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1 Executive Summary

Overall, it appears that pension issues during the last years only got debated more intensely by the most important decision makers in office when they were constrained to do so for reasons for short- to mid-term financial sustainability. The latter holds for the reforms of early retirement "due to very long insurance periods" (i.e. of the so-called "Hacklerregelung"), and the reform of invalidity pensions, both decided in late 2010, and as well for the rather encompassing list of measures decided in early 2012 within a so-called "consolidation package", following the aim to consolidate public budgets. Some of the most important measures regarding pensions within this "consolidation package" are beyond standard indexation of pension benefits in 2013 and 2014, tightening access to early retirement according to the so-called pensions corridor, a partial reform of part-time allowance for older workers and different reform steps regarding invalidity pensions. Overall, these measures follow two main goals: cost containment on the one side and increasing the actual retirement age on the other side, both being the topics most widely discussed in Austria in respective debates during recent years. Currently, further reforms are discussed within the current coalition negotiations between the Social Democratic Party (SPÖ) and the Peoples' Party (ÖVP), taking place after the national elections of September 2013. Both of them in principle agreed to maintain silence on the content and outcomes of negotiations until all chapters of the coalition pact are completed. However, some issues discussed were made public. It is planned to retrench very high pensions deriving from special schemes (like the one of the Austrian National Bank, the Austrian Federal Railways, the Social Insurance Providers or for former politicians) to some degree via a constitutional bill. Furthermore, according to media reports, the ÖVP proposed to bring forward the alignment of the statutory retirement age of women towards the one of men by some years. However, up to now the SPÖ continues to reject such plans. The negotiations on the coalition agreement may as well enclose other issues regarding pensions, but no respective statements have been made publicly.

A number of other challenges evident within the policy area of pensions have not or only rudimentarily been addressed over the last years, both in terms of debates and actual measures decided. This holds true, for example, for the question of adequacy of minimum pensions (in terms of poverty prevention), for questions of the (rather low) intragenerational distributional impact of the pension system and regarding high gender differences in benefit levels..

A related development has for a long time been evident concerning health care. Here, debates and reforms until recently had their focus on financial sustainability, whereas at the same time it appeared that decision makers largely took it for granted that the Austrian health system guarantees a high degree of accessibility and high quality services. It is fair to say that reforms decided in 2009 and implemented during 2010 and 2011 were rather successful in improving the financial situation of the health insurance providers, of which some were said to be close to bankruptcy in 2008. However, for a long time hardly any progress was made regarding another long-standing challenge within the Austrian health system: the very complex structure of decision-making and financing that is supposed to result in substantial inefficiencies, especially regarding the hospital sector. A new attempt to deal with respective challenges has been made with the recent "Health Reform 2012/2013" (*Gesundheitsreform 2012/2013*). Apart of some more or less concretely defined goals, this reform at first instance comprises institutional and procedural reforms, where it has to be awaited if and to what degree they really achieve the intended effects. The reform comes with a new structure of "joint planning and responsibility", were both at the national level and at the level of the federal provinces representatives of the national state, the federal provinces and the health insurance providers

are represented in joint commissions, responsible for planning in the health sector and quality assurance. These commissions develop and decide on one national and nine regional (i.e. addressing reforms at the level of the federal provinces) "target-management contracts" *("Zielsteuerungsverträge")*, enclosing infrastructure development, quality assurance and financing. Regarding financial sustainability, the different institutions involved agreed on a model where increases in health expenditure should not surpass the expected growth of nominal GDP. Independent experts on health care in their appraisal of the health reform 2012/2013 come to different conclusions. Some argue that it lacks concrete measurable and at the same time ambitious goals. Others stress that it at least comes with a significantly increased transparency of planning in health care. Furthermore, they argue that actual reforms implemented according to the Regional Target-Management Contracts over the next three years may – at first sight – be of the type of "small steps reforms" only, but that these projects may lead to a process of more structural reform in the future.

Political discourse on questions of long-term care gained some increased public visibility during the recent years. The initial background was a discussion about organisational features of the system of long-term care cash benefits which started by late 2010, and problems with short-term financial sustainability regarding intramural and extramural social services, to be organised and financed by the nine federal provinces. The result was a (overall not very broad) reform package, decided in spring 2011. Hereby, all competencies regarding cash benefits were bundled at the level of the central state and a "long-term-care fund" was introduced to safeguard the financing of respective social services until 2014. Within the consolidation package of 2012, the latter instrument was expanded until 2016 (by assigning additional funds). It is fair to say that these measures at first instance aimed at prevailing the status quo (even in times of tight budgets), but that, at the same time, they failed to address more structural problems of the Austrian LTC system. A working group has been installed to come up with new proposals for a more structural reform of LTC back in earlier 2011 and presented its results by the end of 2012. The suggestions made are not very concrete regarding a number of issues, which especially holds for the point of a structural organisational reform, asking for more harmonization, but stating that this goal should be met via instruments of soft governance at first instance (increased information on the status quo, common goals on service supply and quality management, increased monitoring and evaluation etc.). Furthermore, the working group did not provide new models for public financing of long-term care. It only agreed that financing should come from general tax revenue, whereas it rejected the idea of a long-term care insurance, as this would lead to a further increase of non-wage labour costs. Overall, question of future organisation of long-term care is on the agenda to some degree, and the reform working group with its report at least helped to put some problems on the table. However, it is unclear if this will have a substantial effect on future developments in the field. Here, the most important retarding force, namely a fragmentation of competencies and accountability remains to be in place. This means that the implementation of the different suggestions made by the reform working group again depends on negotiations between the different stakeholders involved. Furthermore, if none of them takes over a kind of leading role, then it is very unlikely that respective reform procedures really gain momentum.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

The history of the Austrian pensions system comprises more than 100 years of mostly path-dependent development. The first milestone was the introduction of public old-age pensions for white collar employees of the private sector, introduced in 1909. Draft bills for other introduction of old-age pensions for a number of other professional groups where decided during the 1920s, but de facto not implemented until the Nazis took over power in 1938 and Austria got part of the German Reich. In 1939 the German Rules on Social Insurance got introduced in the former Austrian territory, among other introducing old-age pensions for blue collar workers. After WWII, for the time being many German regulations concerning social policy remained in place, however in conjunction with a number of important “Austrifications”, codified within the so-called Social Insurance Transition Act (*Sozialversicherungs-Überleitungsgesetz 1947*). Thereby important steps of adaptation were for example the re-introduction of so-called “self-government” within providers of social insurance and the establishment of the Main Association of Austrian Social Security Institutions (*Hauptverband der Sozialversicherungsträger*), since serving as a co-ordinating governance institution in the area of pensions, health insurance and accidents insurance. In 1956, the General Social Security Act (Allgemeines Sozialversicherungsgesetz/ASVG) replaced the previously valid laws in the field of social security. It covers health, work accident and pension insurance for blue- and white-collar workers in industry, mining, commerce and trade, transport, agriculture and forestry, and it also regulates health insurance for pensioners. Pension insurance for self-employed (except of farmers) got introduced in 1957, old-age benefits for farmers got stepwise expanded as from 1958, with pension insurance comparable to other professions decided in 1969 (and implemented as from 1971).

Since the 1980s, the pension system underwent several reforms. The reforms of 1985 and 1988 aimed at general cost-containment, e.g. by making the benefit formula less generous (see e.g. Mairhuber 2003). The reforms of the 1990s (1992, 1993, 1996, 1997) generally pointed towards the same direction. One important alteration deriving from the reforms 1992/1993 which is still in place is the stepwise increase of the statutory retirement age of women from 60 to 65 years, to be implemented stepwise between 2024 and 2034. Further reforms were decided in 2000, 2003 and 2004 (see e.g. Mairhuber 2003; Fink 2009 and Knell et al. 2006), enclosing an abolition of specific types of early retirement and aiming at mid- to long-term cost containment via more structural reforms and harmonization of pensions of civil servants towards other old-age pensions. Later reforms were of gradual nature, at first instance trying to reduce inflow to different forms of early retirement and invalidity pension.

2.1.2 System characteristics

The by far most important source for the provision of retirement income in Austria is the so-called “statutory pension system” (“*Gesetzliche Pensionsversicherung*”), which is the first pillar of the Austrian pension system (see e.g. BMASK 2012b, 29ff.). It provides old-age pensions, surviving dependents’ pensions, as well as invalidity pensions. Schemes of the second and third pillar are occupational pensions based on works agreements, the so-called “new severance pay scheme” and private savings, where public subsidies are available within

a scheme called "premium-aided pension savings scheme". However, schemes of the second and third pillar have a rather limited role in overall provisions (see below for more details).

Today, the statutory pension system includes, in principle, all people in gainful employment[1] (including most categories of self-employed), with the exception of civil servants, who have traditionally been covered by their own systems. However, under the Act on the "Harmonisation of Austrian Pension Systems", which took effect on 1 January 2005, uniform pension laws were created for all gainfully employed people, including federal civil servants.[2]

Financing

The Austrian statutory pension system is an earnings-related unfunded scheme, organised on a PAYG-basis and at first instance financed by insurance contributions, amounting to 22.8% of gross earnings of employed persons (of which 10.25% to be covered by the jobholder and 12.55% by the employer). For self-employed persons and farmers reduced contribution rates apply, currently amounting to 18.5% and 16.5% respectively. Insurance contributions only have to be paid for earned income up to an upper-earnings limit, currently amounting to a monthly gross earning of EUR 4,440.00 per month.

Although the statutory pension system is at first instance financed from insurance contributions, tax-financed funds play some role as well. According to the so-called "deficiency guarantee", the federal state has to finance pension spending from the general budget if respective outlays are higher than revenues from insurance contributions (which is always the case). Furthermore, there are rules in place stipulating that outlays for some specific elements of the statutory pension system are to be covered by the general budget. Here, the by far most important matter of expense is the so-called "equalisation supplement", which serves as a kind of minimum pension (see below).

In 2012, the overall share coming from the federal budget (so-called "*Bundesbeitrag*") amounted to about EUR 8.323 billion, which equals approx. 2.7% of GDP or 23.3% of overall spending on pensions (i.e. old-age pensions, invalidity pensions and surviving dependants' pensions).[3]

Calculation of benefits and minimum pensions

The formula for the calculation of benefits underwent rather large-scale reforms in the early 2000s (decided in 2001, 2003 and 2004; see e.g. Fink 2009 and Knell et al. 2006 for a more detailed assessment). These reforms are subject to a number of different transitional arrangements, but from a mid-term perspective, the effect will be a largely linear benefit formula (however subject to a lower and upper ceiling). With these reforms, the contribution base to be taken into account was expanded from the "best" 15 years to lifetime earnings. Apart from that, the accrual rate was reduced from 2% to 1.78% per year. The maximum replacement rate of 80% of the assessment base will be reached after an insurance history of

[1] Employees with wages below the so-called marginal earnings threshold (currently EUR 386.80 per month gross) may opt into the old-age insurance on a voluntary basis.

[2] This means that pensions for newly employed federal civil servants are calculated according to the same regulations as those of other persons (for those being younger than 50 in the year 2005, pension entitlements are calculated as a mix of old and new provisions on a pro rata temporise basis, while those older than 50 were exempted from the new system). Furthermore, it should be noted that the federal provinces (*Bundesländer*) run their own systems for their civil servants. However, most federal provinces enacted related reforms during recent years as well, aligning respective regulations towards the rules in place in the normal "statutory pension system". Exceptions are the federal provinces of Vienna and Tyrol, where aims for a harmonisation of the schemes for public servants have been very limited, which was e.g. criticised by the Austrian Court of Auditors in his 2011 report on progress made within "administrative reform" (Rechnungshof 2011, 139ff.).

[3] Source: Hauptverband der Österreichischen Sozialversicherungsträger (2013a, 119) and own calculations.

45 years, instead of 40 years before the reform. This means that benefits are, as a basic principle, granted as a percentage of the earlier contributory income from work (calculated as an average contributory income – the so-called contribution base). The benefit is the higher, the longer the insurance record, and the higher the preceding contributory income from gainful employment.

However, these regulations (so-called "new law") are only fully applied to those who had acquired less than 36 insurance months within old-age insurance before 1 January 2005. For other groups, benefits are calculated as a mix of old (so-called "old law") and new provisions on a pro-rata temporise basis (so-called "parallel calculation"), whereby different regulations apply for different age groups. Furthermore, a rather complicated rule applies for "capping" the losses that derive from the above mentioned reforms, which makes things even more complicated (see Fink 2010 for a more detailed assessment). In 2011 it got decided that the rather complex model "parallel calculation" of pension benefits according to "old" and "new" law will get abolished as from 1 January 2014. Instead, all existing insurance periods are planned to be transferred to a so-called "pension account credit" (*Kontogutschrift*) according to "new law". This will not lead to major changes in benefit levels (see below Chapter 2.1.3), but followed the aim to increase the transparency of the system. However, the transfer from "parallel accounting" towards the "pension account credit" itself is again a rather complicated and for most people likely to be a rather inscrutable procedure.

It is worth noting that the reforms of the early 2000s did not only include measures leading to a retrenchment of benefits, but also some elements intended to soften the possible negative consequences of the pension reforms, especially for women, in the first instance deriving from the extension of the assessment base from the "best" 15 years to lifetime earnings, and to compensate for the disadvantages of women on the labour market to a certain extent. The minimum number of contribution years due to gainful work required for an old-age pension was reduced to seven years (formerly 15 years), and times spent for bringing up children, which are credited as pensionable years, were raised from two years to four years per child. Furthermore, the assessment base for times spent with bringing up children was raised from EUR 650 per month to EUR 1,350 per month (2011: EUR 1,560.98; 2012: EUR 1,570.35; 2013: 1,614.32).

The Austrian statutory pension system does not provide for an unconditional minimum pension for persons beyond a certain age. However, the so-called "means-tested equalisation supplement" ("*Ausgleichszulage*") may - on a partly means-tested basis - apply for persons who are, in principle, eligible to a pension entitlement. This means that pensions of low benefit level may be raised to the so-called "equalisation supplement reference rate" in case of financial indigence. Thereby, apart from the pensioner's income, the income of spouses or partners is taken into account (but not assets). The overall net yearly equalisation supplement reference rate (taking into account insurance contributions for health insurance) currently amounts to EUR 11,129 for singles and to EUR 16,686 for couples. Furthermore, a supplement of currently EUR 129.24 per month is granted per child.

Maximum levels of pensions are indirectly stipulated via the upper earnings limit for insurance contributions (see above), where income above this limit is not subject to insurance contributions, but which is at the same time also not taken into account as contributory income for calculating pensions. In 2012, the maximum pension from the statutory pension

system amounted to EUR 3,034.16 per month (gross; 14 times per year[4]), which equals a yearly net pension of EUR 30,791.38.[5]

Indexation and taxation

Pension benefits in Austria are – in principle – indexed according to the so-called pensioners' price index, applying a specific market basket, but decisions are frequently taken within legislature to index pensions according to a model which is only indirectly linked to the pensioners' price index, leading to different levels of indexation for different benefit levels.

Pensions in Austria are subject to income tax, with the same tax brackets applying as for income from gainful employment. Furthermore, pensioners have to pay social insurance contributions for health insurance, amounting to 5.1% of their pension benefits.

Retirement age and early exit pathways

The statutory retirement age is 65 for men and 60 for women, with the latter planned to be gradually raised as from 2024, also reaching 65 years in 2033.

Austria shows a rather long and vivid history of different schemes of early retirement. Early retirement due to "reduced capacity to work" and "on account of unemployment" was abolished under the reforms of 2000 and 2003. However, other forms of early retirement are still in place, both according to "old law" and according to "new law".

