

ECONOMIC SURVEY OF AUSTRIA 2005:

FRAGMENTED DECISION MAKING NEEDS TO BE REDUCED

This is an excerpt of Chapter 3 in the OECD Economic Survey of Austria, 2005,

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Disaster prevention involves federal and local government

1. In August 2002 the most serious floods for more than 100 years touched large regions north of the Danube and caused damage of about 2% of GDP. Many areas were not prepared for a catastrophe of this kind and the magnitude of individual losses required large scale compensation efforts from public budgets. An analysis of hydrographical trends argued that the likelihood of floods increased. A thorough analysis of the 2002 flood¹ shows that scope for protection against natural disasters is limited. A number of conclusions have been drawn by the experts participating in this project, mainly emphasising passive flood prevention, measures in the catchment area, retention measures and nature-near structural protection measures. The government has also made clear that regional and local hazard zone plans have to be redesigned. This is a competence of the states, which have finished this task for about 65% of municipalities. The new plans identify not only areas at high risk, but also retention areas. Such areas are to be kept free of buildings and transport infrastructure. Past experience shows that natural disasters lead to significant budgetary costs. Measures which would contain the impact of future natural disasters would also curb such costs. *The government should therefore make sure that the measures outlined in a big interdisciplinary flood study are also implemented by the responsible lower levels of government. Conditioning part of federally provided transfers on compliance with appropriate flood risk prevention measures could enhance efforts in the right direction.*

Social assistance

2. Over the last decade or so labour market policies of the federal government have gradually given a larger role to measures designed to activate the unemployed. Developing this approach into a coherent strategy requires that disincentives for labour force participation and employment associated with the provision of social assistance benefits (SH) be addressed as well.

3. SH is subject to legislation by the states, and is financed by the states, with benefits generally administered by associations of municipalities, while unemployment insurance benefits are financed and administered by the federal labour office. SH for income support is means-tested and paid to all persons, working or not, whose income from other sources falls below a certain subsistence level. Those who are able to work are in principle obliged to accept employment to be eligible for SH benefits and have to be registered as unemployed. Recipients who refuse to co-operate might face sanctions. By the end of 2002

benefits were extended to some 91 000 persons living in households, including supported family members. The states' regulations differ with respect to eligibility conditions, the generosity of benefits and modes of organization and financing. Local administrations have some discretion with respect to executing the law. At present the decentralisation of the social assistance system is associated with a number of shortcomings that warrant improvement.

4. First, statistical information on recipients of social assistance is deficient in several respects. Data delivered to the Statistics Office mainly contain information on the stocks of persons or number of episodes associated with aid within a given year, while information on the duration of support and on socio-economic characteristics of the recipients such as age, marital status and education is lacking. Hence, published information does not even allow judgment on basic characteristics such as to what extent support accrues to persons of working age or other age groups. More specifically, the lack of suitable statistical information is rendering analysis of the impact of income support and labour market policies on labour force participation and transitions into and out of employment almost impossible. In the same vein, statistics are not harmonised across states. Some states record only persons receiving permanent income support as opposed to one-off payments, and the definition of permanent support varies across states, ranging from a few months in some states to half a year or a year in others.² Data comparability is further reduced by the regions' discretion on whether or not social assistance is granted in terms of one-off or permanent transfers.

5. Second, dispersed responsibilities across sub-national governments go along with a lack of coherence between income replacement and activation policies that is likely to reduce incentives to accept employment. In principle, receipt of social assistance is conditional on the recipients' willingness to accept employment. However, eligibility standards appear to vary widely across both states and regions. Often, social assistance is granted on a one-off basis, associated with less stringent assessment of work availability, even if receipt of social assistance is not temporary. Efforts to monitor job search activities of social assistance recipients differ across jurisdictions, which may have contributed to variations in the number of SH recipients relative to the level of unemployment across sub-national jurisdictions.

6. Third, some share of SH recipients simultaneously receive unemployment assistance (*Notstandshilfe*, NH), which also provides means-tested income replacement for unemployed persons whose eligibility for receipt of unemployment insurance benefits is exhausted. While both types of benefits are of potentially indefinite duration, NH is extended at a fixed replacement ratio of previous earnings and is administered by the PES. The share of long-term unemployed who receive both types of benefits simultaneously still appears to be relatively small, but there is some evidence that simultaneous claims increased significantly in recent years. Since the share of part-time and atypical employment contracts is increasing, social assistance benefits that top up income replacement provided by the PES are likely to gain further importance. Moreover, the increasing number of older workers, who are subject to a higher risk of long-term unemployment than other age groups, may raise simultaneous take-up of SH and NH in the future. The dichotomy of the two means-tested systems is likely to be associated with inefficiencies. The fact that means-tested benefits, based on different rules, are processed by two different layers of government increases administrative cost. It also raises the bureaucratic exposure of recipients of both types of benefits who need to deal with two separate administrations. Also, each layer of government only bears part of the budgetary costs of means-tested support for the unemployed, which could have a negative impact on placement efforts by both the labour office and the municipalities.

