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BASIC STATISTICS OF AUSTRIA (2010)

THE LAND

Area (thousand km^2)	84	Major cities (thousand inhabitants)	
Utilised agricultural area (%)	38	Vienna	1 699
Utilised forestry area (%)	40	Graz	257

THE PEOPLE

Population (thousands)	8 388	Labour force (thousands)	4 284
Inhabitants per km^2	100.0	Employment (thousands)	4 096
Average annual population growth (2000-10, %)	0.5	Registered unemployment rate (% of the labour force)	6.9
International migration balance (thousands)	27.7	LFS unemployment rate (% of the labour force)	4.4

PRODUCTION

Gross domestic product, current prices		Origin of value added (%)	
In billion €	284	Agriculture	2
Per head (thousands $, PPP exchange rate)	40	Industry	29
		Services	69

THE GOVERNMENT

Per cent of GDP		Composition of National Council of Austria	Number
General government revenue	48.3	(September 2008)	of seats
General government expenditure	53.0	Social Democratic Party of Austria (SPÖ)	57
Gross public debt (Maastricht definition)	72.3	Austrian People's Party (ÖVP)	51
		Freedom Party of Austria (FPÖ)	34
		Alliance for the Future of Austria (BZÖ)	21
		The Greens (GRÜNE)	20
		Total	183

FOREIGN TRADE

Exports of goods and services, % of GDP	55.3	Imports of goods and services, % of GDP	50.6
Main exports of goods (% of total, 2009):		Main imports of goods (% of total, 2009):	
Machinery and transport equipment	37.5	Machinery and transport equipment	32.9
Manufactured goods	21.4	Manufactured goods	15.2
Miscellaneous manufactured articles	12.0	Miscellaneous manufactured articles	15.2
Others	29.0	Others	36.7

THE CURRENCY

Irrevocable schilling conversion rate	13.7603	Currency units per $ (period average):	
(schilling for € 1)		Year 2010	0.76
		May 2011	0.70

Executive summary

The Austrian economy has weathered the crisis well on the back of an export-led recovery. The authorities should seize the opportunity to strengthen reforms and maintain high growth, which in the past has been considerably boosted by European integration effects which are likely to fade out in the future. In this context recommendations from earlier OECD Economic Surveys *remain relevant:*

- *All subsidised avenues into early retirement should be eliminated.*
- *The work incentives of low-skilled workers should be strengthened and their cost of employment reduced. Successful up-skilling programmes should be further developed.*
- *Early child care infrastructure and full-day schooling should be expanded, with recent government initiatives going in the right direction.*
- *Education reforms should continue, to overcome the excessively early streaming of students, and to permit universities to select students and charge tuition fees, accompanied by a comprehensive grant and income-contingent loan system to avoid socioeconomic segregation.*
- *Competition should be further enhanced in network services such as rail, postal services and electricity, as well as in liberal professions.*

Fiscal vulnerabilities, while low in international comparison, have increased through the crisis. The recent consolidation measures may not suffice to prepare for future risks and challenges, not least related to ageing. In these circumstances, Austria should make full use of the performance budgeting framework that it plans to introduce from 2013, for more assertive spending prioritisation and cost-benefit checks. Despite some recent improvements, the tax structure also remains biased against employment and growth and offers room for reform. Key fiscal policy priorities should be:

- *Accelerating fiscal consolidation to bring the debt to GDP ratio below 60%.*
- *Taking more frontloaded action to meet foreseeable medium-to-long-term spending pressures.*
- *Reforming the Domestic Stability Pact and the Fiscal Equalisation Act and implementing the fiscal framework reforms at all levels of government.*
- *Seeking efficiency gains in all major spending areas.*
- *Switching the tax burden away from labour and entrepreneurship toward less distortive taxes.*

The highly regarded Austrian health system is expensive. The governance and funding structure of the system is excessively fragmented, makes too much use of inpatient care in hospitals, and entry and competition are de facto *limited in most health markets. Lifestyle factors are generally not supportive of good health outcomes and put additional pressure on costs. The authorities have introduced several reform initiatives in recent years. These should be continued and intensified in the following areas:*

- *More clearly assign performance, financing and spending responsibilities.*
- *Fully enforce the national capacity plan for inpatient and outpatient care.*

- *Introduce performance-based payment mechanisms in both inpatient and outpatient care and increase competition in the pharmaceutical market.*
- *Promote disease management programmes in all chronic care areas.*
- *Set out challenges of the medium-term fiscal outlook of the system, through detailed health and long-term care spending projections and scenarios.*

Assessment and recommendations

The Austrian economy continues to impress with very good economic performance while maintaining a high degree of social cohesion. This strength rests on three pillars:

- A successful export-oriented economy with entrepreneurs, who understood how to reap the benefits from past decades of European integration for workers, asset holders and the treasury alike.
- A highly skilled and motivated labour force, underpinning generally good labour market performance measured by low unemployment overall and especially low youth unemployment.
- Social partners, taking responsibility for preparing reform proposals for the government and going beyond the traditional role of negotiating wages and work conditions as well as organising social security services.

Austria, like other export-oriented economies, was hit hard by the crisis, revealing particular vulnerability. Positive external shocks in the wake of European integration measures will most likely not continue with the same strength as in the past two decades and drivers of growth will depend more on domestic sources. The currently strong recovery offers a golden opportunity to strengthen reform efforts and consider recommendations from earlier *Economic Surveys*, notwithstanding recent progress (Annex A2), in particular in the following areas:

- While Austria has many employment opportunities for skilled workers in core age groups and an excellent school-to-work system keeps youth unemployment low, there are problems with: *i)* unskilled workers, who face high marginal tax rates; *ii)* older workers, who face a high tax on continuing to work; and *iii)* women at lower income levels, for whom the tax and benefit system interact in a way which makes reconciling work and family responsibilities costly. The government has recently introduced a range of measures in support of better reconciling work and family obligations, the impacts of which should be closely monitored.
- The expansion of Austrian financial institutions into newly emerging market economies after the fall of the *Iron Curtain* is generally seen as a success story. Nevertheless the crisis demonstrated that governments may be implicated in excessive risk taking at non-negligible costs for current and future tax payers. The coming strengthening of capital requirements should be taken as an opportunity to open a discussion with the financial sector as to how the government could be more insulated from future rescue operations.
- Growth and social cohesion will depend more on own policy initiatives to increase potential growth and on reducing the strong tendency to inherit education outcomes over generations.

The structural chapters in this *Economic Survey* address public sector reforms in two areas:

- Fiscal consolidation and institutions: While Austria has made great efforts to improve its fiscal framework at the federal government level, work remains to be done to: *i)* avoid pro-cyclical fiscal outcomes, in particular at lower levels of government and in the social security system, *ii)* better target social transfers; and *iii)* improve the tax structure in order to make taxes less of a burden for economic activity.
- Health care reform: This is occupying stakeholders at all levels of government, encompassing the rich structure of fiscal federal relations in Austria as well as the social partners, both in their role as self-organising the social security sector, as well as drivers of reform in general. The Austrian population has a high regard for its health care system, although in international comparison it comes across as expensive, fragmented and lacking agreed targets.