One form of early retirement according to "old law" is "early retirement on account of long-term insurance contributions" ("*vorzeitige Alterspension bei langer Versicherungsdauer*"). Here, decided as part of the reform 2003, the minimum retirement age is subject to stepwise increase until 2017, up to the statutory retirement age. In July 2012 the minimum age for this form of early retirement is 63 years and 8 months for men, 58 years and 8 months for women. With the reform of 2003, deductions for each year of early retirement have been increased from 3.3% of the benefit to 4.2%. However, this increase of deductions is subject to a "capping" of losses, which in specific cases may lead to somewhat lower actual deductions (see Fink 2010 for more details). For a long time, this scheme used to be the most popular form of early retirement in Austria. In December 2000, no less than 132,167 individuals obtained a benefit according to this scheme, but due to the following reforms, the respective number decreased to 18,331 in December 2010, to 14,811 in December 2011 and then further to 10,720 in December 2012.[6]

One other form of early retirement (again according to "old law") is "pensions subject to very long insurance periods" (so-called "*Langzeitversichertenregelung*" or "*Hacklerregelung*"). Within this scheme, men used to have the opportunity retire without deductions (!) as from the age of 60 and women as from the age of 55 if their insurance periods totalled 45 contributory years (men) or 40 contributory years (women), respectively. This form of early retirement has gained increased popularity over the last years, with the number of individuals receiving such a pension rising from 11,494 in December 2006 to 83,988 in December 2010 and then further to 89,147 in December 2011. Only recently the respective number declined to some minor degree, to 88,763 in December 2012. This scheme was originally planned to expire in 2010, but was then - within the scope of the *Sozialrechtsänderungsgesetz* 2008; BGBl. Nr. I XX/2008 - decided to be prolonged by three years, i.e. until 2013. However, debates on the subject continued and, in October 2010, a new reform of the *Hacklerregelung* was presented, which at the same time prolonged the instrument for some more years. Hereby,

[4] Pensions (same as salaries and wages) are paid out 14 times per year in Austria.

[5] But it should be stressed that retired public servants subject to "old law" may be granted much higher pensions.

[6] Data source: Hauptverband der Österreichischen Sozialversicherungsträger.

the first measure implemented (from 2011) was that prices for post-purchasing of contributory times - for periods of school and university studies - were raised considerably. The other measure of the respective reform will only get applicable as from 2014:

- The entry age will be raised by two years as from 2014, i.e. from 60 to 62 for men and from 55 to 57 for women. Furthermore, the entry age for women born after 1 January 1959 will be increased stepwise to 62 years as from 2014 (the entry age of 62 years for women will be in place as from the year of 2027) and women born after 1 January 1959 will, as men currently, have to have an insurance record of at least 540 months of contribution (previously: 480 months of contribution).
- As from 2014, the number of constellations which may count as “substitutional insurance times” (*Ersatzzeiten*) will be substantially reduced. Then, only times spent within military service and/or alternative service [in lieu of military service] (up to 30 months) and times for raising children (up to five years) will be credited as *Ersatzzeiten*. Other options now existing will be abolished. These options are: post-purchasing of contributory times for periods of school and university studies, times where people obtained sick pay (*Krankengeld*), times of voluntary insurance, times of “prolonged insurance” (*Weiterversicherung*) of recipients and unemployment benefit and unemployment assistance and times of obtaining unemployment benefit and unemployment assistance (which currently counts as *Ersatzzeit* for women born after the 1 January 2005).
- Furthermore, pensions according to the *Hacklerregelung* will be subject to yearly deductions of 4.2% per year of early retirement (again as from 2014).

Although the overall aim of the pension reforms of the early 2000s was cost containment, the “new law” (as formulated by the pension reform 2004) has actually introduced new forms of early retirement.

One is the so-called “heavy labour pension” (*Schwerarbeiterpension*), which effectively came into force on 1 January 2007. It allows for retirement at the age of 60 for men and women[7], subject to a deduction of 4.2% for each year of retirement prior to the regular pension age for benefits calculated according to “old law” (with a maximum ceiling of 15%), and of 1.8% per year for benefits calculated according to “new law”.[8] The general prerequisite is that insurance periods total 45 years and that out of the last 20 years before retirement at least 10 years were spent working in jobs defined as heavy labour, the definition of which is determined according to detailed criteria. This form of early pension is only of minor significance up to now, but the number of people receiving such a pension is steadily growing. In December 2010, a total of 2,395 obtained an early retirement according to this scheme, 3,227 in December 2011 and 3,732 in December 2012.

The second option under the “new law” is the possibility of early retirement through the establishment of a pension corridor (at the age between 62 and 68 years), with deducts/credits 4.2% of the respective benefit per annum. Here, the entitlement originally has been restricted to persons with at least 37.5 years of pensionable service. In 2012 it got decided to increase this threshold to 40 years. This pension corridor is intended to substitute the “early retirement on account of long-term insurance contributions” (which will be completely abolished by 2017; see above). However, this form of early retirement may, in fact, be used together with early retirement according to “old law”, i.e. “early retirement on account of long-term

[7] However, this form of pension is de facto only used by men, as the general statutory retirement age for women is 60 years anyhow.

[8] For individuals who acquired at least 36 insurance months within old age insurance before 1 January 2005 benefits are calculated as a mix of “old” and “new” provisions on a pro rata temporis basis, whereby different regulations apply for different age groups.

insurance contributions". In this case, special deductions apply, which are calculated according to very complicated regulations, with different deductions for benefits calculated according to "old law" and "new law". Currently this form of early retirement may evidently be of interest to men only, as the actual statutory retirement age for women of 60 years lies below that threshold. In December 2010, a total of 10,378 persons obtained a corridor pension, 12,810 in December 2011 and 14,180 in December 2012.

Apart from these options of early retirement in old-age pension, it is worth mentioning that invalidity pensions increasingly tend to serve as a substitute for other forms of early exit from the labour market (see subsequent chapters of this report for more details). This subject has been on the political agenda in Austria for several years, and as from 2010 several decisions were taken to modify access to invalidity pensions (see below Chapter 2.1.3).

2.1.3 Details on recent reforms

First, recent reforms dealt, as already sketched out above (Chapter 2.1.2), with a modification of access to early retirement via "pensions subject to very long insurance periods" (so-called "*Langzeitversichertenregelung*" or "*Hacklerregelung*"). Decided already in 2010, the measures expected to have the highest impact on tightening access to this form of early retirement will only get implemented as from 2014.

A second area of increased reform activity was the one of invalidity pensions. A first reform, as well decided in 2010, got implemented as from 2011. The most important measures were the introduction of mandatory rehabilitation measures before granting an invalidity pension, and changes in regulations on so-called "vocational protection" (*Berufsschutz)*, whereby access to invalidity pensions was somewhat tightened for white-collar employees and skilled workers. But at the same time access to invalidity pension was somewhat eased for unskilled workers within a special new scheme called "hardship provision" (*Härtefallregelung*), which is, however, planned to expire again in 2015 (see Fink 2011 for more details). This reform did not lead to an overall reduction of the number of invalidity pensions in 2011, but the increase of the number of people obtaining such a pension could be somewhat reined when compared to earlier years. In December 2010 a sum of 209,431 persons received an invalidity pension and in December 2011 the respective number was 211,144.

In February 2012, as part of a "budget consolidation package", the government again announced a reform of invalidity pensions, leading to further tightening of access to respective benefits. Some measures decided got implemented as from January 2013; others will only get implemented as from January 2014. The most important steps decided are:

- Invalidity pensions may only be granted in case of enduring inability to work, and not in case of temporary inability to work. Instead, the PES (Public Employment Service; *Arbeitsmarktservice*) will have to deal with this group, which will then have access to a so-called "rehabilitation benefit" instead of invalidity pension. This reform will not directly lead to a reduction of public spending, given the additional costs for rehabilitation measures and the fact that the rehabilitation benefit is of the same level as the invalidity pension. However, indirect cuts in public spending are envisaged due to longer economic activity and later retirement, which are the main goals of this measure. The replacement of invalidity pensions by rehabilitation benefit applies for all persons who have not reached their 50th birthday on 1.1.2014. This means that only the cohort then already in the age of 50 years or older is exempted from this reform.
- According to a specific clause in the rules on "vocational protection" (*Berufsschutz)* people having reached a specific age may be granted access to invalidity pension if they become unable to perform the occupation that they were engaged in for at least ten years

during the last 15 years. Here, only “reasonable occupational changes” have to be accepted by individuals and in 2010, about 43% of all new cases of invalidity pensions in the age above 55 years applied due to this regulation. Now, it has been decided to increase the minimum age level of access to invalidity pension according to this clause stepwise: from 57 years in 2012 to 58 years as from 2013, to 59 years in 2015 and then further to 60 years as from 2017. It is envisaged that this will lead to a reduction in public spending of an amount of EUR 464 million between 2012 and 2016.

- Up to recently, people applying for an invalidity pension were granted a “pension advance” (*Pensionsvorschuss*) while their application was examined by the responsible authorities. As from 1 January 2013, such a pension advance may only be granted after the completion of the relevant medical examinations and a respective decision stating incapacity to work. Instead of the pension advance, respective persons may in future have access to unemployment benefit, unemployment assistance or to benefits from GMI (Guaranteed Minimum Income, which replaced Social Assistance as from 2010/2011). As respective benefits are lower than the pension advance in most cases, it is estimated that this reform will lead to reduction of public spending amounting to EUR 309 million until 2016.

Other recent reforms, as well decided as part of the “budget consolidation package” presented in 2012 are (see as well Fink 2012):

- Beyond standard indexation of pension benefits in 2013 and 2014 (envisaged spending cuts: EUR 2.56 billion until 2016).
- Tightening access to early retirement is the so-called pensions corridor (see above): in future 480 instead of 450 months of pensionable service will be needed to enter early retirement via this scheme (envisaged spending cuts: EUR 509 million until 2016).
- The complicated model of “parallel calculation” of pension benefits according to “old” and “new” law (introduced with the pension reforms of the early 2000s; see above and Fink 2009) got decided to be abolished as from 1 January 2014. Instead, all existing insurance periods are planned to be transferred to a so-called “pension account credit” (*Kontogutschrift*) according to “new law”. This goes ahead with an extension of the assessment base and a lower accrual rate (when compared to the impact of insurance times according to “old law” within the modus of parallel calculation), which could lead to a substantial reduction of future benefits. However, it was decided to mitigate this effect via higher valorisation of “old” insurance records and losses deriving from the change from “parallel calculation” towards the “pension account credit” are capped at a maximum 3.5% (for the reference date of 1 January 2014; for older people even more strict capping is planned). Cost containment effects of this measure are likely to be more substantial “only” in the medium and long-term. Envisaged spending cuts deriving from this measure only amount to a sum of EUR 123 million until 2016.
- Until the end of 2012, older workers (from the age of 60) were exempted from paying social insurance contributions to unemployment insurance. In spring 2012 the government decided to abolish respective exemptions from paying insurance contributions as from 1 January 2013 for all new cases. It was expected that this will lead to additional revenues amounting to a sum of EUR 303 million until 2016. In a related way, the earlier existing exemption from paying unemployment insurance contributions already from the age of 58 got suspended in summer 2011.
- It as well was decided to increase the social insurance contributions of self-employed and of farmers within old-age pension, resulting in additional public revenues amounting to EUR 554 million until 2016.

- Furthermore, the upper earnings limit up to which social insurance contributions have to be paid for income from gainful employment – apart from regular indexation – got raised by an additional amount of EUR 90 in 2013. It was estimated that this would imply to additional revenues of EUR 218 million in the pension system until 2016, and additional EUR 53 million within the unemployment insurance.
- The third pillar of the Austrian pension system was as well been affected by the consolidation package. Within the "premium-aided pension savings scheme" (*Prämienbegünstigte Zukunftsvorsorge*) public subsidies have been cut by about 50% as from April 2012. This measure is of temporary nature, meaning that public subsidies will eventually be increased again after 2016. Savings in public spending were estimated to amount to a sum of ca. EUR 172 million until the end of 2016.
- Within the consolidation package, it got as well decided to introduce a model of ex-ante taxing of funded company pension schemes ("*Pensionskassen*"). Hereby, insured persons, people who already receive a respective benefit, or who will have access to such benefits in the next five years, were offered the option for a reduced ex-ante taxing of their accumulated funds in 2012. Hereby, the tax rate only amounted to 50% of the normal income tax rate applying under other conditions. This increased further net benefits within the respective schemes (due to overall lower taxation), and at the same time it was expected that in 2012 additional revenues for the public budget would amount to approx. EUR 900 million. However, this model also implied that future revenues for the state from income tax will be lower than under normal taxation, which e.g. has been criticised by the Green party in opposition, stating that "future tax revenues are […] sold at a dumping price".[9] In the end, much less persons than originally envisaged used this option, so that additional revenues for the public budget in 2012 only amounted to ca. EUR 255 million.[10]

In the year 2013 literally no new measures got announced regarding the pension system. It appears that the governing parties were not willing to come up with further reforms (most likely enclosing further retrenchment) during the months preceding the national elections held in September 2013. Within the coalition negotiations, currently held between the Social Democrats (SPÖ) and the People's Party (ÖVP) it got evident that the public budget deficit will be much higher in the next years than originally expected, if no further reforms get decided. However, information on how and to what degree public pensions will be affected by the next "budget consolidation package", which appears to be inevitable, is very limited at the time of writing (but see below chapter 2.3 on reform debates).

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

The coverage of the pension system is in principle comparatively high in Austria, as it covers nearly all persons in gainful employment, of which the most important are: employees, the self-employed, farmers, apprentices, and – partly covered via specific schemes – civil servants. For most of these groups a minimum income threshold (*Geringfügigkeitsgrenze*) applies for access of social insurance, but one can as well opt-in to the system even when earned income does not reach the respective threshold or one can decide for voluntary continued insurance in case of economic inactivity. Furthermore, times for bringing up children are counted as insurance period for a maximum of the first 48 months of lifetime per

[9] OTS0163 II, WI 29.02.2012; APA0560 WI, II 29.02.2012.

[10] See http://diepresse.com/home/wirtschaft/economist/1312756/Zusatzpensionen_645-Millionen-weniger-im-Budget?from=suche.intern.portal (retrieved 25.11.2013)

child (for women born after 1.1.1955[11]) and times when receiving benefits from unemployment insurance as well count as insured periods in pension insurance. Still, given the traditionally strong role of the so-called "male-breadwinner" family arrangement, a rather high share of women in the past did not manage to fulfil the preconditions for own benefit entitlements. According to calculations by Gstrein (2009) about 15% of all women in the age 60 and above did not have access to an own or derived old-age benefit in 2003. However, the respective situation is likely to have improved somewhat in the meanwhile due to generally increased work intensity of women over the last decades.

One other traditional problem of the Austrian statutory pension system is the one of rather high differentiation of benefits. This phenomenon derives from the "principle of equivalence"[12], which even got strengthened with the reforms of the early 2000s and which re-produces income inequality within gainful employment within the pension system. Respective imbalances especially get evident when comparing benefits granted to women to the ones granted to men. The problem of rather low pension benefits granted to women does not only apply for the average of existing pensions, but for newly granted pensions as well, where one would expect higher equality of benefits due to rising labour market participation of women. In both cases, direct old-age pensions of women only reach a level of about 55% to 60% of respective benefits of men, depending on whether equalisation supplements are taken into account or not (see Fink 2012).[13] The gap is only somewhat smaller regarding newly granted pensions if invalidity pensions are taken into account as well, which lead to lower outcomes especially in the case of men (see ibid.).

Still, regarding core indicators for social inclusion, as agreed upon at EU-level, the Austrian pension system performs rather well at first sight from an international comparative perspective (see Table 1 below).

[11] For women born before that date a somewhat different model applies, see: https://www.help.gv.at/Portal.Node/hlpd/public/content/27/Seite.270215.html (retrieved 25.11.2013)

[12] Meaning the notion that the level of benefits should at first instance reflect the level and duration of earlier insurance contributions.