7. Moreover, the mode of financing SH poses disincentives for recipients to pick up employment, which appears to be inconsistent with activation policies followed by the PES. In general the states claim back SH benefits from former recipients after they have found employment and once their earnings exceed a certain threshold. This regime reflects the fact that social assistance is considered to be a source of income replacement of last resort and serves as a financing instrument at sub-national government levels.

This practice leads to very high marginal effective taxation of earnings, on top of the one that is induced by the withdrawal of benefits when employment is accepted.³

8. *Social assistance and unemployment assistance for recipients who are able to work should be combined into one means-tested income replacement scheme*, removing the inefficiencies associated with the separate provision and financing of the two means-tested benefit systems. To overcome the lack of coherence between income replacement and activation measures, *responsibility for the financing of social assistance payments should be moved to the federal government, with the federal employment office in charge of disbursing the benefits*. This assignment of responsibilities would allow to more effectively combine benefit payment with the monitoring of job search by all unemployed. *Also, social assistance benefits should not be reclaimed by the states so as to lower the effective taxation of earnings. To reduce incentives to pick up social assistance payments in the first place means testing and work availability testing should be strict.*

Health care

9. While Austria enjoys the highest self-reported satisfactions levels with health care services among EU countries and nearly universal coverage of health care services, a number of fiscal federal issues arise. Responsibilities in funding and financing of health care are fragmented, particularly in the hospital sector, involving the federal government, the state governments, the municipalities and social health insurance. In addition, health care services provided by hospitals and outside the hospitals by practicing physicians have been managed separately.⁴ At the same time, defined quality standards have been missing.

10. While the proportion of GDP devoted to health care spending in Austria – 7.7% of GDP in 2003 – appears moderate, health care costs may be underestimated by 1.8% of GDP.⁵ Incomplete statistical coverage of the states' financing of hospital deficits contributes to the underestimation of healthcare spending.⁶ Details of the states' financial contributions to hospitals are not made public in all states and some states have reclassified subsidies they provide to hospitals as loans, rather than transfers, in recent years.⁷ Implementation of the OECD system of health accounts is expected to improve data transparency as well as the international comparability of Austrian health care spending data in the near future.

11. According to the social insurance association, the social health insurance finances 39% of total spending on hospital-provided services, with the states and municipalities contributing 35% and the federal government 9%.⁸ Most contributions to finance services provided by the government-funded hospital sector are pooled in state-level off-budget health care agencies which manage hospital financing (*Landesgesundheitsfonds*, LGFs⁹). The funding contributions of the federal government, social health insurance and states to the LGFs are determined in an agreement between the federal government and the states. Some states, however, provide additional funds, in part outside the LGFs, mostly to cover deficits of hospitals within their territory, as the contributions to the LGFs agreed by the federal government, social health insurance and the states are subject to budget ceilings.¹⁰ While the funds disbursed by the LGFs are distributed across hospitals according to a national system of diagnosis-related groups (DRGs), states are free to distribute their additional funds according to criteria they determine themselves. Investment spending is born separately by the hospital owners, mostly state and local governments.

12. While the states finance less than half of the government outlays for hospital services, the states play a dominant role in decision making for hospital services (see Box 3.3¹¹), reflecting the assignment of health care policy responsibilities in the constitution. This is likely to weaken incentives to achieve cost reductions in hospital services, as state governments may have an interest in maintaining hospital capacity in their state, but only face part of the cost of doing so, which is likely to reduce incentives to cut excess capacity and take advantage of increasing returns to scale. Hospitals do not face a hard budget constraint, which dulls incentives for cost reduction stemming from the DRGs. In addition, to the extent that state-financing of deficits compensates cost differences across states, cost-saving incentives from the DRG

system are weakened. Some states also split contributions needed to cover spending overruns with municipalities, reducing incentives for cost-effectiveness.¹²

13. While mixed responsibilities characterise financing of the hospital sector, the funding of service provision by practicing physicians is in the hands of the social security system, which sets up the contracts with doctors' associations. Remuneration systems in both sectors have thus evolved separately, generating incentives to shift services for patients treated by hospitals to practicing physicians, and *vice versa*, resulting, in some cases, in the duplication of medical interventions.¹³

Box 3.3. Hospital financing: the new agencies for health

A new system of health care agencies at the federal and state level, introduced in 2005, is in charge of implementing health care policy in both the hospital sector and the sector of practicing physicians as well as channelling financial flows to providers in both sectors for selected projects.