The recovery provides an opportunity to reinvigorate reform efforts

The Austrian economy started to recover in the second half of 2009 on the back of strengthening external demand and has surpassed its pre-crisis peak in the first quarter of 2011. Investment in the metals and machinery sector expanded strongly in the second half of 2010, more than offsetting further declines in construction investment. Consumption has expanded steadily, though at a subdued rate. The labour market recovered quickly from the crisis with employment growing robustly and the unemployment rate falling to 4.2% in late 2010, compared with a crisis peak of 5.1%. Wage growth remained subdued, supporting Austria's competitiveness. Harmonised consumer price inflation increased sharply in early 2011, reaching 3% (year-on-year) in the first quarter, mainly due to energy and food prices as well as minor excise tax hikes on tobacco and mineral oil products. Core inflation, however, also rose somewhat to 1.8% in the first quarter.

The outlook is favourable and fiscal consolidation has begun

Looking ahead, growth in Austria is set to grow above its potential rate in 2011 and 2012 and continue to benefit from robust external demand through its strong trade linkages with Germany (Table 1). The authorities do not expect the opening of the labour market to workers from the new EU member countries on 1 May 2011 to result in disruptive labour inflows, but it could ease skill shortages and also keep wage pressures in check in the near future. In this context, the government's decision to promote skilled labour migration from non-EEA countries through the introduction of a "points based" immigration system (*Rot-Weiss-Rot Karte*) from July 2011 onwards should be welcomed.* As labour productivity increases further, competitiveness and thus exports should remain strong. Real interest

* The *Rot-Weiss-Rot Karte* provides two channels for the admission of skilled labour migrants, one supply-driven for highly-qualified workers without a job offer, and one demand-driven for immigrants with a job offer. In the latter, in addition to other criteria, either a labour market test or an employment in a shortage occupation is required. Admission of skilled workers in shortage occupations has been postponed until 2012 to monitor the impact of the 1 May 2011 opening of the labour market to the EU8. At the same time, labour market access of foreign graduates from Austrian universities and of family members of non-EEA citizens has been facilitated.

Table 1. **Austria: demand, output and prices**

	2007	2008	2009	2010	2011	2012
	Current prices € billion	Percentage changes, volume (2005 prices)				
GDP at market prices	272.1	2.0	–3.4	2.1	2.9	2.1
Private consumption	143.7	0.6	1.2	1.0	0.9	1.2
Government consumption	49.1	4.0	0.4	–0.5	–0.2	0.5
Gross fixed capital formation	58.3	2.8	–7.8	–0.9	3.3	2.5
Final domestic demand	251.1	1.8	–1.1	0.3	1.2	1.4
Stockbuilding[1]	4.7	–0.6	–1.0	0.6	1.0	0.0
Total domestic demand	255.8	1.1	–1.5	1.0	2.1	1.3
Exports of goods and services	161.4	0.5	–15.6	10.3	9.1	6.8
Imports of goods and services	145.1	–1.7	–12.6	8.2	7.8	6.0
Net exports[1]	16.3	1.2	–2.6	1.4	1.1	0.8
Memorandum items						
GDP without working day adjustments	272.5	2.2	–3.9	2.1	2.9	2.1
GDP deflator	–	1.7	0.7	1.6	1.9	1.6
Harmonised index of consumer prices	–	3.2	0.4	1.7	3.1	1.8
Private consumption deflator	–	2.5	–0.7	1.5	2.5	1.9
Unemployment rate[2]	–	3.8	4.8	4.4	4.2	4.0
Household saving ratio[3]	–	11.8	11.1	9.1	9.0	8.9
General government financial balance[4]	–	–1.0	–4.1	–4.6	–3.7	–3.2
Current account balance[4]	–	4.6	2.9	2.5	3.2	3.9

Note: National accounts are based on official chain-linked data. This introduces a discrepancy in the identity *between real demand components and GDP*. For further details see *OECD Economic Outlook Sources and Methods* (*www.oecd.org/eco/sources-and-methods*).

1. Contributions to changes in real GDP (percentage of real GDP in previous year), actual amount in the first column.
2. Based on *Labour Force Survey* data.
3. As a percentage of disposable income.
4. As a percentage of GDP.

Source: OECD Database.

rates are expected to remain low in 2011, which will support investment. Employment growth is expected to be robust in 2011 holding the unemployment rate below the structural level of 4¼ per cent. However, high consumer price inflation will weigh on real disposable income and private consumption growth in 2011. Inflation is expected to decline in 2012, supporting a moderate pick-up in consumption.

Fiscal vulnerabilities, while low in international comparison, have increased in the wake of the crisis. Persistent budget deficits since 1974, even during times of above-potential growth, together with crisis-related measures to support the Austrian financial sector and European rescue operations have raised gross debt to 72% of GDP. The true fiscal situation became more apparent with re-integration into the government accounts of deficit spending and debt from previous off-budget operations (the railway company and hospitals). In 2011 the federal government implemented a consolidation package to gradually reduce the deficit from its peak of 4.6% in 2010 to below 3% of GDP by 2013. The bulk of consolidation efforts falls on spending restraint by the central government (mainly social expenditure cuts).

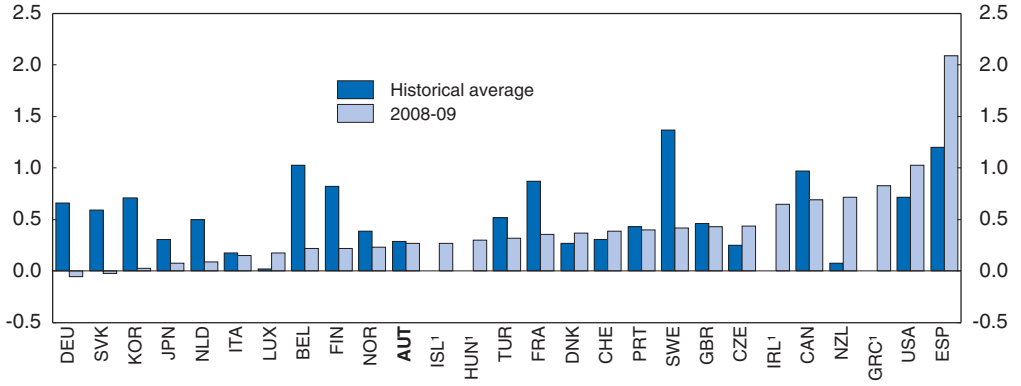
The labour market has weathered the crisis comparatively well

The unemployment rate increased significantly in Austria during the crisis, by about 1.5 percentage points from trough to peak, more than in Germany but less so than the 3 percentage points in the OECD on average. Given the large drop in output in Austria,

which at 3.9% was close to the OECD average of 3.5%, the unemployment reaction was modest, although broadly in line with the historical relationship between GDP and unemployment (Figure 1 and Box A1.2). Total employment fell by about 1% with employment in manufacturing and construction affected most. In line with previous recessions in Austria, the main adjustment to the reduction in demand took place via a reduction in average hours per worker, which accounted for about ¾ of the reduction in total hours worked. This may have reflected skill shortages, as suggested by survey measures, and high overtime hours which facilitated the reduction in hours (Stiglbauer, 2010). However, active labour market policies are likely to have played a role as well (see below).