13 For data including equalisation supplements see (retrieved 25.11.2013): http://www.statistik.at/web_de/static/hoehe_der_durchschnittspensionen_in_der_gesetzlichen_pensionsversicherung__041214.xlsx and http://www.statistik.at/web_de/static/hoehe_der_neuzuerkannten_durchschnittspensionen_in_der_gesetzlichen_pensio_041216.xlsx

Table 1: Income, poverty, social exclusion and income distribution according to age groups (2011)

	Austria			EU-27		
	Total	**Men**	**Women**	**Total**	**Men**	**Women**
Median relative income of people aged 65+ as a ratio of income of people aged 0-64	93	98	89	89	93	87
Aggregate replacement ratio	60	67	52	54	56	52
At-risk-of-poverty rate:						
age 65-	12.0	11.8	12.1	17.1	16.7	17.6
age 65+ / 75+	16.0 / 17.8	11.4 / 13.5	19.3 / 20.4	15,8 / 17.7	13.1 / 14.4	17.9 / 19.9
Severe material deprivation:						
age 65-	4.3	3.9	4.7	9.2	9.1	9.3
age 65+ / 75+	2.0 / 1.2	1.3 / 0.7	2.5 / 1.5	7.2 / 7.3	5.6 / 5.4	8.4 / 8.7
At risk of poverty or social exclusion (EU2020 indicator):						
age 65-	16.9	15.8	18.0	25.1	24.3	25.9
65+ / 75+	17.1 / 18.8	12.0 / 14.3	20.8 / 21.6	20.3 / 22.3	16.9 / 18.2	22.9 / 25.1
Income distribution (S80/S20): age 65- / 65+	3.8 / 4.1	3.8 / 4.1	3.7 / 4.1	5.3 / 4.1	5.3 / 4.2	5.3 / 3.9

Source: EUSILC; Eurostat Database.

When compared to the average of EU-27, in Austria a considerably lower share of people at the age of 65+ is at risk of poverty or faces social exclusion (EU-2020 indicator; Austria: total: 17.1%, men: 12%, women: 20.8%; EU-27: total: 20.3%, men 16.9%: women: 22.9%). The latter is at first instance caused by below average rates of severe material deprivation at the age of 65+ (for both sexes) (Austria: total: 2%; men: 1.3%; women: 2.5%; EU-27: total: 7.2%; men 5.6%: women: 8.4%). Apart from that, the at-risk-of poverty rate of Austrian elderly men aged 65+ (11.4%) and 75+ (13.5%) is somewhat below average of EU-27 (65+: 13.1%, 75+: 14.4%), whereas the at-risk-of-poverty rates of elderly Austrian women (both for the age-groups 65+: 19.3% and 75+: 20.4%) are somewhat higher than at average of EU-27 (65+: 17.9%; 75+: 19.9%).

When compared to the at-risk-of-poverty rate of the population at the age below 65 (total: 12%, men: 11.8%, women: 12.1%), at-risk-of poverty rates of elderly people (aged 65+ and especially aged 75+) are generally higher in the case of Austria. At average of EU-27 a related phenomenon only applies to women. Severe material deprivation in Austria is a much less common phenomenon in the age groups 65+ (total: 2%) and 75+ (total: 1.2%), than it is regarding the ones in the age group below 65 (total: 4.3%). Data on averages of EU-27 point to the same direction, however with a much lower degree of relative differentiation (below 65, total: 9.2%; 65+, total: 7.2%).

In Austria, income inequality (S80/S20) is considerably below average of EU-27 for people at age below 65 years, but only slightly below average of EU-27 regarding elderly people aged 65 and over.

Overall, it appears that the Austrian pension system shows a high degree of adequacy in terms of severe material deprivation, especially for men but to a large degree as well for women. However, when a more relative indicator like being at-risk-of poverty is used, the performance of the Austrian pension system (in terms of social inclusion) is less favourable. The latter especially holds for women (but to lesser degree as well for men), whereby inequalities within the labour market (in terms of earned income and continuity of employment/insurance contributions) get reproduced within the pension system.

Regarding indicators measuring the income replacement role of pensions, the median relative income ratio for people 65+, as a ratio of income of the age group 0-64, at 93% is higher than the EU-27 average (89%) and so is the aggregate replacement ratio (median individual pensions of 65-74 year olds relative to median individual earnings of 50-59 years old) (Austria: 60%; EU-27 average of 54% in 2011).

The gender break-up of all these indicators shows that old-age women currently present higher risk of poverty or social exclusion and severe material deprivation and in general enjoy lower standards of living than old-aged men in Austria. This is mainly a result of women who receive only a survivor's pensions and have no pension entitlement of their own, but also of high gender pay gap and gender difference in the retirement age.

Future adequacy
Regarding future developments, the net theoretical replacement rate (NRR) for a hypothetical male worker with average income from employment retiring at 65 after 40-years career is projected to grow from 85% in 2008 to 88.7% in 2050.[14] The negative effect of 3 years of unemployment which came to 0.6 p.p. of the NRR in 2010 will be three times larger in 2050 (1.9 p.p. smaller NRR with respect to the base case). In the same period the negative effect of a 3 year childcare break would be reduced from 2 p.p. to just 0.8 p.p. (with respect to the base case). The effect of a 10 year career break on the NRR would increase from a loss of about 14.9 p.p. to a loss of 18 p.p. (with respect to the full career base-case).

NRR for high earners would drop from 77.2% to 72.1%, whereas the NRR for low earners would be slightly increased from 83.7% to 83.8%. This means that the NRR for a low income worker will remain to be lower than for an average income worker, which stands out in international comparative perspective and which is questioning the adequacy of the pension system for that group. Furthermore, negative effects of unemployment and of career breaks (other than ones due to childcare) will increase in the future (when compared to the full career base-case). Against this background, challenges for pension adequacy will remain to occur especially in cases of a combination of low earned income and interrupted working careers.

Hereby, it should be stressed that the median relative income of people 65+ (as a ratio of income of people 0-64) as well as public spending for old-age pensions are very high in Austria from an international comparative point of view. However, problems appear regarding the distributional impact of the system, as evident in the data on being at-risk-of-poverty (especially in the case of women). The reforms of the early 2000s did not deal with these problems in a proactive way. The reduction of accrual rates according to a uniform model (irrespective of income levels) and the expansion of the assessment period are likely to lead to a higher incidence of low-level benefits within the system of old-age pensions in the future. The latter is even more likely on the background of the on-going further differentiation of the Austrian labour market, as evident e.g. from a rising share of part-time employment (which is to an extremely high degree concentrated on women) and a growing low-wage sector (for more details on the latter point see e.g. Geisberger/Knittler 2010; Geisberger 2013).

2.2.2 Sustainability

Demography
According to the most recent projections by the Austrian “Commission on Long-Term Sustainability of the Pension System” (Kommission [zur langfristigen Pensionssicherung] 2013a), presented in October 2013, the old-age dependency ratio (the population aged 65 and over as a percentage of the population aged 15-64) will rise from 26.8% in 2012 to 48.6% in 2050 and to 50.5% in 2060 (ibid. 85).

[14] Source for data NRR projections: European Commission (2012).

Employment

The labour market participation rate (age 15-64) is projected to rise from 72.4% in 2012 to 73.5% in 2020, and then further to 77.1% in 2050 and to 77.3% in 2060. Labour market participation rates in the age 55 to 64 are projected to rise from 40.2% (2012) to 60.1% (2060). For women a higher respective increase (from 30.7% to 56.9%) is expected than for men (from 50.3% to 63.4%) (ibid., 20).

The average exit age from the labour market is predicted to rise from currently 57.8 years for men to about 58.5 years in 2020 and then further to approx. 60.4 years in 2030. After that, it is expected to rise further to about 61 years and then remain at about that level-

For women the respective numbers are about 55.2 years in 2012, ca. 56.5 years in 2020, 59 years in 2030 and will then reach a level of close to 60 years.

When taking in mind that the statutory pension age for men currently is 65 years, and that it for women, according to current plans, will stepwise be increased from 60 years to 65 years between 2024 and 2033, these projections appear to be rather conservative. In other words: the experts in the Commission expect the actual retirement age only to increase in the very long run, and only to a level substantially below statutory pension age. This at the same time would mean that different forms of early retirement and invalidity pensions remain to play a significant role.

Data in table 2 shows the distribution of pensions newly granted since 2005. Strikingly, more than two thirds of all new pensioners exit the labour market via an early retirement scheme or via an invalidity pension. The situation improved somewhat recently (i.e. in 2012), but it evidently is still worrying.

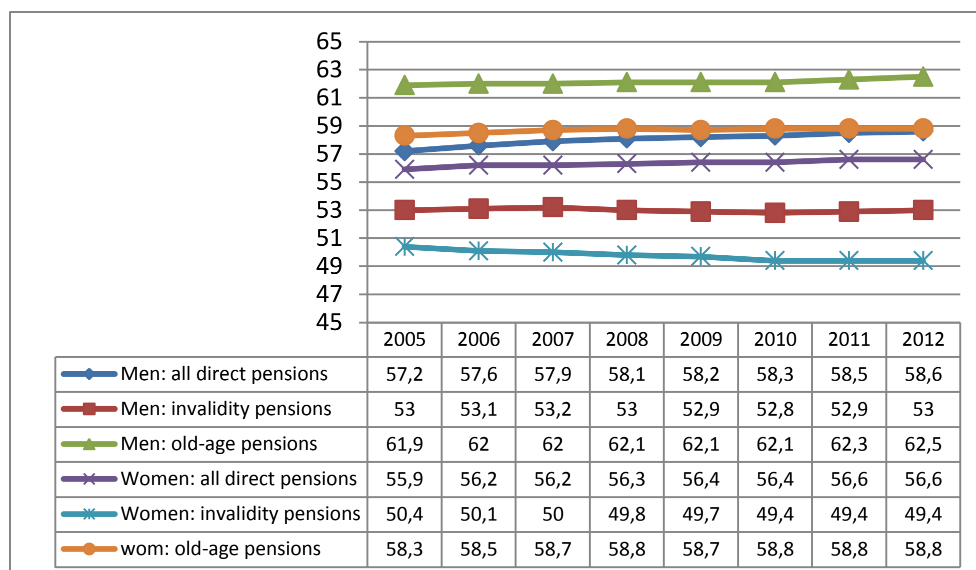
The overall actual retirement age for all newly granted direct pensions (i.e. excluding dependent's pensions) increased only to a marginal degree in Austria over the last years (see Chart 1).

Table 2: Direct pensions newly granted; 2005-2011

	Regular old-age pension		early retirement on account of long-term insurance contributions		Early retirement due to corridor pension		Early retirement due to "very long insurance periods" (Hacklerregelung)		Early retirement due to "heavy labour pension"		Invalidity pension		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
2005	21,663	26.5	29,172	35.7	0	0.0	0	0.0	67	0.1	30,860	37.7	81,762	100.0
2006	21,330	26.1	17,708	21.7	1,124	1.4	11,639	14.2	13	0.0	29,975	36.6	81,789	100.0
2007	24,617	28.1	13,373	15.3	1,610	1.8	17,050	19.5	448	0.5	30,440	34.8	87,538	100.0
2008	25,549	28.8	10,070	11.3	2,601	2.9	19,552	22.0	863	1.0	30,119	33.9	88,754	100.0
2009	26,803	28.0	8,327	8.7	3,763	3.9	26,217	27.4	596	0.6	30,131	31.4	95,837	100.0
2010	25,351	27.7	7,117	7.8	4,643	5.1	25,086	27.4	676	0.7	28,649	31.3	91,522	100.0
2011	26,903	28.9	7,472	8.0	5,337	5.7	23,963	25.8	1,100	1.2	28,278	30.4	93,053	100.0
2012	27,614	30.4	6,684	7.4	5,602	6.2	22,676	25.0	1,132	1.2	27,023	29.8	90,731	100.0

Source: Hauptverband der Österreichischen Sozialversicherungsträger; Büro der Kommission zur langfristigen Pensionssicherung (2013).

Chart 1: Actual retirement age: newly granted direct pensions according to pension type and sex; 2005-2012



	2005	2006	2007	2008	2009	2010	2011	2012
Men: all direct pensions	57,2	57,6	57,9	58,1	58,2	58,3	58,5	58,6
Men: invalidity pensions	53	53,1	53,2	53	52,9	52,8	52,9	53
Men: old-age pensions	61,9	62	62	62,1	62,1	62,1	62,3	62,5
Women: all direct pensions	55,9	56,2	56,2	56,3	56,4	56,4	56,6	56,6
Women: invalidity pensions	50,4	50,1	50	49,8	49,7	49,4	49,4	49,4
wom: old-age pensions	58,3	58,5	58,7	58,8	58,7	58,8	58,8	58,8

Source: Hauptverband der Österreichischen Sozialversicherungsträger; Büro der Kommission zur langfristigen Pensionssicherung (2013).

Expenditure

According to the most recent projections by the Austrian "Commission on Long-Term Sustainability of the Pension System" (Kommission 2013), presented in October 2013, the expenditure for pensions within statutory old-age insurance will rise from 10.1% of GDP in 2012 to a maximum of 13.2% between 2047 and 2051 and will then shrink to 12.7% in 2060. If expenditures for rehabilitation measures and administrational costs are taken into account as well, the respective numbers are 11.2% of GDP in 2012, a maximum of 14.6% between 2047 and 2052, which will then decrease to 14.2% as from 2059 (ibid., table 25 & 26).

However, these data on pension expenditure are somewhat misleading, as they do not take into account costs of pensions of former civil servants, to be covered by the general budget. Hereby, it has to be taken into account that employees of the Federal Republic and the federal provinces will in the future to an increasing degree be covered by the statutory old-age insurance and not by the earlier special pension scheme for this group (so-called *Ruhegenüsse*). This means that the increased spending for the statutory old-age insurance has to be put into relation to developments of costs according to the traditional special pension scheme(s) for civil servants. Respective analyses show that increases in the overall spending for pensions (as well taking into account reductions of spending within the systems of civil servants) are considerably lower than according to the estimations by the "Commission on Long-Term Sustainability of the Pension System". According to the data presented by the "Commission on Long-Term Sustainability of the Pension System" spending for pensions within the statutory pension system will rise by 2.7 percentage points of GDP until 2040, and by 3.1 percentage points of GDP until 2050. However, spending for pensions of civil servants, according to calculations by the Austrian Chamber of Labour (based on the EG Ageing Report 2012), will at the same time decrease by 1 percentage point of GDP until 2040 and by

1.8 percentage points until 2050.[15] This means that the effects on additional costs for the public budget, as projected by the "Commission", are probably too pessimistic.[16]

2.2.3 Private pensions

Private schemes have a rather limited role in overall provisions, although coverage and the accumulated funds have increased somewhat in recent years. In the second quarter 2013 ca. 751,000 persons (or ca. 20% of the dependent employees) were entitled to receive an additional pension from an occupational scheme in the future, and about 77,000 persons (which equals 5.1% of the population aged 65 and above) were already beneficiaries.[17]

The second pillar was somewhat strengthened by the introduction of the new severance pay scheme in 2003. Employers are obliged to pay 1.53% of the monthly gross salary to a staff provision fund set up especially for this purpose. Employees have the option to withdraw their savings in case of termination of a work contract (if specific preconditions are fulfilled) or to keep them until retirement age. The latter option, however, does not seem to be widely used at the moment.

Regarding the third pillar – i.e. private savings – since 2003 public subsidies are available within a scheme called "premium-aided pension savings scheme" (*Prämienbegünstigte Zukunftsvorsorge*). The impact of the "premium-aided pension savings scheme" on the level of future pensions is likely to be rather limited. About 1,614,000 of such contracts on savings plans existed at the end of 2011, covering only about a quarter of the population at the age below 60. Furthermore, the level of premiums paid to such schemes typically appears to be rather low. In 2011, the average premium amounted to about EUR 624 to 699 per year (depending on the type of provider of the scheme) (see FMA 2012).

2.2.4 Summary

The Austrian pension system performs very well on preventing severe material deprivation in old-age, whereas outcomes regarding at-risk of poverty rates are only somewhat more favourable than at average of EU-27 for men, and the at-risk-of-poverty rates of elderly Austrian women are even higher than at average of EU-27. At the same time the Austrian pension system is rather cost-intensive when compared to other Member States of the EU.[18] This, together with the high differences in benefit levels produced by the system points to the direction of a problematic, i.e. rather limited, intragenerational distributional impact of the system in place.

