits are actually used by the benefit recipients.

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, the 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 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 ([346]) in accordance with the Home Care Act *(Hausbetreuungsgesetz),* a maximum amount of EUR 550 per month (when two self-employed carers are deployed) or EUR 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

([345]) Stand: 26 August 2014.

([346]) 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 EUR 2,500 net per month, excluding benefits. Assets are not taken into account. Increases of EUR 400 for every family member who is dependent or entitled to maintenance, and by EUR 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.

in cover expenditure for long-term services and facilities, alongside supporting in the provision of benefits.

The Long-term care fund, established in 2011 and managed by the Ministry of Social Affairs, supports the states and local authorities in the field of long-term care in the safeguarding and improvement of adequate care for dependent people and their families with responsive and affordable care services.

The Long-term care fund, adopted in 2011, is a significant step forward in the harmonisation of long term care services. The long-term care fund, for the years 2011 to 2016, amounts to a total of EUR 1,335 billion. An increase of EUR 700 million has been proposed for 2017 and 2018, currently under negotiation between the federal government and the states.

In addition, the states are responsible for the delivery of institutional inpatient, ambulatory, semi-outpatient and outpatient (i.e. at-home) care services. These services are de facto implemented in cooperation with municipalities and non-profit organisations of the so-called intermediary sector, i.e. social NGOs of different types.

Role of the private sector

Services are being provided by municipalities and non-profit organisations of the so-called intermediary sector, i.e. social NGOs of different types. The role of private providers in the provision of publicly guaranteed LTC provision is unknown. At the same time 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 LTC system no definition of "need of care" exists, but eligibility requirements for cash allowances partly could be seen as a substitute for such a definition. The assessment of the need for LTC is rather based on individual requirements for personal services and assistance. The need for both personal services and assistance is required in order to qualify for federal or provincial LTC allowances.

Needs assessment is based on a doctors' expert opinion. Representatives of other fields (e.g. nursing) are also brought in 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 LTC 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 LTC 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 Federation of Austrian Social Insurance Institutions 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 LTC benefits in-kind and LTC services is in principle not free of charge. Here, means-testing applies, where all kinds of personal income, including LTC cash benefits and assets (which may get capitalised), are taken into account.

LTC 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 are 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 to 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 established. 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 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 supporting the possibility for individual choice.

Recently legislated and/or planned policy reforms

The Working Group on Long-term Care Reform, which was 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 the usually 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 claim under certain conditions care leave benefits (certain level of LTC benefit of the family member in need of care, employment contract lasts since at least three months - comprehensive insurance). A close family member may draw 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 LTC 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 (no LTC benefit necessary) the care leave benefits can be drawn for up to six months (basically 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 the (no LTC benefit necessary) care leave benefits can be drawn for up to nine months (basically five months with the possibility of prolongation up to nine months).

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

In the context of the quality assurance of home care the situation of care-giving relatives has been evaluated 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. On the basis of population ageing and the increasing life-expectancy is foreseeable that the number of –people suffering from dementia will increase. Therefore, the Federal Government, in its current work programme, is prioritising the development of a dementia strategy *"demenzstrategie"*.

The first step towards the strategy was the 2014 report on dementia, *"Österreichische Demenz-bericht 2014*", based on research carried out by the Austria's leading health care company GmbH AHC, on behalf of Ministry of Social Affairs and Health. The report constitutes the status quo as regards the supply situation of people with dementia impairments and provides epidemiological key messages on the prevalence of dementia in Austria.

The technical work has been carried out by 6 working groups in a participative process, emphasising the importance to 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 21 recommendations reflect 7 main targets:

- involvement and empowerment of affected;
- develop width and target-group specific information;
- knowledge and skills;
- uniform conditions;
- ensure offers of dementia care;
- develop coordination and cooperation;
- quality assurance and improvement through research.

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

The future of LTC 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 LTC 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 LTC insurance and clearly stated that LTC services should remain tax-financed. Furthermore, the currently existing model of a combination of universal cash benefits and (means-tested) LTC 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.