Figure 1. **Change in unemployment in the 2008-09 recession in historical comparison**

Okun coefficient (peak-to-trough ratio of the increase in the unemployment rate to the decrease in GDP)



1. Historical average not available.

Source: OECD (2010), *OECD Employment Outlook 2010: Moving Beyond the Job Crisis.*

StatLink http://dx.doi.org/10.1787/888932458501

Since the end of 2009 the Austrian labour market has recovered relatively quickly. The unemployment rate dropped about 1 percentage point to 4.2% in the last quarter of 2010 compared with a reduction of 0.3 percentage points in the OECD as a whole and still rising unemployment rates in the euro area. Total employment now stands above pre-crisis levels in Austria, although a surge in temporary agency workers accounts for a significant part of the rebound and manufacturing employment is still below pre-crisis levels. The share of long-term unemployed and the labour force participation rate remained broadly constant through the downturn, suggesting that hysteresis effects are less of a concern in Austria than in several other OECD countries.

Active labour market policies helped keep people in work

The short-time work (STW) scheme, whereby governments subsidise a temporary decrease in working time, helped prevent layoffs, and two labour market packages enacted in 2009 included measures to increase its attractiveness. However, the recourse to this scheme was quite limited. Participation peaked in April 2009 at 38 000 enrolees, decreased rapidly since, and is currently at negligible levels. About 26 000 employees or less than 1% of total employment were subsidized on average in 2009, compared with more than 3% and 5% in Germany and Belgium, respectively (OECD, 2010a). With an average reduction in working

time by about 26% (BMASK, 2010), the contribution of the STW schemes to the total hours reduction of about 3.6% was about ¼ percentage points. Estimates of counterfactual employment developments without the STW suggest that about 4 000 permanent jobs or 0.12% of total employment, may have been protected by this scheme in Austria compared to about 0.7% and 1.3% of total employment in Germany and Belgium, respectively (Hijzen and Venn, 2011). Some firms have seeked alternative measures, such as temporary lay-offs. Indeed, the number of registered unemployed in 2008 and 2009 with confirmation of future employment rose (Bock-Schappelwein *et al.*, 2011).

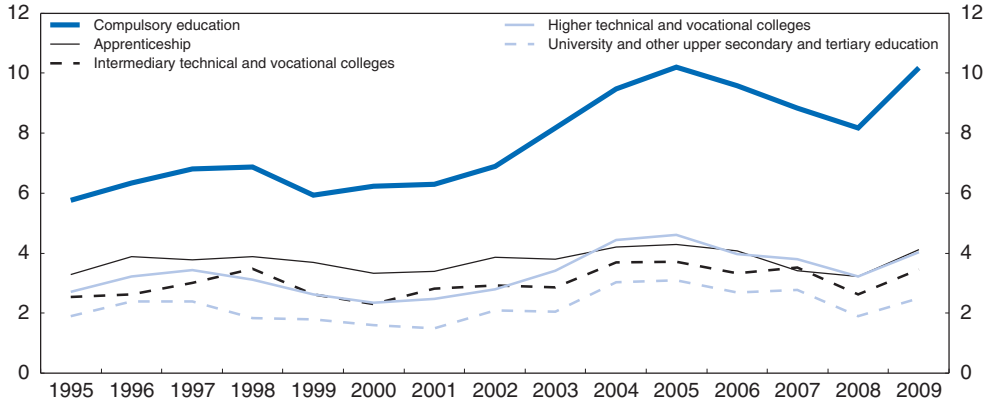
Eligibility was eased or financial support increased for several other active labour market programmes. In particular recourse to subsidized study leave (*Bildungskarenz*) increased significantly during the crisis, from about 1 500 participants on average in 2008 to a peak of 7 500 in February 2010. Participation in up-skilling and re-qualification programmes subsidised by the Public Employment Service (PES) also increased substantially. Finally, the government eased access to the old-age part-time scheme, by which older employees can reduce working hours before retirement without reductions in their pension benefits, and the requirement for firms to hire a new employee for every worker put on part-time was suspended on 1 September 2009. About 4 400 people were granted such eased access in the first year (BMASK, 2010). While this scheme may have helped to prevent lay-offs during the crisis, it runs against necessary efforts to increase the employment potential of older workers, as discussed below.

Better integrating low-skilled, older and female workers into the labour market is a major challenge

As described in the *2009 OECD Economic Survey of Austria,* the Austrian labour market is characterised by a well-performing core of skilled prime-age workers, but also a number of more vulnerable groups, particularly unskilled, older and female workers with family responsibilities, whose labour market experience is less enviable. Unemployment rates of low-skilled workers are high and have been deteriorating in the past (Figure 2). This

Figure 2. **Low-skilled workers fare poorly in the labour market**

Unemployment rate by highest completed education, %



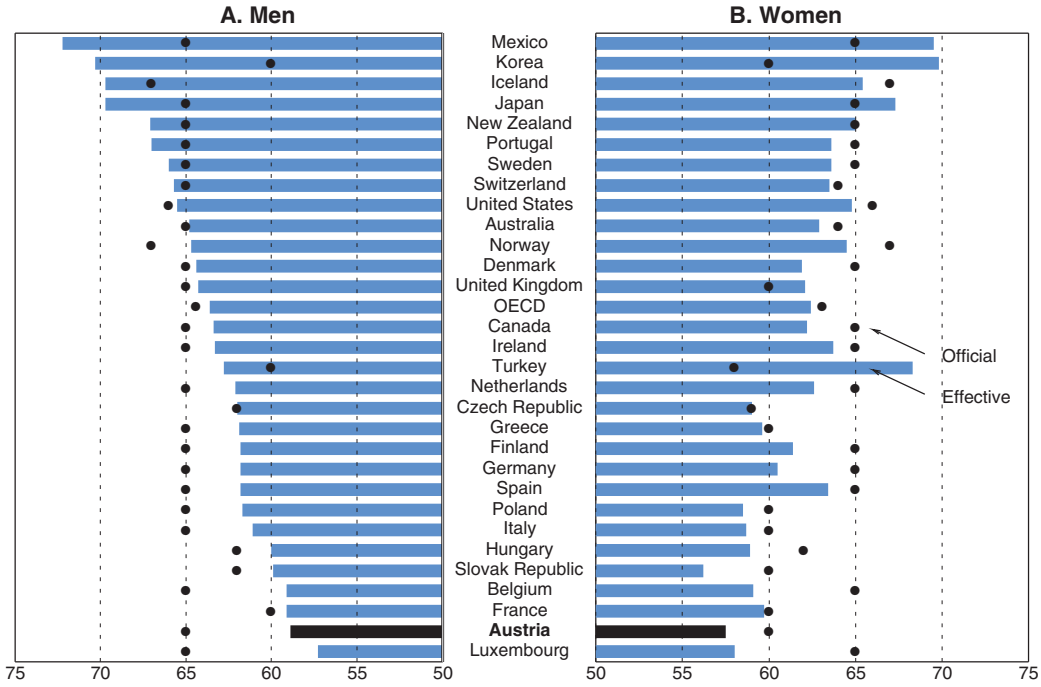
Source: Statistics Austria.