One other problem, which as well contributes to spending, is the high incidence of early exits from the labour market via different schemes of early retirement and invalidity pensions. The latter topic has been on the political agenda for several years now, and decisions have been taken to increase efforts for health and vocational rehabilitation and to tighten access to invalidity pensions and early retirement. These measures show already some (however rather limited) positive effects, but their full impact will only get visible when more elements of the respective reforms get implemented as from 2014.

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[15] See http://blog.arbeit-wirtschaft.at/langfristige-entwicklungstrends-des-pensionssystems-crashszenarien-schauen-anders-aus/ (retrieved 25.11.2013)

[16] See as well: http://derstandard.at/1381370307591/Pensionsexperten-Kurzfristige-Entwarnung (retrieved 25.11.2013)

[17] Source: Data provided by FMA (2013); see: http://www.fma.gv.at/typo3conf/ext/dam_download/secure.php?u=0&file=10831&t=1385117116&hash=8bc6874bca40b0f63ecda2e9b0344ce5 (retrieved 10.11.2013).

[18] On aggregated public spending for pensions (incl. outlays for civil servants) see the Ageing Report 2012 of the EC (European Commission 2012).

As for all EU Member States, projections on future financial development indicate a considerable increase in public spending on pensions. However, for many Member States higher increases are expected than for the case of Austria, where reforms decided as from the 1990s came with a considerable effect of cost containment. Still, the Austrian pension scheme according to these calculations will remain to be one of the most cost-intensive pension schemes of all EU Member States (see e.g. European Commission 2012, 111). According to respective projections cost containment will especially be reached by reducing NRRs for earlier high income earners, but at the same time NRRs of former low income earners will only increase by a very small degree (see above chapter 2.2.1). This means that adequacy problems of benefits, i.e. in the form of low benefit levels for some groups, will remain to be in place if no reforms are taken on this issue.

One other point worth mentioning is the fact that the second and third pillar of the Austrian pension scheme is underdeveloped from an international point of view. However, it can be argued that this is not per se a problem, as long as the first (public and PAYG) pillar of the pension system guarantees adequate benefit levels. The latter could be reached in a revenue-neutral way if the intragenerational redistributive impact of the system would be increased. Problems of financial sustainability of the pension system could be mitigated to a considerable degree if early retirement would be prevented in a consequent way. This would, most likely, lead to higher unemployment of persons at the age above 55. But at the same time deficits in “active ageing” would get more visible, potentially leading to increased efforts to improve the respective situation.

2.3 Reform debates

The question of a further reform of the Austrian pension system has permanently been on the political agenda to some degree, but the intensity of respective debates shows a rather high degree of volatility.

In 2010, reforms on invalidity pensions and old-age pensions due to very long insurance records (*so-called Hacklerregelung*) was debated and decided. In early 2012 respective debates again gained momentum, leading to the reforms sketched out above within the so-called consolidation package. Then, regarding respective attempts by the main political decision makers, debates about the pension system abated to some degree. But recently, within the current coalition negotiations[19] between the Social Democrats (SPÖ) and the Austrian Peoples Party (ÖVP) they reportedly play a significant role again. This recent increase of the intensity of debates on the topic of pensions is as well caused by the fact that a “cashing-up” conducted within the current coalition negotiations (reportedly) came to the result that, when compared to earlier estimations, a sum of 8.7 billion EUR is missing within the pension system until 2018 due to revenues being lower and outlays being higher than indicated by earlier estimations.[20]

Overall, it appears that pension issues during the last years only were debated more intensely by the most important decision makers in office when they were constrained to do so for reasons for short- to mid-term financial sustainability. In times where respective problems were not explicitly apparent, the strategy was to refer to reforms already decided. The message repeatedly was that reforms already had been taken and that their impact has to be awaited before reforms on further debates should take place. This only came to an end when new needs for the consolidation of public budgets got evident or could no longer be disguised.

[19] Subsequent to the national elections held in September 2013.

[20] See for example http://derstandard.at/1381371930239/Das-Nulldefizit-bleibt-das-Ziel (retrieved 15.11.2013)

When in autumn 2012 a group of pension experts intended to start a broader debate on a structural reform of the Austrian pension system, proposing to change it towards a notional defined contribution (NDC) system[21], most political actors[22] refused to start a respective discussion, again arguing that decisions aiming at the long-term sustainability of pensions had already been taken and that the full impact of the reforms decided should be awaited.[23]

Currently, debates on a further reform of the pension system are taking place "behind closed doors" within the ongoing coalition negotiations between Social Democrats (SPÖ) and the Austrian Peoples' Party (ÖVP). Both of them in principle agreed to maintain silence on the content and outcomes of negotiations until all chapters of the coalition pact are completed. However, some issues discussed were made public. It is planned to retrench very high pensions deriving from special schemes (like the one of the Austrian National Bank, the Austrian Federal Railways, the Social Insurance Providers or for former politicians) to some degree via a constitutional bill.[24] Furthermore, according to media reports the ÖVP proposed to bring forward the alignment of the statutory retirement age of women towards the one of men by some years. However, up to now the SPÖ continues to reject such plans.[25] The negotiations on the coalition agreement may as well enclose other issues regarding pensions, but no respective statements have been made publicly.

Regarding pensions of the second and third pillar, it appears that scepticism about purely funded schemes became the norm in light of the unfavourable profit development of such schemes during the last years. Regarding important political actors, voices arguing for a further expansion of the existing schemes are literally absent. It is only the private insurance business and the pension funds that repeatedly ask for an expansion of respective public co-financing and for increased incentives to invest in private pension products.

The European Country Specific Recommendations for Austria, communicated by the Council within the European Semester of Europe 2020, repeatedly suggested the following (CSR No. 2):

"Bring forward the harmonisation of pensionable age for men and women, increasing the effective retirement age by aligning retirement age or pension benefits to changes in life expectancy implement and monitor the recent reforms restricting access to early retirement and further improve older workers' employability in order to raise the effective retirement age and the employment rate of older workers."[26]

Most of these points have been on the agenda of the political debates mentioned above to some degree. The strongest reluctance appears to exist regarding the point of "aligning retirement age or pension benefits to changes in life expectancy", and – up to recently – as well concerning "bringing forward the harmonisation of pensionable age for men and women". However, regarding the latter point, the intensity of debate appears to rise to some

[21] See http://www.euro.centre.org/beitragskonten/index.php (retrieved 15.11.2013)
[22] For one of the few exemptions, see: http://www.salzburg.com/nachrichten/oesterreich/politik/sn/artikel/iv-unterstuetzt-pensions-experten-aufruf-29744/ (retrieved 15.11.2013)
[23] See e.g. http://www.wienerzeitung.at/nachrichten/oesterreich/politik/489114_Pensionen-Hundstorfer-gegen-weitere-Reform.html ; http://www.linz-land.spoe.at/fileadmin/user_upload/Organisationen/BO/BO_Linz_Land/Bilder/News/Krist_Hermann/pdf/PensionsreformOEGBAK.pdf; http://www.vol.at/scharfe-kritik-an-expertenaufruf-zur-ultimativen-pensionsreform/3367441 (retrieved 25.11.2013)
[24] See http://derstandard.at/1381372279261/Verfassungsgesetz-gegen-Pensionsprivilegien-geplant (retrieved 25.11.2013)
[25] http://diestandard.at/1385168548635/Frauen-und-Lehrer-entzweien-SPOe-und-OeVP (retrieved 25.11.2013)
[26] See http://register.consilium.europa.eu/pdf/en/13/st10/st10619-re01.en13.pdf

degree more recently, with the ÖVP reportedly pushing for such a reform within the coalition negotiations (see above).

Regarding the goal to rise the effective retirement age, only slight improvements were made in Austria over the last years. This was criticized by different stakeholders and political actors, and some of them even argued that the effective retirement age may only get increased substantially if the statutory retirement age would be raised.[27] However, the government followed their usual strategy of arguing that the full implementation of reforms already decided, aiming at a higher actual retirement age, should be awaited, stressing that the first steps of these reforms already implemented show first positive effects.[28] Still, the Minister for Work and Social Affairs recently announced that efforts to reduce access to invalidity pensions would eventually have to be increased by further expanding rehabilitation measures etc. already in place.[29]

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

The roots of the Austrian sickness insurance go back to the last quarter of the 19th century, when in 1887/1888 the industrial accident and health insurance scheme for workers was introduced, following the model of Bismarck's social policy programme.[30] After the collapse of the Austro-Hungarian Monarchy an extension of the coverage of health insurance took place to all people with employment contracts, service contracts or waged work (including civil servants). Furthermore dependent family members of insured persons were included into health insurance. In 1956, the General Social Security Act (*Allgemeines Sozialversicherungsgesetz/ASVG*) replaced the previously valid laws in the field of social security. It covers health, work accident and pension insurance for blue- and white-collar workers in industry, mining, commerce and trade, transport, agriculture and forestry, and it also regulates health insurance for pensioners. Coverage of health insurance increased stepwise between the end of WWII and the early 1980s – from about 66% in 1948 to 96% in 1980. This increased coverage was achieved by a number of different measures, inter alia by the introduction of the Act on Health Insurance for Farmers (B-KVG) in 1965 and the Health Insurance Act for Self-Employed Tradesmen (GSKVG) in 1966. Furthermore, unrestricted access to hospital care, preventive check-ups, examinations for young people and rehabilitation were progressively introduced as new services.

One area that over the last decade has repeatedly been subject to reform debates is the one of health care in hospitals and the planning and financing of this sector. Here shared and/or overlapping competencies exist between the Federal Republic and the federal provinces (*Länder*). The most important respective regulations are the Act on Hospitals and Sanatoriums (*Krankenanstalten- und Kuranstaltengesetz/KAKuG*, first issued in 1957) at the level of the national state and nine different respective implementation laws ("*Ausführungsgesetze*") at the

[27] See e.g. OTS0164 II, WI 17.10.2013; OTS0179 WI, II 29.10.2013; APA0295 II, WI 24.10.2013; OTS0124 WI 04.11.2013.
[28] See e.g. OTS0125 II 12.06.2013; OTS0141 II 17.10.2013; OTS0190 II, CI 29.10.2013.
[29] See APA0299 II, WI 29.10.2013.
[30] The source for the following paragraph is the overview on the history of the Austrian health system by Hofmarcher/Rack 2006 (12ff.) and by Hofmarcher (2013).

level of the nine federal provinces. It is important to note that according to Art. 12 (1) 1. of the Austrian Constitution the Federal Republic regarding health care in hospitals only has the competency to decide on "basic principles" (so-called "*Grundsatzgesetzgebung*"), which in principle gives the federal provinces a rather large degree of discretion in organizing this sector via their implementation laws. Still, since the late 1970s several attempts have been made to co-ordinate the governance of the hospital sector according to common criterions. The formal instrument repeatedly used here are "agreements according to Art. 15a of the Austrian Constitution" (so-called *"15a Vereinbarung"*) between the Federal Republic and the federal provinces. In the more recent past, important respective steps were taken with the so-called "health reform 2005" and the "health reform 2012/2013" (see below for details), whereby the latter not only enclosed an amendment of earlier 15a-agreements, but as well a new federal "Health-Target Governance Act" (*Gesundheits-Zielsteuerungsgesetz/G-ZG*).

3.1.2 System characteristics

In principle, the health system is under the responsibility of the Federal Republic. One very important exception is, as already mentioned above, the hospital sector, where the federal provinces are in charge of deciding and enforcing so-called implementation laws (*Ausführungsgesetze*), and where the Federal Republic only has the competency to enact so-called basic laws (*Grundsatzgesetzgebung*). For better coordination in this sector, the Federal Republic and the Länder have repeatedly concluded mutually binding agreements to ensure health care provision within their respective competences. Apart from that, it is important to note that in Austria social insurance providers are supposed to be self-governing bodies (so-called *Selbstverwaltungsträger*). This implies that they have important regulatory functions, especially in respect of outpatient health service.

The Austrian health sector shows a system of "mixed financing" (see Statistik Austria 2012, 81ff. for more details). In 2011, approx. 23% of all health expenses (including expenses for long-term care) were covered by the private sector, and about 77% by the public sector. Regarding the private sector, approx. 74.9% of respective outlays take the form of private out-of-the pocket payments, 19.8% come from private health insurance providers, about 4.8% from non-profit organisations serving households and ca. 0.5% from corporations (other than health insurance). Regarding the public sector, about 58% of all expenses are covered by health insurance contributions and about come 42% from the tax yield.[31]

The public share on overall health expenditure increased during the 1990s (starting at ca. 73% in 1990) but– until recently remained largely stable since 2000 (at a level of about 75 to 76.3%).

The Austrian health insurance covers a wide variety of different services, like for example primary health care services provided by contract physicians of the Austrian social health insurance funds, specialised in-patient and out-patient care, emergency care, dental services, prescription medicines, medical devices such as walking aids, wheelchairs or blood glucose strips, ambulance services, preventive and health promotion services including vaccinations or screening examinations and rehabilitation services. However, patients may face out-of pocket payments, for example when using health services which are not included in the benefits catalogue of their social health insurance fund (see chapter 3.2.1 below for details).

[31] Data provided by Statistik Austria according to OECD System of Health Accounts: http://www.statistik.at/web_de/static/laufende_gesundheitsausgaben_nach_gesundheitsleistungen_und_-guetern_leist_055362.xlsx & own calculations.

Access to public health services is, in principle, organized via an insurance system, covering people in gainful employment, persons receiving specific cash benefits (like for example benefits from unemployment insurance, from the pension system etc.) and dependent family members (see chapter 3.2.1 for details). Overall, about 99% of the Austrian population are covered by public health insurance.

3.1.3 Details on recent reforms

Recent reforms of the Austrian health system at first instance dealt with questions of organizational structures and efficiency, whereas other issues (like for example the question of the bandwidth of services covered by public health insurance, health insurance contribution rates etc.) were on the agenda to much lesser degree. The aim to improve organisational and governance structures is a long standing issue in Austria, given the traditional problem of overlapping competencies and very complicated structures of financing, which until recently especially prevailed in the area of inpatient (i.e. hospital) care. The so-called "health reform 2005" led to a gradual institutional re-design (establishing new or replacing existing co-coordinative institutional bodies)[32], but without resolving structural problems of shared and/or overlapping competencies and complicated financing structures (see e.g. Czypionka et al. 2009; 2010; Schelling 2010).

A new attempt to deal with respective challenges has been made with the recent "Health Reform 2012/2013" (*Gesundheitsreform 2012/2013*). In the Austrian NRP 2013 this reform got labelled as being a "milestone", aiming at better organisation and sustainable finances of the health system (Bundeskanzleramt 2013, 6). However, apart from some more or less concretely defined goals, this reform at first instance comprises institutional and procedural reforms, where it has to be awaited if and to what degree they really achieve the intended effects.

The health reform 2012/2013 comes with a new structure of "joint planning and responsibility". Both at the national level and at the level of the federal provinces representatives of the national state, the federal provinces and the health insurance providers are represented in joint committees, responsible for planning in the health sector and quality assurance. Hereby, in addition to the already existing (but somewhat modified) "Federal State Health Commission" (*Bundesgesundheitskonferenz - BDK*) and the "Federal Provinces Health Platforms" (*Ländergesundheitsplattformen*) new "Target Management Commissions" got established both at the level of the Federal Republic and the federal provinces (*Bundeszielsteuerungskommission – BZK* and *Landeszielsteuerungskommissionen -LZK*). Within these commissions, the federal provinces, the health insurance providers and the Federal Republic decide on one national and nine regional (i.e. addressing reforms at the level of the federal provinces) "target-management contracts" (*Zielsteuerungsverträge*), enclosing infrastructure development, quality assurance and financing. Regarding financial sustainability, the different institutions involved agreed on a model where increases in health expenditure should not surpass the expected growth of nominal GDP. Furthermore, if expenditure exceeds the envisaged level or if "target management contracts" are not put in place or implemented properly at the level of the federal provinces financial sanctions may apply, where additional costs deriving from a backlog of reform have to be covered by the institution identified to be responsible for them (within a so-called arbitration process).