The new federal health care agency (*Bundesgesundheitsagentur, BGA*), is in charge of the planning of health care supply for all stationary and ambulatory services, setting up indicative budgets, setting quality and accounting standards, further development of remuneration systems and fostering health promotion. For example, the BGA is in charge of developing a proposal to reform the remuneration of services which have been generating incentives to shift patients to stationary treatments.

The new state health care agencies (*Landesgesundheitsfonds, LGFs*), implement guidelines of the *Bundesagentur* in these policy areas at the state level. The LGFs also take decisions which are binding for both the states and the social security association and take over the role of the former *Landesfonds*, pooling the financial resources from the social health insurance, the federal government and the states for hospital funding. Failure to implement guidelines of the BGA can lead to the withholding of funds to the LGF, up to 1.6% of total inpatient care spending.

The LGFs are also in charge of designing projects to improve the coordination of services between the ambulatory and the stationary sectors. 1% of the LGF's funds are earmarked to such projects ("reform pool") in 2005 and 2006, rising to 2% in 2007. The respective state and the social health insurance have to agree on these projects which are required to benefit both parties financially. Thus, the "reform pool" should, for example, compensate the social health insurance financially for the shifting of treatments from the hospital sector to practicing physicians. The social health insurance remains in charge of contracting and paying for services provided by practicing physicians, but has to follow guidelines set by the federal and state health agencies, for example, on the number of doctors who can contract services with the health funds.

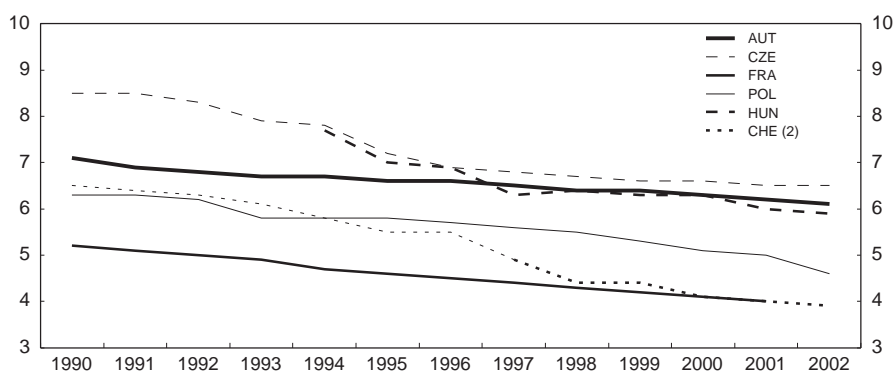
The BGA and LGFs include representatives of the main players in health care service financing: health funds, the federal government and state governments, as well as representatives of the patients' and doctors' associations. While the federal government will have a majority of votes in the federal health agency, consensus is generally required. Moreover, all matters that affect hospitals require the approval of the states, while matters concerning the practicing physicians require approval of the social health insurance. In the LGFs, the respective states have a majority of votes on decisions on hospital-provided healthcare services, while the social security association has a majority concerning decisions on care outside the hospital sector.

14. While take-up of services of practicing physicians – as measured by the number of patient visits per population – is moderate in comparison to other OECD countries, the hospital caseload in Austria is the highest among all OECD countries and recorded substantial increases in the years following the introduction of DRGs in 1997.¹⁴ The large hospital caseload is in part explained by the large acute-bed capacity interacting with the DRG system. While the introduction of DRGs in hospital financing helped to bring about a substantial fall in the duration of hospital stays, helping to slow the rapid rise in hospital care expenditure, high hospital capacity has exacerbated incentives for health care providers to maximise hospital admissions which typically result from DRG financing systems, thus undermining cost-reducing effects of DRGs.¹⁵ Moreover, Austria has made less progress in reducing acute care beds than other countries with high hospital capacity (see Figure 3.5). Indeed the federal audit court, among others, has noted significant overcapacity, suggesting that hospital services to the tune of € 3.8 billion (about 1.7% of GDP) should be shifted from the hospital sector to practicing physicians. The social insurance association

estimates that between 30 and 40 hospitals in Austria should be closed on both medical and economic grounds, as advantages from increased specialisation and increasing returns to scale of hospital size for both costs and quality of care may not be fully utilised in some cases. Moreover, hospital outputs, measured according to DRG points, could possibly be achieved at substantially less input costs, according to recent studies.¹⁶ Fragmented decision making in health care financing and spending responsibilities has thus contributed to the fact that efficiency reserves in the hospital sector have not been fully exploited and that the allocation of service provision across the various health care providers leaves room for improvement.