StatLink http://dx.doi.org/10.1787/888932458824

problem is generating a growing concern in Austria and the crisis was a reminder of the particular vulnerability of this group in economic downturns. Employment of this group can in general be improved through up-skilling and re-qualification measures and by lowering their costs to employers. Austria already spends a substantial share of total expenditures for active labour market programmes on training measures (55% compared with 25% in the average OECD country as of 2008). *To reduce the costs to employers, cuts in employer social security contributions for low-skilled workers should be considered. In this context, the "wage top-up" (*Kombilohn*), introduced in 2006 and reformed in 2009, could be extended to further well-defined groups of low-skilled workers.*

Despite recent improvements, labour force participation rates for older workers (aged 55-64) remain low and the average effective age of labour-market exit for men is 58.9 years, the second lowest among all OECD countries (OECD, 2011a) (Figure 3). The high number of people exiting the labour market through disability pensions as well as still existing early retirement programmes are the major reasons. *The introduction in 2011 of the right for rehabilitation in addition to compulsory rehabilitation before eligibility for a disability pension and initiatives to improve work-place quality are steps in the right direction. They should be complemented with a further strengthening of eligibility criteria, including an obligation to look for jobs in alternative occupations.* Other important early retirement schemes are available in Austria. Under the early retirement scheme for long-term contributors to the public pension system (*Hacklerregelung*) employees who have paid contributions for 40 (women) or 45 (men) years can retire at 55 (women) or 60 (men) without any reductions in pension benefits. The provision that time spent in non-compulsory education can be substituted

Figure 3. **The average effective retirement age is too low**



Note: The effective retirement age shown is for the five-year period 2004-09; the pensionable age is shown for 2010.
Source: OECD, *Pensions at a Glance 2011: Retirement-Income Systems In OECD and G20 Countries*, Figure 2.3, p. 43.
StatLink http://dx.doi.org/10.1787/888932458843

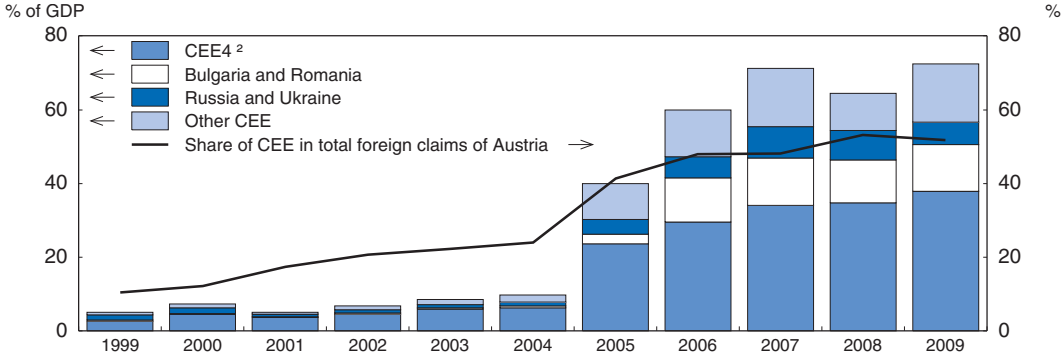
for regular years of contributions by paying a lump-sum per month is particularly problematic, as it increases the incentive for high-skilled individuals to leave the labour market, even though this lump-sum was increased significantly on 1 January 2011. The decision to tighten this scheme by 2014 – the authorities expect they can halve the current yearly inflow – is welcome and should not be postponed again. *Merging the scheme into an actuarially neutral pension scheme, which neither subsidises nor penalises retirement at different ages, would be preferable.*

Family support in Austria is biased in favour of cash benefits thus making it expensive to reconcile work and family obligations, both in terms of benefits lost and cash and organisational expenses for childcare. Women are relatively more often working part time and finding it less attractive to work when there are small children to look after. Therefore, an income-based child care allowance (*Kinderbetreuungsgeld*) was introduced in January 2010, which is in principle meant to partially substitute the income of parents who wish to withdraw from the working life for a shorter period only, and would normally earn a higher income. As outlined in earlier *Economic Surveys*, efforts to rebalance family support should continue through expanding early child care and education infrastructure and the availability of full-day schooling. Therefore, the coalition partners decided at the end of May 2011 to continue the expansion of childcare facilities, especially for children aged up to three years.

The financial sector is recovering

As highlighted in the *2009 OECD Economic Survey of Austria*, the rapid and successful expansion of Austrian financial services into the newly emerging economies of Central and Eastern Europe (CEE) and South-East Europe (SEE) poses significant regulatory challenges. The global financial crisis severely affected the international portfolio of the Austrian banking sector. The impact was mainly coming through the high exposure to economies in CEE and SEE with some of them experiencing a severe downturn following a period of excessive credit growth (Figure 4). Further risks were revealed through the high level of

Figure 4. **Build-up of Austrian banking assets in CEE**[1]



1. CEE includes: Albania, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Former Yugoslav Republic of Macedonia, Moldova, Republic of Montenegro, Poland, Romania, Russia, Republic of Serbia, the Slovak Republic, Slovenia, Turkey and Ukraine. The country coverage slightly differs between trade, FDI and banking statistics.
2. CEE4 includes: the Czech Republic, Hungary, Poland and the Slovak Republic.

Source: Bank for International Settlements and *OECD Economic Outlook Database*.

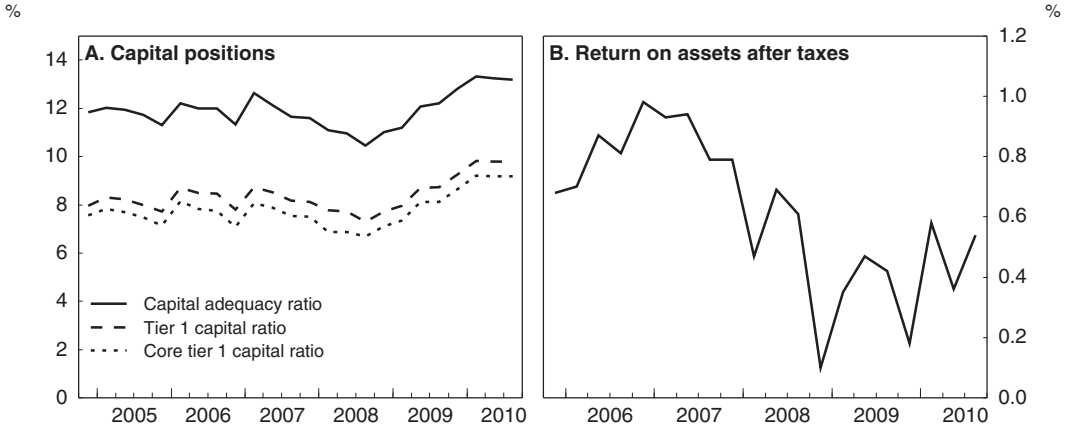
StatLink http://dx.doi.org/10.1787/888932458862

lending in foreign currencies, including to Austrian clients, and to a lesser degree, the participation in high-risk international investments in other regions.