[32] 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 level of the federal provinces (for more details see Hofmarcher/Rack 2006).

The first National Target-Management Contract (*Bundeszielsteuerungsvertrag*), covering reforms between the years of 2013 and 2016, was presented in June 2013. The Regional Target-Management Contracts (*Landeszielsteuerungsverträge*) should have been presented by the end of September 2013, but four out of nine federal provinces did not present their contract in time.

The National Target-Management Contract (see Bundeszielsteuerungsvertrag 2013) encloses more general declarations of intent and announcements of future procedural steps to be taken than concrete numerical targets. And if such numerical targets get announced, they do not appear to be very ambitious. Concrete targets are the reduction of the rate of hospitalization by 1.1% per year or a reduction of the length of hospital stay by 0.8% per year. Per federal province, until 2016 only a minimum of two new "innovative ambulant service structures" (*Neuartige Ambulante Versurgungsstrukturen; NAV*; i.e. group practices) are expected to be put in place. And it gets announced that each federal province will have to come up with a minimum of just one project to transfer selected bundles of day clinic services to the ambulant sector. Regarding procedural aspects, the National Target-Management Contract appears to be somewhat more ambitious. It gets announced that quality of medical treatment will in future be monitored as a matter of routine and that regular assessments on patient satisfaction will take place. Furthermore, during 2013 and 2014 new processes aiming at an "alignment of service density" are planned to take place, where – inter alia – "parallel structures" and "overprovision" are planned to be reduced for the goal of higher efficiency. It is completely unclear at the time of writing what the actual impact of these processes will be, as results by respective analyses at the level of the federal provinces and of working groups dealing with these topics are not expected before 2014.

A brief checkup of the Regional Target-Management Contracts already available at the time of writing show that they generally do not enclose plans that would imply a significant over-implementation of the measures and goals agreed upon in the National Target-Management Contract.

Independent experts on health care in their appraisal of the health reform 2012/2013 come to different conclusions. Some argue that it lacks concrete measurable and at the same time ambitious goals, or even come to the conclusion that most of the reform is nothing more than PR-gags. Others stress that it at least comes with a significantly increased transparency of planning in health care. Furthermore, they argue that actual reforms implemented according to the Regional Target-Management Contracts over the next three years may – at first sight – be of the type of "small steps reforms" only, but that these projects may lead to a process of more structural reform in the future.[33]

Overall, it appears to be fair to say that the health reform 2012/2013 is not likely to solve some of the evident problems of the Austrian health system, like very high rates of hospitalization, very long hospital stays, inefficiency due to parallel structures or sub-optimal treatment due to a lack of planning for a clear-cut structure of "points of best service" and a rather high geographical differentiation of accessibility of high-quality services (see Hofmarcher 2013; Gönenç et al. 2011) in the short run. However, it appears that these problems have at least been recognized and put on the political agenda. At the same time, to deal with them within actual reforms, a model of rather small-step adaptation has been put in place, whereas ideas of more radical change where not put in place due to the resistance of different political players (like the federal provinces and the interest organizations of the medical professions).

[33] See e.g. http://medonline.at/2013/kontroverse-diskussion-zur-gesundheitsreform-in-graz/ for an overview in respective judgments (retrieved 05.11.2013)

One other important reform decided in 2012 is the introduction of a so-called "Electronic Health Register" (*Elektronischer Gesundheitsakt; ELGA*).[34] Hereby, individual data about the medical history, treatments, prescribed drugs etc. get filed electronically, with (selective) access to this data for independent physicians, hospitals and (to a more limited degree) also pharmacies. The aim of this information system is to help to prevent suboptimal treatment caused by a lack of information on the side of the – in some cases many – treating physicians. One other goal is to avoid costly multiple medical examinations and multiple prescription of drugs, which is not only inefficient in financial terms but also implicates health risks. The decision on the ELGA was accompanied by intense debates, whereby especially physicians, and parts of their professional interest organization (the Austrian Medical Chamber) where against its introduction. Main arguments presented against the ELGA were that the setup and maintaining of this system would turn out to be very costly, that it would come with useless additional administrative burdens to be rendered by physicians and that protection of privacy would not be guaranteed for patients.[35] Partly in response to the latter point (protection of privacy), it got finally decided that patients can opt-out of the coverage by ELGA, deciding that their health data will not get stored within the system. According to the Ministry of Health the introduction of the ELGA comes with initial costs of ca. EUR 130 million and with maintenance costs of EUR 18 million per year. However, at the same time the system, according to estimations by the ministry, when fully implemented as from 2017, have a cost containing effect of amounting to approximately EUR 129 million per year.[36]

3.2 Assessment of strengths and weaknesses

3.2.1 Coverage and access to services

About 99% of the Austrian population are covered by the social health insurance (see as well Fuchs 2009), which is – in principle – organised as a compulsory insurance for people in gainful employment and for people receiving cash benefits from systems of social protection (like pensions or unemployment benefits). However, health insurance in Austria goes far beyond the scope of insurance for employed persons and people receiving cash benefits from social insurance since, in addition to the directly insured parties, it also covers dependent members of their families. About one third of the persons covered by the statutory health insurance are co-insured family members who do not pay contributions of their own (e.g. children, housewives/househusbands). Periods without insurance appear to be a short-time phenomenon in many cases (see for more details Fuchs 2009, 329), and people who are not covered by health insurance may opt in to the system at their own expense (however, some waiting periods may apply here.). Furthermore, for people without insurance but receiving means-tested Social Assistance, the Social Assistance providers used to cover the cost for health care services. Traditional Social Assistance was replaced by the so-called Guaranteed Minimum Income scheme (GMI) as from September 2010 and benefit recipients are now included in normal health insurance. The latter is a positive step, as there is some evidence that the earlier "special" scheme for recipients of Social Assistance came along with social stigmatisation and – in some cases – with below standard health treatment.

[34] For the act on the ELGA (BGBl. I No. I 111/2012) see: http://www.ris.bka.gv.at/Dokumente/BgblAuth/BGBLA_2012_I_111/BGBLA_2012_I_111.pdf (retrieved 05.11.2013); for further information: http://www.elga.gv.at/

[35] See e.g. OTS0014 CI, II 07.05.2011; APA0213 II, CI 18.05.2011; OTS0142 CI 28.04.2011 ; OTS0024 CI, II 29.10.2011 ; OTS0024 CI, II 29.10.2011.

[36] OTS0331 II 10.11.2011.

Patients can choose their family physician and have free access to most other forms of medical care. In contrast to many other countries, there is no obligation in Austria to enrol with a specific physician or to consult them prior to accessing specialised (inpatient) treatment, which means that physicians have no gate-keeping function. It is also possible to consult ambulatory outpatient departments of hospitals without prior consent of the family physician or one's health insurance fund.

However, take-up of selected health care services may be linked to special conditions or prerequisites such as age or type of illness or may also involve co-payments. These may be calculated according to fixed rates (e.g., a prescription fee for medicines, in 2013: EUR 5.30) or as percentages (e.g., a 20% co-payment for most services provided by physicians for persons insured with certain health insurance funds). Patients will also face out-of pocket payments when using health services which are not included in the benefits catalogue of their social health insurance fund. These include, for instance, payments for OTC medicines, daily allowances for in-patient care (currently – depending on the federal province – between 12 and 19 EUR per day for the first 28 days in hospital per year), expenditure for certain dental services or for the services of physicians who have no contract with the social health insurance fund in question. Payments made for the latter may partially be refunded to the insured person by their social health insurance fund. Irrespective of some general duties for private co-payments etc. the degree of equity in accessing services in Austria appears to very high (see as well OECD 2011a, 30; Hofmarcher 2013, 263ff.). This is inter alia caused by the fact that for persons with special needs, for persons with low income or for persons who are chronically ill some exemptions from co-payments exist. Here, the most important one is the exemption from the obligation of paying the prescription fees for medicines, which currently applies for about a quarter of the insured population.

According to assessments by international organisations (see e.g. OECD 2011a) and national experts (see. e.g. Habl et al. 2010) access to services in Austria – at least from an international comparative point of view – to a comparatively low degree depends on the overall social situation of the patient. According to data provided by EU-SILC, less than 1% of the lowest income quintile in Austria reports unmet needs for medical examination in Austria for financial reasons, which holds for nearly 5% at average of EU-27 (indicator hlth_silc_08). And as well self-reported unmet needs of dental examinations due to financial reasons of the lowest income quintile, changing between ca. 2.5% and 4% over the years, is considerably lower than at average of EU-27 (ca. 7% to 8%) (Indicator hlth_silc_09). Furthermore, different surveys show a high generally very high satisfaction of the population with the overall health system (see Hofmarcher 2013, 263ff.).

Still, this does not mean that no problems would exist regarding access to health services (see Hofmarcher 2013, 268ff. for an overview), for example:

- Reportedly, waiting times for some surgeries tend to be shorter for patients with an additional private insurance.
- Regarding some services, offers and accessibility vary to a large degree between different regions. Regional deficits are especially evident regarding ambulatory rehabilitation, and here in particular in the area of neurorehabilitation, concerning palliative services, and as well regarding psychiatric care and psychological care – with regional deficits especially existing for ambulatory and out-patient services and concerning children and youngsters.
- Furthermore, regional differences as well exist regarding the degree of development of the general spectrum of health services, with e.g. the federal provinces of Vienna and

Upper Austria showing a higher scope of services than federal provinces with a lower GDP per head.

- More detailed analyses on the actual "social selectivity" of the health system are very rare. However, e.g. research on the likelihood of attending a dentist in Austria is by 40% higher in the highest income decile than in the lowest income decile, which is – from an international comparative point of view – a very high degree of differentiation (see Hofmarcher 2013, 268).

3.2.2 Quality and performance indicators

Quality and performance indicators to some degree point towards a more problematic situation than one would expect on the background of high coverage rates, high (self-reported) accessibility and rather high equality in access to health services (outlined above).

Both for men and women, numbers for healthy life years in percentage of the total life expectancy are considerably lower than at average of EU-27 (see Table 3). Given the fact that the overall life expectancy is rather high in Austria, the absolute number non-healthy life years is rather high in Austria. This inter alia indicates deficits within health prevention, which at the same time is likely to imply high burdens and financial costs within the area of long-term care (see below Chapter 4; for the case of Austria as well Aiginger 2011). Although the indicator of "healthy live years" derives from subjective self-assessment respective results should be interpreted with caution[37], this results still indicate a substantial need for improvement (see as well Hofmarcher 2013, 270ff.). According to an assessment by the OECD (OECD 2010), using non-parametric methods (so-called Data Envelopment Analysis), life expectancy in Austria could be by about 2.5 years higher if resources would be used as efficient as in the countries identified as benchmarks. At the same time, according to these calculations, the current life expectancy could have been reached with health expenditure being by 25% lower than they actually are. Other related calculations come to largely similar results (see Hofmarcher 2013, 271) and show at the same time that the efficiency of the funds allocated within the health system (measured as "lost" life-years) to a considerable degree vary between the different Austrian federal provinces (see ibid., 273; Gönenç et al. 2011).

[37] See, with further references, the 2013 EHLEIS report for Austria: http://www.oeaw.ac.at/vid/download/EHLEIS_Austria_Issue6_GER.pdf

Table 3: Life expectancy and healthy life years; 2004-2011

	2004	2005	2006	2007	2008	2009	2010	2011
	Life expectancy in absolute value at birth							
Females								
EU-27	81.5	81.6	82	82.2	82.4	82.6	82.9	83.2
Austria	82.1	82.2	82.8	83.1	83.3	83.2	83.5	83.9
Males								
EU-27	75.2	75.4	75.8	76.1	76.4	76.7	77	77.5
Austria	76.4	76.6	77.1	77.4	77.8	77.6	77.9	78.3
	Healthy life years in absolute value at birth							
Females								
EU-27	:	62.5	62.5	62.6	62.2	62	62.7	62.2
Austria	60.4	60.1	61	61.5	59.7	60.8	60.7	60.4
Males								
EU-27	:	61.1	61.8	61.7	61.1	61.3	61.9	61.8
Austria	58.3	58.2	58.7	58.7	58.3	59.5	59.5	59.8
	Healthy life years at birth in percentage of the total life expectancy							
Females								
EU-27	:	76.6	76.3	76.1	75.5	75.1	75.7	74.8
Austria	73.5	73.1	73.7	73.9	71.6	73.1	72.8	71.9
Males								
EU-27	:	81	81.5	81.1	80	79.9	80.4	79.8
Austria	76.3	75.9	76.1	75.9	75	76.7	76.4	76.3

Source: Eurostat Database, [hlth_hlye]

Evidently, the quality of health services matters for the efficiency of the health system. Both within politicians and the population there is a "widely shared belief that health services are of a high quality in Austria" (Gönenç et al. 2011, 31). Yet, national health experts observe that this assertion is only to a very low degree backed by objective criteria or indicators, as respective data until recently scarcely have been available: "The Austrian system's operating without standard quality indicators is indeed one of its distinct characteristics" (ibid.). Furthermore, according to the rather limited information that *is* available, Austria repeatedly is not an international best performer regarding a number of quality indicators (see Hofmarcher 2013, 271ff. for an overview):

- Child mortality could be reduced to a considerable degree over the last three decades, but it is still somewhat higher than at average of EU-15 and it substantially surpasses the one in the respective best-performing European countries.
- Austria during the last decades succeeded in reducing mortality rates from certain frequent diseases clearly below OECD averages, and below averages in other high income countries such as Sweden, Denmark and the Netherlands (notably from infectious diseases, and from the diseases of the digestive and respiratory system). In other areas, outcomes are similar to comparable countries (such as the diseases of the circulatory and genitor-urinary systems, and cancers) (see as well Gönenç et al. 2011, 31). At the same time the age-standardised 5-year survival rate of breast cancer is now lower than at OECD-average, as in other countries the respective situation improved to an even higher degree than in Austria. A related picture applies for example for the rate of cardiac death within 30 days after a hospital stay (see Hofmarcher 2013, 275).
- Further problems appear to be evident regarding health prevention. The Austrian system is for example characterized by a comparatively limited outreach of certain important vaccination programmes.[38] As a result, the incidence of a serious disease

[38] There are some concerns however that available vaccination data in the Austrian context could be

such as hepatitis B is higher than in comparable countries (Gönenç et al. 2011, 32). From a more general perspective, outlays for health prevention (1.8% of overall health spending) are considerably lower in Austria than at average of EU-27 (2.9% of overall health spending) (Aiginger 2011; Hofmarcher 2013, 277).

- At first sight, standard health-related lifestyle elements in Austria do not differ significantly from OECD averages. At closer examination however, there are especially three important sources of concerns. alcohol consumption, smoking, and diet (OECD 2011a, 110; Gönenç et al. 2011, 37; Hofmarcher 2013, 275ff.). According to respective data, Austria has one of the highest rates of alcohol consumption among the population above 15. Smoking rates remain at high levels, while they have declined in other countries. In contrast, Austria has one of the lowest daily fruit eating among the 15 years old. Rates of physical activity are also below OECD averages. As a result, overweight rates (especially as well of young persons) have strongly increased in the 2000s, at a much higher pace than in most other countries. The increase in obesity rates was also above OECD averages.
- One other point of concern is the topic of inequality in health-related behaviours and outcomes. Overall, it appears that respective differentiations are rather low in Austria from an international comparative point of view, but regarding a number of parameters they are still substantial and some of them even point to the direction of increasing social stratification of health-related behaviour and outcomes (see for an overview Hofmarcher 2013, 275ff.; Gönenç et al. 201, 40).
- The Austrian health system shows an excessive bias towards hospital services. The number of acute beds is (although it got reduced) extremely high by international standards, as is the number of hospital discharges. On the positive side, the average length of stay in hospital could be reduced to some degree over the last decade, and it actually is somewhat shorter than at average of EU-25 (OECD 2012, 81).