The financing of the current LTC system appears to be safeguarded for the next three years, partly due to the decision to prolong the Long-term Care Fund until 2016. After that, given the rising demand, additional funds will have to be made available. But the degree to which economic resources for LTC will be raised will then again be subject to negotiations between the federal government and the states. Negotiations on the budget redistribution between the federal government and the states, including in the area of long-term care, are currently taking place for the period 2017-2021.

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. ([347]) 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.

Challenges

Austria has a relatively fragmented system of LTC, 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 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.

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

- **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.

- **To facilitate appropriate utilisation across health and long-term care:** 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 2.1.1: **Statistical Annex – Austria**

GENERAL CONTEXT

GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	231	242	253	266	282	292	286	295	309	317	323	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	31.0	31.9	31.7	32.8	33.4	33.1	30.9	32.0	32.6	33.4	33.2	26.8	27.6	28.0	28.1	27.9
Population, in millions	8.1	8.1	8.2	8.3	8.3	8.3	8.3	8.4	8.4	8.4	8.5	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	1.0	1.0	1.0	1.0	1.0	1.1	1.2	1.2	1.2	1.3	:	1.0	1.0	1.0	1.0	:
Per capita PPS	272.2	285.5	291.8	312.3	321.0	339.9	363.2	388.2	401.0	413.2	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	1.9	2.1	2.1	2.1	2.2	2.3	2.3	2.4	2.4	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	81.5	82.1	82.2	82.8	83.1	83.3	83.2	83.5	83.8	83.6	83.8	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	75.9	76.4	76.6	77.1	77.4	77.7	77.6	77.8	78.3	78.4	78.6	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	69.6	60.4	60.1	61.0	61.4	59.9	60.8	60.8	60.1	62.5	60.2	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	66.2	58.3	58.2	58.7	58.7	58.5	59.5	59.4	59.5	60.2	59.7	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	21.9	21.9	21.9	23.9	32.3	31.8	34.8	34.1	33.1	34.5	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	10.2	10.2	9.4	10.2	10.3	9.7	9.5	9.7	9.6	9.7	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	19	42	66	89	91	93	74	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	87	116	145	174	177	179	166	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	1.3	1.9	2.5	3.2	3.2	3.2	2.8	2.0	2.2	2.2	2.3	2.1
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	:	247	:	290	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Sources: EUROSTAT, OECD and WHO

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

PROJECTIONS

Population	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**MS Change 2013-2060**	**EU Change 2013-2060**
Population projection in millions	8.5	8.8	9.3	9.6	9.7	9.7	15%	3%
Dependency								
Number of dependents in millions	0.78	0.86	0.97	1.09	1.20	1.22	57%	40%
Share of dependents, in %	9.2	9.7	10.5	11.3	12.3	12.6	38%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	1.4	1.5	1.8	2.1	2.5	2.7	91%	40%
AWG risk scenario	1.4	1.6	2.1	2.7	3.5	4.2	199%	149%
Coverage								
Number of people receiving care in an institution	74,043	82,275	100,481	120,703	149,263	160,157	116%	79%
Number of people receiving care at home	165,851	183,653	216,191	252,896	295,172	304,786	84%	78%
Number of people receiving cash benefits	458,254	513,479	617,720	734,274	877,573	920,906	101%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	8.2	8.8	10.1	11.5	13.6	14.3	74%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	90.0	90.9	96.1	100.0	100.0	100.0	11%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	37.7	37.2	37.8	38.3	38.9	39.5	5%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	62.3	62.8	62.2	61.7	61.1	60.5	-3%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	73.4	73.4	73.7	74.0	74.5	75.1	2%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	26.6	26.6	26.3	26.0	25.5	24.9	-7%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	44.9	44.3	45.3	46.3	47.0	48.7	9%	-2%
Unit costs of home care per recipient, as % of GDP per capita	7.3	7.2	7.5	7.8	8.1	8.5	16%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	16.3	16.3	16.5	16.6	16.9	17.3	6%	-2%

Sources: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".