Substantial public intervention was needed to support the banking sector in the wake of the global crisis. The Austrian authorities introduced in 2008 a top-up of the deposit guarantee scheme of EUR 10 billion, EUR 15 billion for capital injections in financial institutions, and EUR 75 billion for supporting interbank lending and for government guarantees of bank bond issuance. Some of these funds were later reallocated to guarantees to non-financial corporations and euro support measures. Nevertheless, EUR 15.9 billion of federal guarantees for debt instruments, and EUR 7.5 billion for capital injections and asset guarantees are still in place. Two banks, including one of the six largest banks, had to be nationalised. *While the support should stay in place as long as needed, clear exit strategies would lift uncertainty and enhance market confidence.*

In light of the high fiscal costs of the crisis, efforts have been stepped up aiming at a better and higher capitalisation of financial institutions, especially the systemically important ones. The capitalisation of Austrian banks is improving, particularly among the largest banks that used to be the most leveraged prior to the crisis (Figure 5). In contrast to the situation in early 2009, recent rounds of stress tests show that even deep negative shocks would not threaten solvency. There is also no sign of credit rationing in the domestic economy. However, despite reaching a consolidated core capital adequacy ratio of 9.8% (OeNB, 2010), Austrian banks continue to have a below-average capital adequacy. Basel III capital requirements will require raising the quality of the capital base and building additional buffers. The total size of newly required capital due to Basel III and the repayment of government support is estimated at between EUR 15 and 18 billion considering a period until 2020, which might lead to a cumulative decline in GDP growth by 0.23 percentage points over three years (Kopp *et al.*, 2010), in line with estimates for the euro area (Slovik and Cournède, 2011). Raising new capital might be difficult, however, given the importance of the multi-tier decentralised sector in Austrian banking. Weak local equity market performance may also pose a problem, given an increased risk-aversion among international investors, the introduction of the bank tax and a strong competition

Figure 5. **Profitability and capital adequacy of Austrian banks**[1]



1. Consolidated data.

Source: OeNB.

StatLink http://dx.doi.org/10.1787/888932458881

for equity capital among European banks. *It would be advisable to require all major banking groups to present a clear medium-term strategy of capital strengthening, including a gradual repayment of government capital.*

The recent rebound in profitability is primarily driven by the recovery of CEE economies. The major Austrian banks continue to see sustainable and profitable growth opportunities in the CEE region and remain committed to lending there in the medium and long term. However, the profitability of Austrian banks remains well below its pre-crisis level. Moreover, not all losses, particularly on foreign exchange lending, seem to have been recognised by foreign subsidiaries and loan-loss provisions are expected to increase further (Pann *et al.*, 2010). Financial stability plans should therefore be ready in the event that the situation worsens substantially in one or more CEE countries.

As was revealed by the crisis, the cross-border supervisory architecture in Europe prior to the crisis was prone to supervisory failures, high compliance burden and insufficient attention to stability at the group level (De Larosière Group, 2009). These problems are now being addressed in Austria and internationally (Box A1.1). The Vienna Initiative/European Bank Coordination Initiative (a round table platform including all major banks, national authorities, the European Commission and international financial organisations active on a particular market) provided and continues to provide an important platform for crisis management. Furthermore, the introduction of the European Systemic Risk Board and the European Banking Authority is expected to bring sustained gains in terms of early warning systems, regulatory harmonisation through a single European rule book, strengthening of supervisory colleges and improved co-operation in crisis prevention and management within the EU. *The Austrian supervisory authorities should co-operate very closely with these newly established authorities. An attempt should also be made, directly by the Austrian supervisors, and indirectly by Austrian authorities in the context of the EU accession and EU neighbourhood policy dialogues, to expand the use of these new supervisory tools in co-operation with supervisors in non-EU countries, where Austrian banks are active.*

Medium-term growth will depend crucially on domestic structural policy reform…

Despite the broadening recovery, Austria faces several challenges over the medium term and potential growth is unlikely to return to pre-crisis levels unless structural reforms are pushed forward. First, fiscal policy is moving towards consolidation, damping demand and even stronger consolidation efforts than currently planned might be necessary in the future (see Chapter 1). Second, the growth impetus from European integration is likely to weaken over the coming years. Over the previous decade, strong export growth to the CEE region and robust productivity growth in the export sector stemming from company restructuring in the wake of EU accession boosted economic growth (Breuss, 2010). Finally, ageing will also negatively affect potential growth. Under current projections from the Statistical Office, the working age population will grow more slowly after 2011 and contract after 2020.

To counteract these growth-moderating forces further structural reforms are required and recent government plans go in the right direction (Annex A3). Besides further potential for reforms to increase labour utilisation as discussed above, the recent OECD growth benchmarking exercise (OECD, 2011b) points towards necessary improvements in labour productivity. Simulations for comparable other countries show that the gains from product market reform can be considerable (Arnold and Wörgötter, 2011). Two areas deserve special

attention. First, while the manufacturing sector is characterised by strong productivity and output performance, the service sector is lagging behind. Product market reforms to strengthen competition in the service sector are therefore warranted. Second, further reforms of the educational system are required. In particular the graduation rates from academic tertiary education remain low in international comparisons and lifting these rates might be necessary to complement and fully reap the benefits of reforms already undertaken to strengthen the innovative capacity (OECD, 2009; 2007). In this context, while difficult to calculate, a recent study (Ederer *et al*., 2011) estimates that Austria could lift its real GDP growth potential by about 0.3 percentage points on average between 2010 and 2020 if all R&D, education and employment targets set out in the EU *Lisbon Strategy* and the follow-up strategy called *Europe 2020 – A European strategy for smart, sustainable and inclusive growth* were reached.

… in particular in the service sector…

There is ample room for improvement in network industries, where high network access prices and widespread state ownership deter market entry and thus competition and innovation. Austria has continued to implement EU directives relating to the network industries. *However, further progress should be made in monitoring market behaviour, tackling distortive behaviour of incumbents and improving the corporate governance of state-owned enterprises. Further stimulating* de facto *competition in these sectors, in particular in the rail and postal services, is a matter of urgency. Continuing privatisation efforts, notably in the electricity sector, would also be welcome*.

Restrictive regulations remain widespread in the professional services sector. In particular, self-imposed regulations and licensing requirements and compulsory membership in professional associations hinder competition and productivity growth. *These regulations should be further curbed and compulsory membership in professional associations for liberal services abolished, while maintaining high quality standards and consumer protection. Regulations preventing the establishment of interdisciplinary firms between liberal professions and other businesses* – e.g. *between lawyers, tax advisers and management consultants – should also be reduced*. More generally, an evaluation of Austrian competition law is currently being carried out and a reform proposal was recently finalised by the social partners.

… and in the education system

While the Austrian educational system provides good vocational skills, technological change and international competitive pressures require new and more generic skills. Specific and well-recognised weaknesses of the Austrian educational system are: *i)* the average academic performance of students and especially the underperformance of immigrants; *ii)* the strong dependence of educational performance and choices on socioeconomic backgrounds and the early streaming into different educational routes; and *iii)* the low tertiary enrolment rates. The previous *Economic Survey* identified the following areas for improvement: *i) increasing the participation in pre-school education, with a particular focus on children from weak socioeconomic and immigration backgrounds; ii) overcoming the excessively early streaming of students in compulsory education; iii) rationalising the present school infrastructure and re-investing freed resources into improving teachers quality; and iv) greater university autonomy in selecting students and charging tuition fees accompanied by a comprehensive grant and income-contingent loan system to avoid socioeconomic segregation*.