3.2.3 Sustainability

The total expenditure on health care (excluding expenditure on long-term care) rose from 7.5% in 1990 to 8.8% of GDP in 1999 and to 9.1% in 2004. Between 2004 and 2008 respective numbers remained rather stable (9.1% in 2008), but spending in % of GDP increased significantly in 2009 (9.6%) – at first instance due to a decline of the GDP during the financial and economic crisis (whereas additional growth in expenditure was lower than in earlier years). In 2010, spending for health amounted to 9.5% of GDP, in 2011 to 9.2%. This reduction originates both from lower nominal increases in health spending than in earlier years[39] and from a higher growth rate of GDP.

The declared goals of the above mentioned "health reform 2012/2013" are twofold: To sustain or (regarding specific points) even to enhance quality of healthcare, and at the same time to guarantee for cost containment. The different institutions involved (the Federal Republic, the Main Association of Austrian Social Security Institutions and the different Health Insurance Organizations, as well as the Federal Provinces) agreed on a model where increases in health

incomplete and may underestimate actual vaccination rates.

[39] In 2010 spending for health increased by 2% in nominal terms, in 2011 by 2.2%. During the 1990s, it yearly increased – at average – by 6%, between 2001 and 2008 by 4.5%. Source: Data provided by Statistik Austria according to OECD System of Health Accounts: http://www.statistik.at/web_de/static/gesundheitsausgaben_in_oesterreich_laut_system_of_health_accounts_oecd_199_019701.xlsx (retrieved on 11.11.2013) & own calculations.

expenditure should not surpass the expected growth of nominal GDP (3.6% until 2016). According to data by the Ministry of Health, "the health reform 2012/2013" – when compared to earlier budget forecasts – will lead to cuts by social insurance providers amounting to a sum of 1.372 billion EUR. Furthermore, it got announced that cuts in respective spending by the federal provinces regarding the hospital sector are expected to amount to a sum of up to EUR 2.058 billion until 2016 (BMG 2012). From a mid-term perspective, the Federal Ministry of Health announced that the health reform 2012/2013 – by adjusting the growth of health spending to the growth of nominal GDP – will lead to a cost containment amounting to 11 billion EUR until 2020. However, critics charged that these numbers are premised on a too pessimistic "alternative budget scenario" which would take place without the reform, and that the goals of cost containment are at the same time not very ambitious. The envisaged effects of cost containment are predicted according to the assumption that yearly nominal growth for health care would amount to ca. 4.2% without the reform, and to ca. 3.6% with the reform. However, estimated growth rates in the "alternative budget scenario" are much higher than they actually were over the last two decades.[40]

3.2.4 Summary

Overall, an assessment of strengths and weaknesses of the Austrian health system comes to mixed results. One the one hand, equality in access to health services appears to be rather high by international standards, which as well holds for general availability and quality of services (though objective data on the latter are rather scarcely available for Austria). On the other hand, integration between different strands of health services (of the inpatient, outpatient and ambulant type) shows deficits, deriving from traditionally complicated structures of planning, coming along with competencies split (and partly shared) between different actors and institutions and lacking overall structural planning. This not only implies that it is sometimes difficult for patients to select between optimal sources of treatment, but as well comes with problems of efficiency and sustainability. Furthermore, regarding health prevention and as well health outcomes (measured according to international standard indicators) Austria repeatedly does not belong to the group of international best performers. The recent "health reform 2012/2013" has put many of these problematic issues on the agenda. However, given the fact that this reform at first instance aims at stepwise improvement, to be reached via institutional and procedural innovations now enacted, the actual future outreach and impact of the reform is rather unclear at the time of writing. Pessimists expect rather limited improvements only, whereas optimists hope that first positive steps will gain momentum, leading to de facto more widespread steps of reform.

3.3 Reform debates

The question of a structural and encompassing reform of the health system is a long-standing issue in Austria (see the ASISP reports for 2009 and 2010: Fink 2009; Fink 2010). Respective debates took place on the background of a very complicated organisational structure, entailing a considerable decentralisation of powers and multiple financing instruments. The latter continued to apply irrespective of the reforms of 2005, which were aimed at improving integrated planning (for more details see Hofmarcher/Rack 2006; Hofmarcher 2013; Trukeschitz et al. 2013). Given the limited actual positive effects of the "health care reform 2005" the issue of a structural reform of the health system remained on the agenda and

[40] See http://www.selbsthilfe-oesterreich.at/selbsthilfekonkret/selbsthilfekonkret-12013/gesundheitsreform-kosmetik-oder-realistische-chance/ (retrieved on 11.11.2013)

respective negotiations repeatedly took place between the health insurance providers, the interest organisations of the physicians, the Federal Republic and the federal provinces. However, for a long time it appeared that progress made within these negotiations was largely absent due to differences deriving from the structural interests of different stakeholders involved. In October 2011 representatives of the federal provinces announced that an agreement on how to reform the competencies within the health sector should not be expected before the mid of 2012, or – more likely – only towards the end of the year 2012.[41] The then dominating "dawdling around" may be explained by the fact that the respective "agreement pursuant to Article 15a" between the Federal Republic and the federal provinces, dealing with respective issues, was anyhow planned to remain applicable until the end of 2013 and some stakeholders were not really willing to change something structural before that date.

Then, in February 2012, the Austrian Government presented its so-called "consolidation package" on public budgets, which to some degree speeded up things regarding the envisaged health care reform. In the context of this consolidation package the Federal Republic, the federal provinces and the Association of Austrian Social Security Institutions (*Hauptverband der Sozialversicherungsträger*) agreed on the above mentioned numerical targets of cost-containment.[42] After that, additional and rather lengthy negotiations followed, leading to the "National Target-Management Contract" (*Bundeszielsteuerungsvertrag*), presented in June 2013.

As already sketched out above, the "health reform 2012/2013" addresses many of the challenges repeatedly stressed by international organisations like the OECD, national health experts and as well the EU country specific recommendations within the Europe 2020 strategy: the lack of integrated mechanisms of planning and financing, a strong bias towards inpatient services, deficits in health prevention etc. In institutional terms, the Health Reform 2012/2013 did not really overcome the problem of shared competencies and it will not lead to true "one-stop financing", as repeatedly urged by national experts and the OECD (see for example: Czypionka et al. 2009; 2010; Schelling 2010; OECD 2011a; see as well Trukeschitz et al. 2013). Inter alia for this reason, some experts and as well political players, especially opposition parties[43] and the interest organisations of the physicians[44], remained sceptical about the likely future impact of the reform. However, the intensity of reform debates on the health system declined after the principal decisions on the reform 2012/2013 had been taken, and for example the presentation of the "target-management contracts" (*Zielsteuerungsverträge*) at the level of the federal provinces in late 2013 did not gain much public attention.

Interestingly and irrespective of rather widespread reform debates in the recent years one topic did only get addressed rather scarcely in an explicit way, which is the one of equality of access to health services and the social stratification of health outcomes. The latter point has only been addressed insofar, that respective stakeholders and decision makers repeatedly stated that the structural reform under discussion and cost containment measures should not lead to restricted access to health care, but should have their emphasis on increasing efficiency at different levels.

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[41] APA0329 II, CI 05.10.2011.
[42] APA0285 II, WI 15.02.2012.
[43] See e.g. OTS0258 II 26.04.2013.
[44] See e.g. OTS0049 CI, II 21.05.2013; OTS0147 CI, II 21.05.2013.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

Long-term care is a rather young distinct area of social policy in Austria. It was only in 1993, when the two major cornerstones of the Austrian long-term care regime got introduced. The first one consists of the Federal Long-Term Care Allowance Act (*Bundespflegegeldgesetz, BPGG*)[45], codifying cash benefits for people in need of long-term care. The second one, as well decided in 1993, is an "agreement according to article 15a of the Austrian Constitutional Act" on measures for people in need of long-term care, agreed upon between the Federal Republic and the federal provinces.[46] According to this agreement, the federal provinces have to develop an adequate and comprehensive system of institutional, semi-institutional and home-based care services with full geographical coverage. However, he binding force of this agreement is rather limited as there are no sanctions attached.

4.1.2 System characteristics

The Austrian system of long-term care has a twofold design, consisting of cash benefits on the one hand, and publicly organised long-term care services on the other hand (see Österle 2013 for an overview). The respective cash benefit is called long-term care benefit (*Pflegegeld*). As from the beginning of 2012 long-term care benefits, originally introduced in 1993, fall within the sole competency of the Federal Republic, whereas before as well the federal provinces granted this kind of benefit (for specific groups). *Pflegegeld* is granted without means testing (against income or assets) and according to seven different levels, corresponding to a categorisation of seven different levels of individual care requirements / the health status of the person in need of care. The benefit currently amounts to EUR 154.20 per month in level 1 (the lowest level), but may be as high as EUR 1,665.80 in level 7. 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 long-term care benefits are actually used by the benefit recipients.

In addition, pursuant to the above mentioned agreement according to Article 15a of the Federal Constitution Act (endorsed in 1993) the federal provinces are responsible for establishing and upgrading a decentralised and nationwide 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 not-for-profit organisations of the so-called intermediary sector, i.e. social NGOs of different types (for an overview see e.g. Riedel/Kraus 2010, 21ff. Biwald et al. 2011; Trukeschitz et al. 2013). Services get financed by (co-)payments of persons in need for long-term care (who usually at the same time get the long-term care cash benefit, intended to partly cover these outlays) and by the general budgets of the federal provinces and municipalities (on a needs-tested basis in case of insufficient financial resources of the person in need for long-term care).

[45] BGBl. Nr. 110/1993 most recently changed by BGBl. I Nr. 71/2013; see http://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10008859 (retrieved 25.10.2013)

[46] BGBl. Nr. 866/1993; see: http://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10001280 (retrieved 25.10.2013)

Financing of long-term cash benefits comes from the general budget of the federal state, public financing of benefits in kind from the budgets of the federal provinces and municipalities, and, via the general fiscal equalisation scheme (Finanzlastenausgleich) and the so-called Long-term Care Funds (Pflegefond), introduced in 2011, as well from the budget of the federal state. This means that public spending on long-term care (in the more narrow sense, i.e. without care provided by the health system) is 100% tax financed in Austria.

The issue of data on actual public and private spending (see as well Trukeschitz/Schneider 2012) for LTC is somewhat tricky in the case of Austria, as for a long time different types of documentation existed in the different federal provinces so that within national documentation data repeatedly derived from estimations only. According to data provided by Statistik Austria in its time-series on LTC spending as operationalized within the OECD System of Health Accounts overall spending for long-term care increased from 0.95% of GDP in 1990 to about 1.3% of GDP in 1994 (when long-term care cash benefits were introduced) (see Annex Table 2). Thereafter, this number remained largely stable until 2008 but increased to about 1.56% in 2009 and then again sticked at about the same level thereafter. The growth effect in 2009 occurred due to decreasing GDP but also due to a raise of the benefit levels of long-term-care cash benefits, as decided in 2005 and 2008, and a growing number of people in need for long-term care.[47] In 1994 about 85% of all spending on long-term care was covered by the public sector, whereas about 15% came from private sources. The public share somewhat decreased during the following years (down to about 79.8% in 2004), but then remained largely stable and increased somewhat in 2010 and 2011 (to about 81.2%). Over the last decade the number of recipients of long-term-care cash benefits (plus 100,000 or plus 33% between 1999 and 2012) has increased to much larger degree than overall spending for LTC in % of GDP, which has been rising by about 19.5% during the same time.

Recently, new data on LTC-spending of the federal provinces has been made available via the so-called “Long-term Care Database”, implemented as from 2012 as part of the “Act on the long-term care funds” (see below chapter 4.1.3). These data indicate somewhat higher total spending on LTC than the data within the above mentioned time-series of Statistik Austria. According to the new data in 2011 total spending for LTC amounted to 1.77% of GDP (see Annex Table 2). Of this total sum 0.81% percentage points were allotted to cash benefits, 0.96% to benefits in kind/services provided by the federal provinces. The latter as well includes funds coming from co-payments by persons receiving respective services or by their relatives and other revenues of the federal provinces from other sources, which together amount to ca. 0.41% of GDP.

4.1.3 Details on recent reforms in the past 2-3 years

Several reforms took place in the area of long-term care over the last years, however without changing the major institutional setting of the system in place. The only major exception, decided within a reform package on the so-called “long-term care fund” (*Pflegefonds*), was that long-term care cash benefits (*Pflegegeld*) as from 2012 fall within the sole competency of the Federal Republic. Before, specific groups[48] were granted this benefit by the federal provinces. This reform came with a reduction of institutions responsible for the grading of care necessities in individual cases (according to the given seven-level model) from 303 (sic!)

[47] Data according to OECD System of Health Accounts, provided by Statistics Austria: http://www.statistik.at/web_de/static/gesundheitsausgaben_in_oesterreich_laut_system_of_health_accounts_oecd_199_019701.xlsx.

[48] At first instance co-insured persons like children and homekeepers, persons receiving benefits from the minimum income schemes of the federal provinces and employed persons.

to eight. However, the "explanatory notes" ("*Materialien*") on the respective bill do not announce to what degree administration costs are expected to be reduced by this measure.[49]

Overall, the main rationale for the decision on the Long-term care Funds Act (*Pflegefondsgesetz*; BGBl. I Nr. 57/2011)[50] was not the one to improve organisational structures, but to ensure mid-term financial feasibility of the system in place. During 2010, it got evident that federal provinces and municipalities faced increasing problems in financing intra- and extramural benefits in kind. Against this background the Federal Republic, the federal provinces and the municipalities agreed in March 2011 on the introduction of a joint "long-term care fund", planned to serve as an interim solution for respective financing problems until 2014. In sum, EUR 685 million were made available for the time until 2014, of which 2/3 are to be financed by the Federal Republic and 1/3 by the federal provinces and the municipalities. In February 2012 it got decided to prolong the long-term care fund until 2016, and that hereby additional funds of EUR 650 million will be made available.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

As already mentioned above LTC cash benefits (*Pflegegeld*) in Austria is not means tested in terms of personal or family income or assets, but in principle granted as a universal benefit. At the same time seven different levels apply, structured according to the health conditions and the amount of care requirements of the respective person.

In contrast, 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 capitalized), are taken into account. Only if the respective services cannot be financed via these resources, they – or the remaining part – of respective costs get financed by the federal provinces within Social Assistance and the Guaranteed Minimum Income Scheme. Furthermore, in most federal provinces a scheme of so-called "*Familienregress*" has been in place, which as well obliged relatives of persons in need for institutional care to means-tested co-payments, if respective costs could not be covered via personal income (incl. LTC cash benefits) and capitalization of assets of persons in need for LTC. These schemes of "*Familienregress*" got abolished step by step in all federal provinces, but in Styria co-payments by children for parents (and for parents for children) in need for institutional LTC got re-introduced in summer 2011.[51]

Information on regional disparities of accessibility of services until recently lacked validity, as the federal provinces applied different models of documentation implying that data in a number of cases was not directly comparable. Within the Long-term care Funds Act of 2011 (see above) it got as well decided that a so-called "long-term care database" will be introduced. The long-term care database covers information on: a. The number of persons receiving different types of benefits in kind and services (mobile/outpatient care, stationary/in-patient care, semi-stationary care, short-term (inpatient) care, alternative housing, case- and care management; b. Full-time equivalents of care personnel used to fulfil respective tasks; c. Spending for respective benefits in kind and services (according to two variants: gross=total; net=gross minus co-payments by persons receiving respective services

[49] http://www.parlament.gv.at/PAKT/VHG/XXIV/I/I_01208/index.shtml. (retrieved on 05.11.2013).
[50] See http://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=20007381
[51] See http://www.politik.steiermark.at/cms/beitrag/11538246/2494255/ for details (retrieved on 05.11.2013).

or by their relatives and minus other revenues – e.g. transfers by the federal provinces health funds).