Figure 3.5. Hospital capacity

Acute care beds per 1 000 population¹



1. Refer to source for details of concept variations across countries.
2. Break 1996/1997 due to implementation of a new system of hospital statistics.

Source: OECD Health Data 2004, 3rd edition.

15. To raise efficiency in health care provision, the government has launched an initiative to overcome fragmentation in health care financing and spending. In particular, the LGFs, created in 2005 on the basis of an agreement between the federal government and the states, bring together the government institutions involved in health care financing and have been given the task to co-ordinate health care service provision across hospitals and practicing physicians (see Box 3.3). The assignment of responsibilities to the different government institutions and the funding has largely remained unchanged, however.

16. The new LGFs can issue guidelines which are binding for both the social health insurance and the states, marking progress in bringing together disparate decision-making powers on hospital-provided health care services and services provided by practicing physicians. However, the approval of each state is still required for any decisions regarding the hospitals in its territory, while states continue to finance only part of the outlays for hospital-provided services. In addition, the states have been given some share of decision-making on the provision of services by practicing physicians, which they do not finance, which adds to split decision-making and financing responsibilities on health service provision. Consensual decision-making among the various institutions involved in the health care agency system may slow progress in health care reform. New earmarked funds for fostering coordination between the ambulatory sector and the stationary sector are unlikely to be a substitute for an efficient assignment of responsibilities.

17. *Sub-national levels of government should not be able to block hospital supply planning decisions unless they are fully in charge of paying for hospital-provided health care services. Indeed, it should be possible to close hospitals which under-perform quality standards. More fundamental reform should aim*

at assigning financing and spending responsibilities for both the hospitals and practicing physicians to one government institution, giving it the role of purchaser of health services. To this end the health care agencies could be developed further to purchasers of all health care services, including services provided by practicing physicians. The health care agencies would have to be placed in the responsibility of only one level of government which should also be in charge of financing the agencies in full. Economies of scale in the hospital sector, in particular, suggest that the federal government level would be best suited for this task. Assignment to the states may be feasible if the agencies can purchase hospital services across the borders of the states, but would also require that the states raise substantial own tax revenues to ensure cost-effectiveness. An alternative option for reform would be to assign financing and spending responsibilities for both health care sectors to social health insurance.

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Programme management in environmentally sensitive areas can be improved

18. Austria is continuing to provide considerable resources for improving sustainable development. With 2.4% of GDP pollution abatement and control costs are the highest among the OECD member countries providing such data.¹⁷ Performance is in general good, however it is not always clear how this relates to spending, suggesting that there is scope to improve the efficiency of resource allocation for programmes aiming at supporting sustainable development.

19. In April 2002 the Austrian Federal Government adopted a National Strategy for Sustainable Development identifying 20 key objectives covering social, economic and environmental dimensions of

sustainable development. Implementation is based on annual work programmes. Progress is monitored along 48 indicators and published in annual reports. An external evaluation is planned. This framework promises to deliver a high degree of policy integration on the level of individual programmes, although coverage is not yet complete (Box 3.4) and prioritisation and cost efficiency is not guaranteed. While the wealth of information provided in the progress and indicator reports is commendable it is not possible to link progress to individual programmes or the interaction of programmes. While the data underlying the indicators have in general been compiled only since 2003, the indicators are already used for international comparisons to some extent. No attempt is made yet to benchmark best practice or programme targets. No mechanism is available to deal with conflict cases, which could help prevent lengthy court proceedings. *The annual implementation reports should contain an explicit statement about the main indicator changes to be achieved by individual programmes. The terms of reference for the evaluation of the overall strategy should include an explicit request to assess the cost effectiveness of individual programmes. Future prioritisation of programmes should take cost effectiveness explicitly into account. A mechanism should be put in place within the National Strategy for Sustainable Development which would allow the reconciliation of the different dimensions of sustainable development before the start of supra-regional projects. Indicator reports should include benchmarking information, which would allow a comparison of how Austria fares with respect to programme efforts and international best practice performance.*

Box 3.4. The Semmering Tunnel

An example for missing policy integration across different levels of government

A headline example of missing policy integration of different sustainable development goals is the decade-long conflict over a tunnel, which would shorten rail-travel time between Vienna and the southern states of Carinthia and Styria by about half an hour. The project volume is about € 1 billion, of which about € 100 million have been spent already. The government of Lower Austria opposes the project because of local nature protection concerns while the governments of Styria and Carinthia together with the federal government support the project for economic and transport policy reasons including enhanced opportunities to shift transport volume towards the less environmentally damaging rail transport. The current railtrack over the Semmering is not fit for big containers and rapid trains. Hence transporting goods and persons between Vienna and the southern states of Carinthia and Styria mainly runs on roads. The basic issue is that a supra-regional project can be blocked on the grounds of local concerns, which obviously are not consolidated on a higher level.