Significant policy initiatives are being undertaken but the need for deeper reform in several areas remains, as underlined by the disappointing results in the most recent PISA survey:

- In the area of pre-school education, free one year compulsory pre-school on a half-day basis was introduced in September 2010. Some *Länder* (regional governments) went further and introduced compulsory pre-school at an earlier age for children with deficits in speech and languages (*e.g. Vorarlberg*). Some progress has also been made to improve co-operation between federal, *Länder* and municipal governments with the adoption of a framework of education for pre-school institutions in 2009.
- To overcome the early streaming of students in compulsory schooling, the Austrian government had launched the "New Secondary School" (*Neue Mittelschule*), which unifies the "general" and "academic" lower secondary school for pupils aged 10 to 14, in a pilot project in 67 schools in the school year 2008-09. The number of participating schools has risen to 320 since then but participation of the "academic" lower secondary schools is still very low (only 11 of the 320 schools). An evaluation of the project is scheduled for 2012. A number of initiatives and projects have been launched to improve teacher quality.
- In tertiary education, additional funds have been invested and are planned for 2011 and 2012 to improve the teaching and research infrastructure. In March 2011 Austria adopted a comprehensive strategy for research, technology and innovation (*Strategie der Bundesregierung für Forschung, Technologie und Innovation*), which includes different measures to improve and clarify the financing of public universities. In addition several measures have been taken to improve the governance and transparency of tertiary educational institutions.

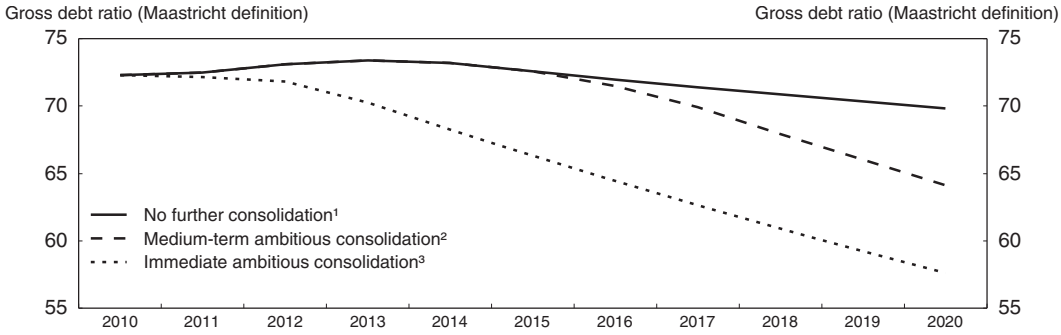
Public sector inefficiencies have become less affordable

Although Austria's fiscal performance does not compare unfavourably against other EU or OECD countries, future expenditure pressures stemming from liabilities incurred by the public sector urge a quick reversal of the increase in the deficit and debt ratio. Public finances worsened markedly over the past two years, driven by discretionary stimulus, financial sector support measures, the operation of automatic stabilisers and a comprehensive revision of government data by Eurostat. Consolidation measures specified in the 2011 Budget are expected to bring the deficit back to below 3% of GDP by 2013 and then to 2% by 2015. OECD simulations suggest that this may not be sufficient to bring down debt rapidly enough (Figure 6). By contrast, an ambitious and front-loaded consolidation programme may reduce the debt-to-GDP ratio below 60% by 2020. A less front-loaded scenario, even if ambitious in the medium-term, would leave the debt-to-GDP ratio above 60% by 2020. *To bring the debt ratio back to a sufficiently declining path and forestall possible financing risks, the pace of fiscal consolidation should thus be stepped up.*

Long-term spending pressures do not play a big role in reform preparation

Medium- and long-term challenges are considerable and do not seem to have triggered much frontloaded policy action so far. The government expects that population ageing will add an extra 3.1% of GDP to public spending at the 2060 horizon. A recent OECD report (2011a), however, shows that the increase in pension costs due to demographics alone may be 9 percentage points higher than currently projected for that year, unless work careers

Figure 6. **Alternative consolidation and debt dynamics scenarios**



1. Nominal GDP growth of 4.7% in 2011 and 3.7% thereafter, and a budget deficit of 3.7% of GDP in 2011 with a gradual reduction to 2% of GDP by 2015 and no further consolidation thereafter is assumed.
2. Same assumptions as in (1) but further consolidation of 0.5% is assumed after 2015 until a budget deficit of 0.5% is reached.
3. Same nominal GDP growth assumptions as in (1) and (2) but the deficit is gradually reduced from 4.6% in 2010 to 0.5% of GDP by 2014 and held constant thereafter.

Source: OECD calculations based on data from *OECD Economic Outlook Database*.

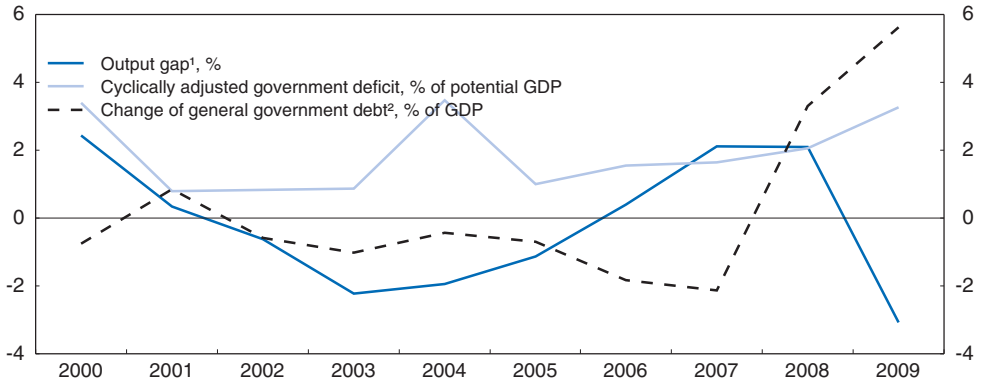
StatLink http://dx.doi.org/10.1787/888932458900

are extended and pension benefits reduced significantly relative to earnings, which seems unlikely without further policy action (see above). Costs may also grow faster in other areas. Projections suggest that health care costs up to 2030 may be more than 4 percentage points higher than currently expected (see Chapter 2). Long-term care spending projections are also subject to upward risks, and the expected reprioritisation of spending programmes may lead to additional fiscal tensions. Another risk factor going forward is state guarantees to public enterprises, the banking sector, and other euro area countries, which have reached significant amounts. *There is a need for a more forward-looking fiscal agenda to prepare for future fiscal stress. Medium to long-term fiscal projections should be more instrumental in guiding front-loaded policy action – keeping in mind the long implementation and outcome lags of structural policies. Transparency with regard to off-budget entities and contingent liabilities of the public sector should be increased. In this regard, an evaluation of the medium- and long-term fiscal impact of putting government programmes into off-budget vehicles should be undertaken.*

Problems in controlling debt suggest the fiscal framework needs further strengthening

Austrian gross government debt remained high during good times and the opportunities provided in boom periods were missed (Figure 7). Existing fiscal rules such as the medium-term target of a balanced budget over the business cycle have not prevented the gross debt ratio from remaining on average 5 percentage points above the Maastricht 60% gross debt ceiling during the decade preceding the crisis. Off-budget operations which eventually show up on the government balance sheet have been one factor here. This history suggests the fiscal framework currently in place could usefully be strengthened. *The current fiscal rule should be augmented with a debt objective which implies steadily paying down debt beyond the 60% level. Past slippage from missing the target of budget balance over the cycle should be made visible on a notional account and lead to corrective measures in subsequent budget periods at all levels of government. In this context, specifying a target rate of growth of real general government spending would help.*

Figure 7. **Austrian government debt remained high**



1. Output gap of the total economy.
2. General government gross financial liabilities according to Maastricht definition.