Table 4 shows the "standard format", in which respective data is provided by Statistics Austria. What has to be taken into account is that these numbers only address services financed or co-financed via Social Assistance or Guaranteed Minimum Income (GMI).[52] This means that services financed by people in need of long-term care, who can to 100% afford respective services from their own income or via the capitalisation of assets, are not covered in respective data. Evidently, the data presented in the "standard format" of Statistics Austria per se is not very informative. What gets evident is that some services appear to be completely missing in some federal provinces (short-term inpatient care; alternative dwellings; case- and care-management) and that the proportion between persons covered by different kinds of services within one federal province varies to a large degree when the federal provinces are compared to each other.

Table 4: Care Services[1]) of the Federal Provinces [2]) 2011

Federal Province	Outpatient/mobile services	Inpatient/stationary Services	Semi-inpatient/stationary services (Day-Care)	Short-term inpatient/stationary care	Alternative dwellings	Case- and care-management
	Persons looked after [3])					
Total	**140,157**	**74,789**	**5,053**	**5,513**	**11,021**	**65,938**
Burgenland	4,611	2,018	149	0	0	0
Carinthia	10,521	5,018	64	402	79	1,483
Lower Austria	25,326	11,924	433	2,416	0	15,571
Upper Austria	31,150	15,681	852	9	8	9,500
Salzburg	5,779	3,861	544	420	0	3,027
Styria	15,044	15,473	253	0	654	0
Tyrol	8,295	5,400	337	782	0	5,279
Vorarlberg	12,531	2,054	421	505	120	298
Vienna	26,900	13,360	2,000	979	10,160	30,780
	Care Attendants (full-time equivalents) [4])					
Total	**11,945.7**	**30,572.6**	**(395.6)**	**(249.3)**	**(475.3)**	**(702.6)**
Burgenland	242.2	818.7	16.8	0.0	0.0	0.0
Carinthia	1,045.0	1,596.8	4.4	n.a.	14.1	4.0
Lower Austria	2,705.0	4,673.0	23.5	18.3	0.0	489.0
Upper Austria	1,305.6	5,351.8	43.9	1.0	2.1	38.7
Salzburg	591.9	1,868.9	32.8	n.a.	0.0	14.2
Styria	943.0	4,257.4	19.1	0.0	45.1	0.0
Tyrol	557.1	2,591.3	29.1	n.a.	0.0	n.a.
Vorarlberg	166.9	1,176.7	n.a.	n.a.	n.a.	7.7
Vienna	4,389.0	8,238.0	226.0	230.0	414.0	149.0

Source: STATISTIK AUSTRIA, Pflegedienstleistungsstatistik. Prepared 31.01.2013; - 1) Services of long-term care, if (co-)financed by funds of Social Assistance and Guaranteed Minimum Income (GMI) Respectively; services without "help for disabled" (Behindertenhilfe) and "basic maintenance" (Grundversorgung). - 2) If data is not available for all federal provinces (n.a.), then the "total" refers to the remaining federal provinces (in brackets). -3) Total number in the year under review (yearly sum). -4) Number at the end of the year under review (31.12.).

To get a closer picture of the respective situation, the number on persons looked after can be set into proportion with the number of the recipients of long-term care cash benefits (as a proxy for the number of people in need for long-term care). In doing so, "coverage rates" for different kinds of long-term care services can be calculated (Table 5).

[52] Furthermore, services via so-called disability aid (Behindertenhilfe) and primary care (Grundversorgung for asylum seekers) are as well not covered in these data.

Table 5: Care Services[1)] of the Federal Provinces 2011; coverage rates according to number of recipients of long-term care cash benefits (Pflegegeld) [2)]

Federal Province	Number of recipients of long-term care cash benefits	Outpatient Services	Inpatient Services	Semi-Inpatient Services (Day-Care)	Short-term inpatient care	Alternative Dwellings	Case- and Care-management
		Coverage Rates					
Total	**438,449**	**31.97**	**17.06**	**1.15**	**1.26**	**2.51**	**15.04**
Burgenland	19,734	23.37	10.23	0.76	0.00	0.00	0.00
Carinthia	33,634	31.28	14.92	0.19	1.20	0.23	4.41
Lower Austria	85,309	29.69	13.98	0.51	2.83	0.00	18.25
Upper Austria	70,956	43.90	22.10	1.20	0.01	0.01	13.39
Salzburg	23,985	24.09	16.10	2.27	1.75	0.00	12.62
Styria	73,792	20.39	20.97	0.34	0.00	0.89	0.00
Tyrol	29,412	28.20	18.36	1.15	2.66	0.00	17.95
Vorarlberg	16,261	77.06	12.63	2.59	3.11	0.74	1.83
Vienna	85,366	31.51	15.65	2.34	1.15	11.90	36.06

Source: STATISTIK AUSTRIA, Pflegedienstleistungsstatistik; Prepared 31.01.2013 & own calculations - 1) Services of long-term care, if (co-)financed by funds of Social Assistance and Guaranteed Minimum Income (GMI) respectively; services without "help for disabled" (Behindertenhilfe) and "basic maintenance" (Grundversorgung). 2) The number of recipients of long-term care cash benefits serves as a proxy for people in need of care.

Evidently, coverage rates on out- and inpatient services differ to a very substantial degree between the federal provinces. The same holds for the reported numbers of care-attendants in long-term care, when they get adjusted to the size of the likely demand (according to the proxy of recipients of long-term care cash benefits) and then indexed (see Table 6 below).

Table 6: Care Attendants (full-time equivalents) per number of recipients of long-term care cash benefits (*Pflegegeld*), indexed: total = 100

Federal Province	Outpatient/mobile services	Inpatient/stationary Services	Semi-inpatient/stationary services (Day-Care)	Short-term inpatient/stationary care	Alternative dwellings	Case- and care-management
	Care Attendants (full-time equivalents) per number of recipients of LTC cash benefits; total=100 [1)]					
Total	100.0	100.0	100.0	100.0	100.0	100.0
Burgenland	45.0	59.5	94.4	0.0	0.0	0.0
Carinthia	114.0	68.1	14.5	n.a.	38.6	7.4
Lower Austria	116.4	78.6	30.5	37.7	0.0	357.7
Upper Austria	67.5	108.2	68.5	2.5	2.8	34.1
Salzburg	90.6	111.7	151.7	n.a.	0.0	37.0
Styria	46.9	82.7	28.7	0.0	56.4	0.0
Tyrol	69.5	126.4	109.7	n.a.	0.0	n.a.
Vorarlberg	37.7	103.8	n.a.	n.a.	n.a.	29.5
Vienna	188.7	138.4	293.4	473.8	447.4	108.9

Source: STATISTIK AUSTRIA, Pflegedienstleistungsstatistik. Prepared 31.01.2013; & own calculations;
1) Number at the end of the year under review (31.12.) & own calculations.

Overall, the evident large variation of coverage rates of LTC benefits in kind and LTC services points to the direction that substantial deficits are likely in a number of federal provinces. However, more encompassing assessments on this point are largely missing at the time of writing (see as well Österle 2013).

4.2.2 Quality and performance indicators

For institutional care in Austria no common system for quality assurance and documentation exists. The nine federal provinces enacted different kinds of regulation on this issue (for an overview see BMASK 2012, 38ff.) but it is unclear if and to what degree these regulations actually guarantee high quality standards within institutional care, as respective outcome documentations are not available publicly on a regular basis.

Concerning long-term care in private households, first results are now available from an assessment organised by the Federal Ministry of Labour, Social Affairs and Consumer Protection (see BMASK 2012a, 24ff.). Hereby, within home visits the quality of long-term care got assessed according to a three stage scale (A, B, C), whereby in stage C two subtypes exist (C+ and C-).[53] The respective situation got appraised according to the following domains: 1. functionality of the housing situation; 2. body care and hygiene; 3. quality medical-nursing care; 4. nutrition incl. liquid intake; 5. housing situation concerning hygiene; 6. activities and participation in social life. Overall 5,276 home visits where conducted between August and December 2012 and the results of the assessment where overwhelmingly positive (see BMASK 2012, 30ff.). In none of the 6 dimensions gravely problematic situations (C- und C+) occurred in more than 0.7% of all cases. Level B classifications applies to ca. 1.5 to 3.5 for all cases in all but one domain, namely functionality of housing, where the situation turned out to be somewhat problematic in about 10.5% of all home visits. Consequently, A-ratings were given in more than 95% of the cases in all domains except of functionality of housing (ca. 89%).

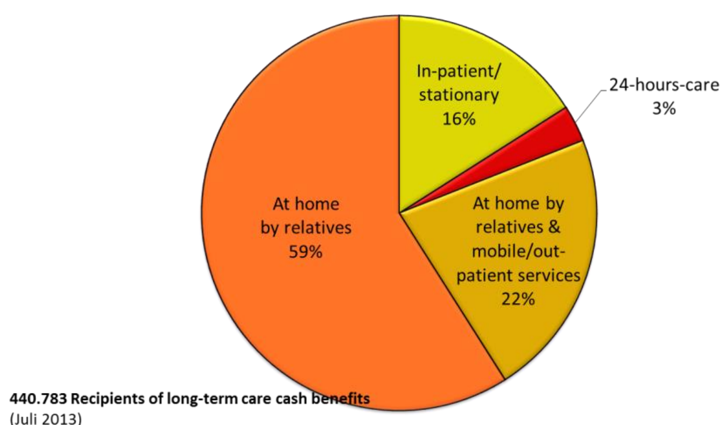
However, these positive results should be interpreted with caution. The reason for this is that only 9.4% of all the home visits in this assessment took place in households with benefit recipients of long-term care cash benefits (*Pflegegeld*) of the level five or higher (whereas in reality this group amounts to ca. 15.5% of all recipients of respective benefits). In other words: persons with comparatively high need of care are somewhat underrepresented. Furthermore, no breakdown is presented according to the seven different benefit levels of Pflegegeld (associated with different health status and need for care).

Overall, it appears to be fair to say that, irrespective of first steps taken to improve the documentation of and assurance of quality within home-based care further steps should be taken in this respect. This is especially true given the situation that about 60% of all recipients of long-term care cash benefits are looked after by relatives and friends only[54] (see Chart 2), and do not make use of any kind of institutional care, whereby the latter often serves as a kind of quality assurance in cases of mixed care arrangements.

[53] The assessment tool is a further developed version of ASCOT (Adult Social Care Outcomes Toolkit), originally developed in the UK.

[54] For a more detailed discussion on home care in Austria see Österle/Bauer 2012.

Chart 2: Long-term care arrangements 2013



Source: Federal Ministry for Labour, Social Affairs and Consumer Protection (BMASK)

4.2.3 Sustainability

Apart of estimations by the OECD (see e.g. OECD 2013) and the European Commission (European Commission 2012) the most cited national assessment estimating future demand (and future spending) on long-term care in Austria got presented by WIFO in 2008 (Mühlberger et al. 2008). This study presents a number of different scenarios for the years 2020 and 2030. According to the base-scenario (taking into account demographic changes only) the number of recipients of long-term care cash benefits will rise from 393,120 in 2006 to 631,426 in 2030, or by 60.6%. The most optimistic estimations of the "better-health scenario" (lower bound scenario of this scenario) indicate an increase to 536,041 recipients of long-term care cash benefits, or by 36.35%. In combination of different scenarios of the demand- and the supply-side real overall public spending according to the lower bound scenario will rise by 66% until 2030, according to the middle scenario by 159.7% and according to the upper bound scenario by 206.5% (see ibid. 34). The by far larger part of these increases derives from additional spending for benefits in kind, whereas cash benefits are estimated to rise to much lower degree. What at the same time gets evident here is a substantial range of possible developments, depending on how the respective parameters are set.

One other projection presented GÖG in 2012 (see GÖG 2012) indicates lower expected increases in spending for LTC-services than the ones presented by Mühlberger et al. (2008). GÖG applied a number of assumptions on likely future measures of cost containment and increased efficiency within organisational structures of LTC services. According to their estimations, spending for LTC services is likely to rise by 43.3% between 2010 and 2025 (net spending for LTC services; middle scenario).

What is clear irrespective of these different results of projections of future developments is the fact that public spending for LTC will have to rise substantially in the future even to sustain the current rate of coverage by formal care. Furthermore, as indicated by the huge variation of coverage rates between federal provinces, at least in some of them deficits in

formal care are already currently evident. The above mentioned long-term care fund, first introduced in 2011, is dedicated both to cover costs of the existing system and to enhance care services (especially of extramural care). However, given the limited amount of financial resources available from the long-term care fund and the huge differentiation of respective services already in place in the different federal provinces no far-reaching impact in sense of a standardization of the availability of LTC services is to be expected from the long-term care fund. In fact, it more is an instrument to safeguard the short-term financial feasibility of the structures already in place. Regarding the more long-term perspective, it is largely unclear how financial feasibility should be guaranteed in future. Yet, the most important stakeholders appear to agree that public spending for LTC services should as well in future remain to be financed via taxes, whereas the idea of a public LTC-insurance did not find many supporters (see below chapter 4.2.4).

Regarding formal carers problems of shortage of availability and the question of unfavourable working conditions within this sector are long-standing issues in Austria. Over the last decade, several measures have been decided to improve the respective situation, but many challenges still prevail (see e.g. the report of the "Reform working Group Long-term Care" (*Reformarbeitsgruppe Pflege*), presented in December 2012 (Reformarbeitsgruppe Pflege 2012).

According to estimations by the "Reform working Group Long-term Care" (*Reformarbeitsgruppe Pflege*) the demand for formal care attendants within services and benefits in kind provided by the federal provinces will rise from ca. 45,000 full-time equivalents in 2010 to about 67,500 full-time equivalents in 2025 (see Table 7). At the same time it is fair to say that no clear cut and encompassing political strategy exists on how to increase the availability of qualified LTC personnel.

Table 7: Projections for the number and structure of care attendants

	2010	2025	Change in %
Case- and Care-management	160	300	+87.5
Alternative Dwellings	2,750	4,500	+63.6
Short-term inpatient care	285	700	+145.6
Semi-Inpatient Services (Day-Care)	325	750	+130.8
Inpatient Services	30,135	43,100	+43.0
Outpatient Services	11,500	18,300	+59.1
Total	45,155	67,650	+49.8

Source: Reformarbeitsgruppe Pflege (2012, 15). Based on cost-projections for LTC services by GÖG (2012).

The future need for LTC is evidently not only influenced by demographic changes, but as well by the overall health condition of the growing number of elderly people. For this reason health prevention and rehabilitation is as well of major importance in the context of LTC. As already sketched out in the chapter on health (Chapter 3.2.2 above) health prevention appears to be one of the traditional weak points of the Austrian health system. Some positive steps have been taken on this point over the last years, but major challenges continue to exist (see Hofmarcher 2013, 189ff. for details).

4.2.4 Summary

Long-term care cash benefits are not sufficient to cover the total costs of formal LTC services and for that reason additional private outlays and/or funding via the minimum income schemes of the federal provinces (and hereby the capitalisation of available private assets) are the norm in case that people in need for LTC/their families opt for more encompassing formal care arrangements. Furthermore, availability of formal care arrangements varies to a very large degree when the nine federal provinces are compared to each other. Overall, this leads to a situation where a rather large part of LTC is performed via informal care of family members, or – in some cases – friends and neighbours etc.

Given the challenges of substantial regional differences of accessibility of services and respective quality assurance, a high rate of informal care (and potential related problems of quality and the conflicting goal of increasing formal employment of women), rising demand for LTC, shortages of qualified care personnel, and lacking financial sustainability the whole LTC system resembles a building site with many unsolved problems.

4.3 Reform debates

It is fair to say that challenges and problems of the current LTC system got more public and political attention in Austria over the last year. Furthermore, respective debates to some degree broadened in terms of content. In earlier years, respective public political statements on most cases had their focus on issues of cash the long-term care cash benefit (*Pflegegeld*) only, where opposition parties repeatedly criticized that this benefit does not get indexed for inflation in Austria on a regular basis. Then, towards the end of the first decade of the 2000s, the topic of so-called "24 hours care" at home very much dominated respective debates. Hereby, people in need of LTC are looked after by privately hired caretakers (at first instance from Eastern Europe; see Fink 2009, 20ff.; Bauer/Österle 2012; 2013), and this type of care arrangement originally in most cases was of the type of undeclared work, with then a black marked for such services evolving. Political decisions were made to legalize such care arrangements, whereby at the same time some minimum quality standards got stipulated and public financial subsidies were made available (see Bachinger 2009 and Österle 2013 regarding regulation on "24 hours care at home").

