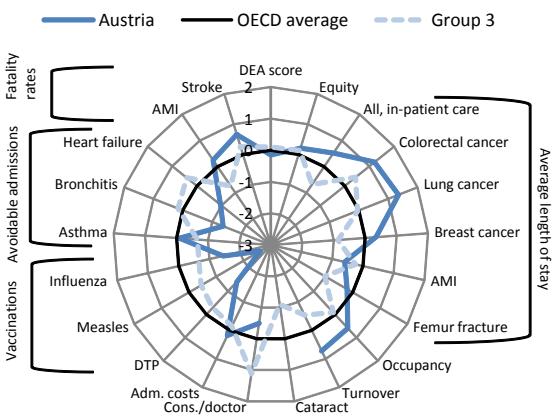
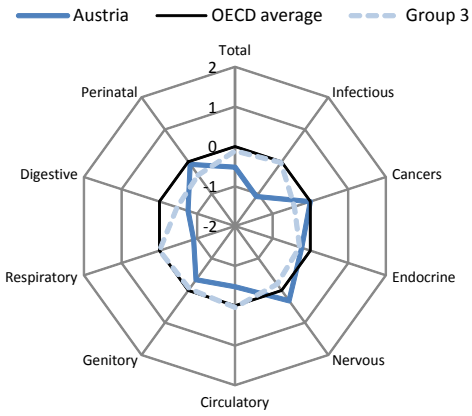
Austria: health care indicators

Group 3: Austria, Czech Republic, Greece, Japan, Korea, Luxembourg

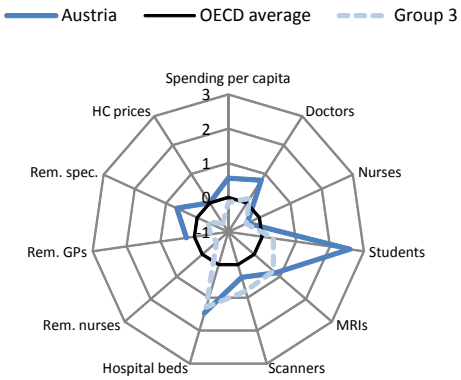
A. Efficiency and quality



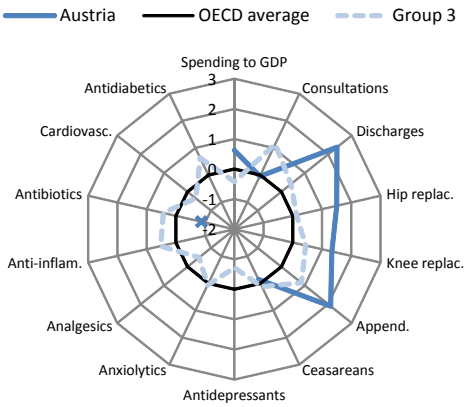
B. Amenable mortality by group of causes



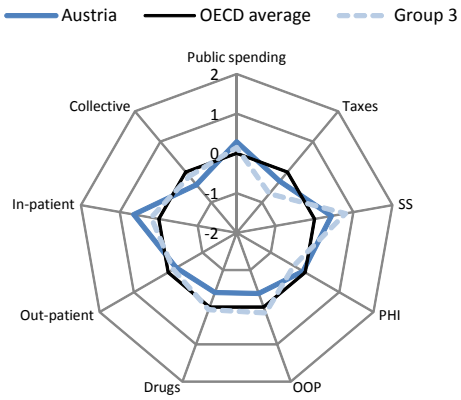
C. Prices and physical resources



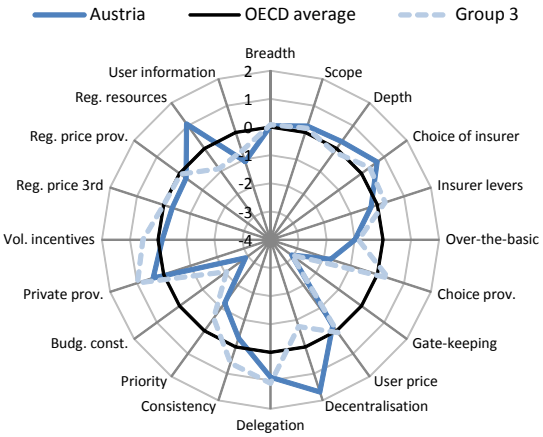
D. Activity and consumption



E. Financing and spending mix



F. Policy and institutions



Note: Country groups have been determined by a cluster analysis performed on policy and institutional indicators. In all panels except Panel A, data points outside the average circle indicate that the level of the variable for the group or the country under scrutiny is higher than for the average OECD country (e.g. Australia has more scanners than the OECD average country).
In Panel A, data points outside the average circle indicate that the group or the country under scrutiny performs better than the OECD average (e.g. administrative costs as a share of total health care spending are lower in Australia than on average in the OECD area).
In all panels except Panel F, data represent the deviation from the OECD average and are expressed in number of standard deviations.
In Panel F, data shown are simple deviations from the OECD average.

Source : OECD Health Data 2009; OECD Survey on Health Systems Characteristics 2008-2009; OECD estimates based on Nolte and Mc Kee (2008).

AUSTRIA

GROUP 3: Public basic insurance coverage with little private insurance beyond the basic coverage. Extensive private provision of care, with wide patient choice among providers and fairly large incentives to produce high volumes of services. No gate-keeping and soft budget constraint. Limited information on quality and prices to stimulate competition.

Efficiency and quality	Prices and physical resources	Activity and consumption	Financing and spending mix	Policies and institutions	Weaknesses and policy inconsistencies emerging from the set of indicators
About average DEA score; low rates of amenable mortality	Higher health care spending *per capita* and as a share of GDP	More hospital discharges *per capita*	Lower out-of-pocket share	More generous insurance coverage	Consider whether rebalancing resources from the in-patient to the out-patient care sector could contribute to increasing health spending efficiency. Introducing gate-keeping arrangements and/or restricting the use of retrospective payment of costs for hospitals could be options to avoid excessive in-patient activity. Reforms should also aim at increasing the quality of out-patient/preventive care
Rather high hospital (output) efficiency	More acute care beds *per capita* than the OECD average		Higher in-patient share	Less choice of provider	
Below average scores on the quality of out-patient and preventive care	More doctors and students *per capita*. Higher relative income level of specialists and GPs		Lower drug share	Less private provision and volume incentives and more regulation of resources	
				More decentralisation and less consistency. Less priority setting and little constraint put on health care spending via the budget process	Enhanced priority setting, more choice among providers and information on the quality and prices of services could help. Improve consistency in the allocation of responsibilities across levels of government as decision-making and financing are still often divided among different levels of government

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