Source: OECD, *OECD Economic Outlook Database*.

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Further developing the budgetary framework at all levels of government is needed

The introduction of a four-year medium-term expenditure framework in 2009 marked an important improvement in budgetary planning. Expenditure slippages have been avoided and "December fever" successfully contained. However, the expenditure framework covers less than half of total government spending and has not fully eliminated pro-cyclical trends stemming from revenue windfalls. Austria is much better in containing expenditures in bad times than in good or better-than-expected periods (Brandner *et al.*, 2009). While the cyclical position (as measured by the change in the estimated output gap) improved by about 4% of GDP between 2003 and 2008, the underlying deficit deteriorated. This may be related to the design of inter-governmental fiscal relations, with sub-federal levels receiving their share of mostly cyclically-sensitive tax revenues without being required to contribute to consolidation. *A reform of inter-governmental fiscal relations would help contain expenditures. In particular, the* Domestic Stability Pact (DSP) *and the* Fiscal Equalisation Act *should be reformed with a view to implementing the major elements of the federal budgetary reforms, and avoiding pro-cyclical spending at sub-federal levels. The recent enforcement of the sanctioning mechanism in the case of non-compliance with the targets set out in the* DSP *is welcome but implementation will be crucial. The focus of the* DSP *should be extended towards debt and spending targets. The medium-term expenditure framework should be applied at all levels of government.*

Budget processes should facilitate choices and ensure implementation

Generating the budget savings needed to safeguard Austria's fiscal position requires strategic decisions with strong political economy content, with respect to programme prioritisation, agreement on welfare provision and high-quality service delivery. The introduction of performance budgeting in 2013 offers the prospect of creating a more efficient budgeting process where prioritisation and performance checks make overall spending targets more achievable. It holds major promises in Austria, where many long-established spending programmes absorb large resources on a routine basis, with constituencies built up with vested interests in their continuation irrespective of social benefits and costs. *In order to facilitate the introduction of performance budgeting as planned,*

technical and preparatory work is necessary and needs to be undertaken as scheduled. Key policy objectives in the main public spending areas need to be defined, adequate performance indicators developed, and a clear procedure on how to use them in the concrete budgeting process has to be set out.

Public spending needs to be substantially restrained

For the considerable consolidation effort to become least damaging for growth it is important to use the reformed fiscal framework in its fully rolled-out form. Containing public expenditure is the first-best option to durably consolidate public finances and prepare for upcoming fiscal challenges, given the above-average ratio of expenditures to GDP in Austria (53% in 2010, up from 49% before the crisis). Consolidation should concentrate on raising public sector efficiency, which can bring the public spending ratio down by 3 percentage points of GDP. OECD experience (in Germany for example) suggests that the most effective way to reduce public wage costs is to replace only a certain fraction of departures. The counterpart is the need for efficiency/productivity increases to preserve service quality.

Social spending should be better targeted

Scope for expenditure reductions also exists with respect to transfer spending. Austria is one of the highest spenders among OECD economies on social transfers, accounting for over 20% of GDP. The savings potential may be significant, not only in pension benefits, which is the largest component (see below), but also in other schemes such as transfers to families and housing subsidies. Better targeting of these programmes via means-testing would be justified, but acquired rights make this difficult. Yet a move in this direction will be hard to avoid if the generosity of benefits for those who need them is not to be severely reduced in the future.

Austria devotes a sizeable share of public social expenditures to pensions, partly because private pension provision plays a limited role, but also because Austrians retire much earlier and on more generous terms than most other OECD citizens. Early retirement continues to be relatively easy and even financially attractive, posing a heavy burden on those who continue to work. On unchanged policies, additional pension costs will be very high from 2020 onwards, when the "baby boom" generation retires and the old-age dependency ratio increases significantly. Another cost-driver of the current system is the existence of the separate pension schemes for civil servants at state and municipal level. While at the central government level pensions of civil servants are by now fully harmonised with the private sector, similar reforms at the state level have very long phase-in periods or have not started at all. *The government should eliminate all subsidised avenues into early retirement. Penalties for early retirement and benefits from continued work should be increased. The introduction in 2011 of measures for prevention and rehabilitation, as well as a tightening up of the precondition for the own-occupation assessment, should be closely monitored and the own-occupation based assessment of disability should be abolished if necessary. The pension schemes of the civil servants of states and municipalities should be fully harmonised and incorporation into the general pension scheme accelerated.*

The scope for efficiency gains needs to be identified sector-wide

In practice, resource savings need to be achieved in the context of individual programme demands and the potential for efficiency savings, with a view to maintaining service quality. In this context, Austria turns out to be one of the less efficient OECD countries in terms of value for money from health spending, suggesting that savings could be made (see below). Austria is also lagging with respect to the efficiency of education spending compared with international best practice, and could thus save resources without compromising educational outcomes. By contrast, Austria is spending marginally less on tertiary education than an average OECD country, although meeting the EU average. It is unlikely that more public financing will become available, *so that the issue of tuition fees should be reconsidered (see above)*.

Growth-friendly capital spending should be maintained

Public investment cuts risk reducing growth in the long run. In considering investment projects, however, it is important to balance returns with costs. Adopting open tendering procedures can deliver substantial savings in government procurement. While the degree of fiscal federalism within Austria might play some role in determining the size of individual procurement lots, *there seems to be considerable scope for Austria to increase the volume of its tendering processes*. Significant reductions in tender prices, together with more selective approach to the appraisal of public investment projects would help to contain public spending growth without compromising the growth-enhancing potential of government capital spending. *Public-Private Partnership (PPP) arrangements could also play an increasing role in delivering improved public services and infrastructure*. However, PPP options should be used only when there is a genuine efficiency gain or cost-effective risk transfer, and not as a device simply to keep government borrowing off-budget.