The problems of financial feasibility regarding LTC services provided by the federal provinces and the municipalities, which got evident in 2010 and then lead to the introduction of the "long-term care fund" (see above chapter 4.1.3), provoked some more encompassing debates on the future of the LTC-system in Austria. A "reform working group on long term care" (*Reformarbeitsgruppe Pflege*; inter alia comprising of representatives of the Federal Republic, the federal provinces, the municipalities and different interest organisations) got introduced in 2011 and presented its' results in December 2012 (see Reformarbeitsgruppe Pflege 2012). The suggestions of the above mentioned reform working group are not very concrete regarding a number of issues, which especially holds for the point of a structural organisational reform, asking for more harmonization[55], but stating that this goal should be met via instruments of soft governance at first instance (increased information on the status quo, common goals on service supply and quality management, increased monitoring and evaluation etc.). Furthermore, the working group did not provide new models for public financing of long-term care. It only agreed that financing should come from general tax revenue, whereas it rejected the idea of a long-term care insurance, as this would lead to a further increase of non-wage labour costs (see Reformarbeitsgruppe Pflege 2012).

[55] See for an overview on this issue e.g. Österle 2013; Trukeschitz et al. 2013.

Overall, question of future organisation of long-term care is on the agenda to some degree, and the reform working group with its report at least helped to put some problems on the table. However, it is unclear if this will have a substantial effect on future developments in the field. Here, the most important retarding force, namely a fragmentation of competencies and accountability remains to be in place (see as well Österle 2013). This means that the implementation of the different suggestions made by the reform working group again asks for negotiations between the different stakeholders involved. Furthermore, if none of them takes over a kind of leading role, then it is very unlikely that respective reform procedures really gain momentum.

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Press releases:

OTS = press release Originaltext-Service by Austrian Press Agency

APA = press release via Austrian Press Agency

Annex 1 – Key publications

[Pensions]

HAUPTVERBAND DER ÖSTERREICHISCHEN SOZIALVERSICHERUNGSTRÄGER (2013). Handbuch der österreichischen Sozialversicherung – 2013, Vienna, 190p. retrieved on 01.11.2013 from http://www.hauptverband.at/mediaDB/788530_Handbuch_der_oesterreichischen_Sozialversicherung.pdf
"Handbook on the Austrian Social Insurance System 2010"

This handbook informs about the development of Austria's Social Security in 2010 and includes comprehensive data in the areas of health, pension and accident insurance, maternity benefits and long-term care benefits. It also gives an overview of legal modifications in social security law enacted in 2010.

HAUPTVERBAND DER ÖSTERREICHISCHEN SOZIALVERSICHERUNGSTRÄGER (2013b). Statistisches Handbuch der österreichischen Sozialversicherung – 2013, Vienna, 208p. retrieved on 01.11.2013 from http://www.hauptverband.at/mediaDB/912068_Statistisches_Handbuch_der_oesterreichischen_Sozialversicherung.pdf
"Statistical Handbook on the Austrian Social Insurance System 2010"

This handbook informs about the development of Austria's Social Security in 2012 and includes comprehensive data in the areas of health, pension and accident insurance, maternity benefits and long-term care benefits. In contains data, tables and charts on revenues, spending and numbers o benefit recipients etc. At the same time it does not provide any interpretation of the respective data.

BUNDESMINISTERIUM FÜR ARBEIT, SOZIALES UND KONSUMENTENSCHUTZ, Sozialbericht 2011–2012. Ressortaktivitäten und sozialpolitische Analysen, Vienna, 2012, 349 p., retrieved on 15.11.2013 from http://www.bmask.gv.at/cms/site/attachments/3/7/2/CH2171/CMS1353079209699/sozialbericht_2011_gesamt.pdf
"Social report 2011-2012. Department activity and socio-political analyses"

This report of the Ministry of Labour, Social Affairs and Consumer Protection informs about activities in the areas of the statutory Social Insurance, consumer protection, long-term care provision, disabled persons' affairs, means-tested minimum income, pensioners' affairs, international and EU social policy and others. It provides data on social spending, risk of poverty and social exclusion, development and distribution of incomes and financial assets. It includes a chapter on exit pathways from the labour market to pensions (24 p.).

[Health care]

HOFMARCHER, MARIA (2013). Das Österreichische Gesundheitssystem. Akteure, Daten, Analysen, Vienna, 324 p. retrieved on 20.10.2013 at: http://bmg.gv.at/cms/home/attachments/9/8/1/CH1066/CMS1379592073352/oe_gesundheitssystem.pdf
"The Austrian Health System. Actors, Data and Analyses"

This book informs in a comprehensive way about the history, reforms, outcomes and current challenges of the Austrian health system.

HAUPTVERBAND DER ÖSTERREICHISCHEN SOZIALVERSICHERUNGSTRÄGER (2013). Handbuch der österreichischen Sozialversicherung – 2013, Vienna, 190p. retrieved on 01.11.2013 at http://www.hauptverband.at/mediaDB/788530_Handbuch_der_oesterreichischen_Sozialversicherung.pdf
"Handbook on the Austrian Social Insurance System 2010"

This handbook informs about the development of Austria's Social Security in 2010 and includes comprehensive data in the areas of health, pension and accident insurance, maternity benefits and long-term care benefits. It also gives an overview of legal modifications in social security law enacted in 2010.

HAUPTVERBAND DER ÖSTERREICHISCHEN SOZIALVERSICHERUNGSTRÄGER (2013b). Statistisches Handbuch der österreichischen Sozialversicherung – 2013, Vienna, 208p. retrieved on 01.11.2013 at http://www.hauptverband.at/mediaDB/912068_Statistisches_Handbuch_der_oesterreichischen_Sozialversicherung.pdf
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[Long term care]

ÖSTERLE, AUGUST (2013). Long-Term Care Reform in Austria: Emergence and Development of a New Welfare State Pillar, in: Costanzo Ranci/Emmanuele Pavolini (eds.): Reforms in Long-Term Care Policies in Europe. Investigating Institutional Change and Social Impacts, New York, 159-178.

This book chapter provides a very good overview on the development and actual reform challenges of the Austrian LTC system.

BMASK (2012). Österreichischer Pflegevorsorgebericht 2011, Vienna, 111 p. retrieved on 01.11.2013 at http://www.bmask.gv.at/cms/site/attachments/5/0/4/CH2094/CMS1313493260454/pflegevorsorgebericht_2011[1].pdf

Austrian Lon-term Care Report

This is the 18th annual report of the working group on long-term care provision, founded in 1993 to facilitate joint provisions of the Federal State and the Federal Provinces and secure the sustainability of affordable care provision. It informs about general developments, quality assurance, cash and in-kind benefits. It is the most encompassing yearly documentation on long-term care in Austria.

BUNDESMINISTERIUM FÜR ARBEIT, SOZIALES UND KONSUMENTENSCHUTZ, Sozialbericht 2011–2012. Ressortaktivitäten und sozialpolitische Analysen, Vienna, 2012, 349 p., retrieved on 15.11.2013 from

http://www.bmask.gv.at/cms/site/attachments/3/7/2/CH2171/CMS1353079209699/sozialbericht_2011_gesamt.pdf

"Social report 2011-2012. Department activity and socio-political analyses"

This report of the Ministry of Labour, Social Affairs and Consumer Protection informs about activities in the areas of the statutory Social Insurance, consumer protection, long-term care provision, disabled persons' affairs, means-tested minimum income, pensioners' affairs, international and EU social policy and others. It provides data on social spending, risk of poverty and social exclusion, development and distribution of incomes and financial assets. It includes a specific chapter on recent reforms in LTC (10 p.).

HAUPTVERBAND DER ÖSTERREICHISCHEN SOZIALVERSICHERUNGSTRÄGER (2013). Handbuch der österreichischen Sozialversicherung – 2013, Vienna, 190p. retrieved on 01.11.2013 at http://www.hauptverband.at/mediaDB/788530_Handbuch_der_oesterreichischen_Sozialversicherung.pdf
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HAUPTVERBAND DER ÖSTERREICHISCHEN SOZIALVERSICHERUNGSTRÄGER (2013b). Statistisches Handbuch der österreichischen Sozialversicherung – 2013, Vienna, 208p. retrieved on 01.11.2013 at http://www.hauptverband.at/mediaDB/912068_Statistisches_Handbuch_der_oesterreichischen_Sozialversicherung.pdf
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Annex 2 – Additional tables

Table 1. Spending on LTC according to System of Health Accounts (OECD)1) 1990 - 2011

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
	in Mio EUR																					
Public spending on long-term care total	1,056	1,091	1,145	1,428	1,871	1,934	1,912	1,942	2,057	2,185	2,224	2,262	2,297	2,368	2,483	2,614	2,745	2,886	3,147	3,483	3,654	3,845
Of which at-home care and long-term care cash benefits	*890*	*913*	*951*	*1,188*	*1,219*	*1,334*	*1,293*	*1,238*	*1,271*	*1,315*	*1,355*	*1,388*	*1,408*	*1,446*	*1,490*	*1,561*	*1,628*	*1,722*	*1,807*	*1,977*	*2,070*	*2,161*
Of which long-term care at isntitutions (and other spending)	*166*	*178*	*194*	*241*	*653*	*600*	*619*	*705*	*786*	*870*	*869*	*874*	*889*	*923*	*994*	*1,053*	*1,117*	*1,164*	*1,340*	*1,507*	*1,584*	*1,684*
Private spending for long-term care	235	250	276	296	318	340	364	389	409	439	487	515	537	580	627	649	675	693	748	836	863	887
Total spending for long-term care	**1,291**	**1,340**	**1,421**	**1,724**	**2,190**	**2,274**	**2,275**	**2,332**	**2,466**	**2,624**	**2,712**	**2,777**	**2,835**	**2,949**	**3,110**	**3,263**	**3,420**	**3,579**	**3,895**	**4,319**	**4,517**	**4,732**
GDP	136,135	145,949	154,189	159,275	167,219	174,794	180,560	184,321	191,911	199,266	208,474	214,201	220,529	224,996	234,708	245,243	259,034	274,020	282,746	276,151	286,397	300,712
	in % of GDP																					
Public spending on long-term care total	0.78	0.75	0.74	0.90	1.12	1.11	1.06	1.05	1.07	1.10	1.07	1.06	1.04	1.05	1.06	1.07	1.06	1.05	1.11	1.26	1.28	1.28
Of which at-home care and long-term care cash benefits	*0.65*	*0.63*	*0.62*	*0.75*	*0.73*	*0.76*	*0.72*	*0.67*	*0.66*	*0.66*	*0.65*	*0.65*	*0.64*	*0.64*	*0.63*	*0.64*	*0.63*	*0.63*	*0.64*	*0.72*	*0.72*	*0.72*
Of which long-term care at institutions (and other spending)	*0.12*	*0.12*	*0.13*	*0.15*	*0.39*	*0.34*	*0.34*	*0.38*	*0.41*	*0.44*	*0.42*	*0.41*	*0.40*	*0.41*	*0.42*	*0.43*	*0.43*	*0.42*	*0.47*	*0.55*	*0.55*	*0.56*
Private spending for long-term care	0.17	0.17	0.18	0.19	0.19	0.19	0.20	0.21	0.21	0.22	0.23	0.24	0.24	0.26	0.27	0.26	0.26	0.25	0.26	0.30	0.30	0.30
Total spending for long-term care	**0.95**	**0.92**	**0.92**	**1.08**	**1.31**	**1.30**	**1.26**	**1.27**	**1.28**	**1.32**	**1.30**	**1.30**	**1.29**	**1.31**	**1.33**	**1.33**	**1.32**	**1.31**	**1.38**	**1.56**	**1.58**	**1.57**

Source: STATISTIK AUSTRIA, version 31.01.2013;
http://www.statistik.at/web_de/static/gesundheitsausgaben_in_oesterreich_laut_system_of_health_accounts_oecd_199_019701.xlsx & own calculations 1) Within the System of Health Accounts, spending for LTC for the case of Austria repeatedly derives from estimations, given a lack of sound empirical dat

Table 2. Spending on LTC-services according to the "Long-term Care Database" and spending for Long-term Care cash benefits (*Pflegegeld*)

LTC spending by federal provinces for services/benefits in kind 2011						
Federal Province	**1. Outpatient Services**	**2. Inpatient Services**	**3. Semi-Inpatient Services (Day-Care)**	**4. Short-term inpatient care**	**5. Alternative Dvellings**	**6. Case- and Care-management**
	Gross Spending (in EUR)					
Total	**486,432,512**	**2,181,633,523**	**21,551,486**	**10,450,101**	**(158,333,624)**	**9,933,304**
Burgenland	6,726,803	50,603,642	349,220	-	-	-
Carinthia	24,162,430	138,804,449	432,522	550,000	.	185,103
Lower Austria	68,357,875	316,759,111	898,070	4,118,416	-	1,974,403
Upper Austria	65,084,478	325,343,062	1,634,596	11,091	173,860	2,134,729
Salzburg	17,995,390	90,544,771	629,380	233,216	-	864,467
Styria	49,000,000	366,652,174	1,199,500	-	1,198,402	-
Tyrol	26,914,206	130,998,917	831,622	420,266	-	235,227
Vorarlberg	21,073,000	77,666,706	242,127	1,131,404	1,167,863	100,625
Vienna	207,118,330	684,260,691	15,334,449	3,985,708	155,793,499	4,438,750
	Net Spending (in EUR) [5])					
Total	**314,764,696**	**1,140,154,640**	**18,432,337**	**6,178,384**	**(68,121,690)**	**9,585,716**
Burgenland	5,308,522	20,804,218	349,220	-	-	-
Carinthia	19,332,430	63,485,204	432,522	550,000	.	185,103
Lower Austria	40,525,597	147,887,178	898,070	2,118,416	-	1,974,403
Upper Austria	44,539,758	140,166,535	1,391,854	6,963	52,792	2,132,094
Salzburg	14,538,846	42,615,035	629,380	233,216	-	864,467
Styria	30,200,000	201,997,846	645,000	-	753,580	-
Tyrol	18,588,322	66,552,539	390,067	320,283	-	235,227
Vorarlberg	9,884,903	43,386,143	242,127	765,840	514,692	100,625
Vienna	131,846,319	413,259,942	13,454,096	2,183,666	66,800,626	4,093,797
	GDP in Mio EUR					
	300,712					
	Gross Spending in % GDP					
Total	0.16176026	0.725489346	0.00716682	0.003475119	0.052652912	0.003303262
	Net Spending in % GDP					
Total	0.104673141	0.379151693	0.006129565	0.002054585	0.022653466	0.003187673
	Outpatient Services	**Services of "inpatient type" (sum of 2. to 5.)**				**Case- and Care-management**
Total Gross Spending in % GDP	**0.16176026**	**0.788784197**				**0.003303262**
Total Net Spending in % GDP	**0.104673141**	**0.413176982**				**0.003187673**
	Spending for all benefits in kind/services provided by the federal provinces (sum of 1 to 6)					
Total Gross Spending in % GDP	**0.953847718**					
Total Net Spending in % GDP	**0.521037796**					
	LTC spending for long-term care cash benefits by the federal state & the federal provinces in 2011					
Federal state in Mio. EUR	2,070.60					
Federal provinces in Mio. EUR	379.07					
Total in Mio. EUR	2,449.67					
Total in % GDP	**0.81**					
	Total spending for LTC in % GDP					
Total Gross Spending in % GDP	**1.77**					
Total Net Spending in % GDP	**1.34**					

Source: STATISTIK AUSTRIA, Pflegedienstleistungsstatistik. Prepared 31.01.2013; & own calculations.

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