The project made multiple preparations necessary, was started, but is now on hold because of a natural protection decree of the state government of Lower Austria, rejecting the project:

First the rail track between Vienna and the Italian border was declared a high performance track by a decree of the federal government.

Second a law concerning the financing of the tunnel project passed the federal parliament.

Third a decree of the minister of transport charged the high performance rail track company (*HL-AG*) with the realisation of the project.

1989 Start of planning phase.

1990 Positive assessment of the environmental impact of the project.

1991 Choice of the track by decree (out of 19 alternatives).

1993 Economic analysis of the project by an external consultant (*Prognos AG*) demonstrates the project to be preferable relative to alternatives (renovation of the 150 year old track, construction of a new track without a tunnel).

1994 Final permission by the highest rail track authority after hearing all concerned federal and local government authorities and after consideration of all public (including environmental) interests.

1994 Start of construction works.

1994 Start of the natural protection proceedings under the jurisdiction of the state of Lower Austria.

1999 The Austrian Constitutional Court (*Verfassungsgerichtshof*) confirms that the competence in issues of natural protection is with the states – even concerning rail track construction, which is a federal competence - but that the states have to consider supra-regional matters when issuing a decree in this area.

2000 Stop of construction works after a negative natural protection decree from the government of Lower Austria.

2001 Second negative nature protection decree concerning the project.

2003 The federal parliament passes a motion to encourage the federal government to implement its decisions

concerning the construction of the Semmering Tunnel.

2004 The high administration court (*Verwaltungsgerichtshof*) rejects the negative natural protection decree because of an excessive interpretation of competences. The state of Lower Austria is asked to repeat the natural protection examination.

2004 The government of Lower Austria solicits new expertise, which argues that 12 out of 14 swamps would be endangered if the construction of the tunnel were continued.

Notes

1. Analysis of flood events 2002 – FloodRisk, interdisciplinary project carried out at the Ministry of Agriculture, Forestry, Environment and Water Management with more than 150 participating experts. The project also benefited from co-operation with Swiss government institutions.
2. See Bock-Schappelwein (2004).
3. Statistical information on the extent to which the states re-claims benefits is incomplete. However, the ratio between SH spending and revenues on account of the SH system varies substantially between states – ranging from 110% to 3% in 2001 – which might reflect to some extent differences in regress policies. For example, the state of Vienna does not reclaim SH benefits. However, the variation in the revenues ratio might be overstated as reporting across states is uneven. Some states do not report full revenues to Statistics Austria, and in some cases revenue items are included which are not strictly associated with SH granted to households. See Bock-Schappelwein (2004).
4. Streissler (2004).
5. See *e.g.* Hofmarcher *et al.* (2004).
6. Rechnungshof (2002) In particular, state and municipality funding to cover deficits of hospitals are not recorded as health spending. In addition long-term care for the elderly which is recorded as health spending in other OECD countries is not recorded as health spending in Austria.
7. Streissler (2004). OeNB (2004). Reclassification of subsidies as loans has resulted in a reduction of general government spending and the general government's deficit, as measured in the national accounts, by about 0.3 % of GDP.
8. Including funding provided by hospital owners, which in most cases are the *States* and the municipalities. Patients out-of-pocket spending and private health insurance contribute 5%, social assistance 1% of revenues.
9. The *Landesgesundheitsfonds* replaced the *Landesfonds* in 2004. See Box 3.3 for details.
10. The funds of the federal government and social security are distributed across hospitals according to a DRG system.
11. The states also played a predominant role in the *Landesfonds* which were in charge of hospital funding before introduction of the LGFs.
12. Hofmarcher and Riedel (2001).
13. See *e.g.* Streissler (2004).
14. Austrian hospital discharge statistics include same-day discharges since 1996, which is not the case in most OECD countries, making Austrian hospital discharges appear larger relative to other countries. However, those OECD countries which also include same-day separations in discharge statistics – Hungary, Luxembourg, New Zealand and the United States – have substantially lower discharges than Austria. See OECD (2003b).
15. Docteur and Oxley (2003).
16. Hofmarcher *et al.* (2005), Hofmarcher *et al.* (2002).
17. See the 2003 *OECD Environmental Performance Review for Austria*.

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