Tax burden should be moved away from labour

Despite some recent improvements, the tax structure continues to be biased towards distortive taxes on labour and entrepreneurship, while the share of growth-friendly taxes on immovable property and consumption is lower than in other OECD countries (Figure 8). Hence, there remains significant scope to make the tax structure more conducive to growth. *The tax system should be rebalanced with a view to increasing work incentives, encouraging investment, entrepreneurship, and reducing tax-induced distortions.*

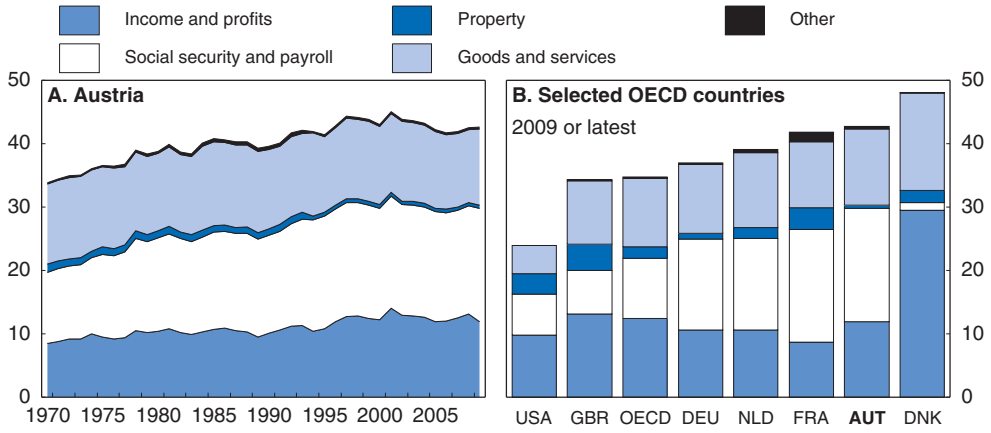
While average tax rates are high for almost all workers, marginal tax rates are particularly high at low income levels, due to the interaction of social security contributions, personal income tax and the benefit system. This reduces incentives for transition from inactivity to employment and from part to full-time employment. Priority should therefore be given to lowering the fiscal burden on low-skilled workers, who are most likely to respond to stronger work incentives. *This group of workers could be best helped by reducing social security contributions or introducing in-work benefits that top up wages.*

Tax increases in the consolidation package rightly concentrate on areas least harmful to growth

Budget consolidation relies to some extent on higher taxation, but the demand impact on the recovery is attenuated by a focus on increasing the taxation of environmental externalities, financial capital and capital gains. The switch towards greater reliance on

Figure 8. **The tax structure is biased towards distortive taxes on labour**

As % of GDP



Source: OECD, Revenue Statistics Database.

StatLink http://dx.doi.org/10.1787/888932458938

capital taxes as part of a larger tax reform could be taken further by smoothing out other distortions. The share of property taxes is very low by international standards, mainly because land and building values have hardly been adjusted over the past decades. *Valuations of real estate and land should be brought to market values*. Other taxes on property include inheritance and gift taxes which are also negligible in Austria, while OECD countries on average raise around 0.5% of GDP from this source. The Austrian tax reform process has gone in the opposite direction in recent years, with inheritance and gift taxes being allowed to expire in 2008 after the assessment of the tax base was ruled unconstitutional by the Constitutional Court. International practice differs greatly, but *the reinstatement of these taxes should be considered, within the wider context of a review of capital taxation in general.*

Box 1. **Summary of fiscal policy recommendations**

Develop a more forward-looking fiscal agenda

- Achieve more upfront consolidation in the next few years to bring the debt-to-GDP ratio below 60% by 2020. Medium- to long-term fiscal projections should be more instrumental in guiding front-loaded policy action. Increase transparency with regard to off-budget entities and contingent liabilities of the public sector.

Strengthen the fiscal framework at all levels of government

- Reinforce the current fiscal rule with a debt objective. In this context, specifying a target rate of growth of real general government spending would help.
- Reform the *Domestic Stability Pact* and the *Fiscal Equalisation Act* with a view to implementing expenditure frameworks at sub-federal levels.
- Performance budgeting should be applied at all levels of government.

Box 1. **Summary of fiscal policy recommendations** *(cont.)*

Restrain public spending

- Reduce public wage costs by replacing only a fraction of retiring government employees. Seek efficiency gains in all major public spending areas, notably in the education and health care sectors. Strengthen tendering processes in public procurement. Use Public-Private Partnerships when there is a genuine efficiency gain.

Better target social and pension transfers

- Eliminate all subsidised avenues into early retirement.
- Increase the targeting of social transfers.

Make the tax structure more employment and growth friendly

- Rebalance the tax system with a view to increasing work incentives, encouraging investment and entrepreneurship, and reducing tax-induced distortions.
- Reinforce work incentives for low income workers by reducing social security contributions or introducing in-work benefits.
- Review the taxation of capital. Valuations of real estate and land should be brought to market values and the reinstatement of inheritance and gift taxes considered.

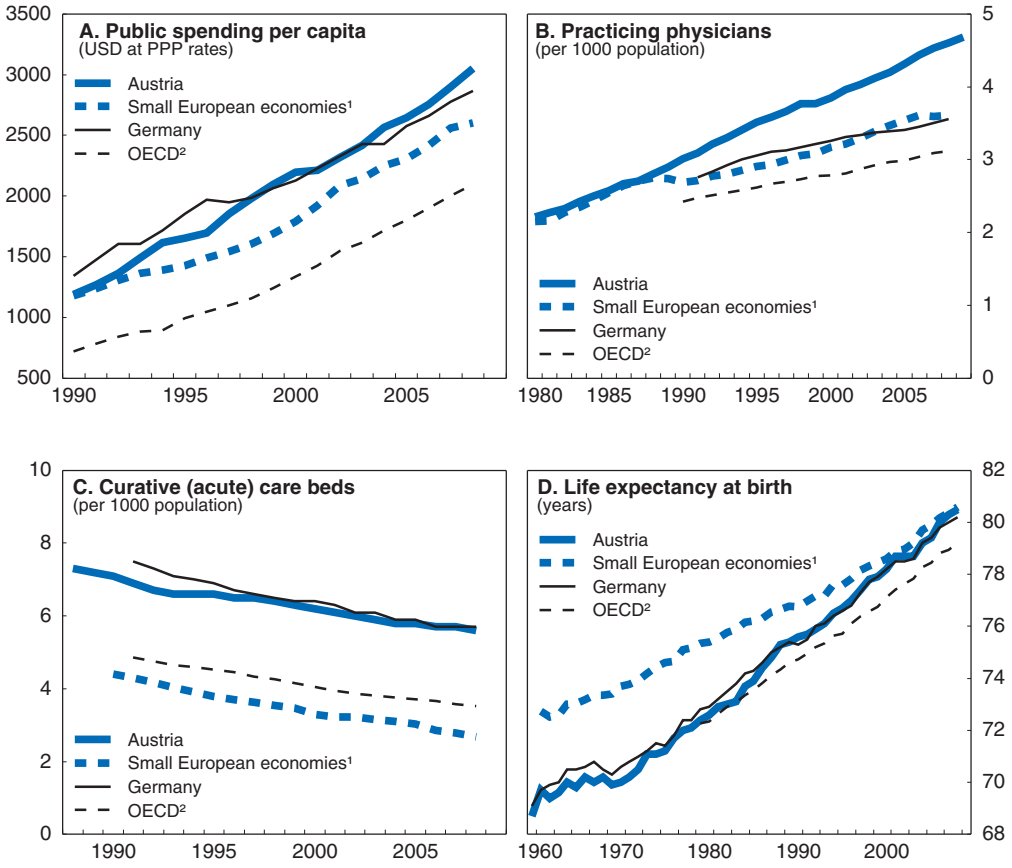
Reforming a highly regarded but costly health system

Austria dedicates very large public and total resources to health (Figure 9). The share of total health spending in GDP, at 11% is among the highest in OECD, mainly due to high public spending (8.5%). Health accounts for about 16% of total general government spending. The number of generalist and specialist physicians, and the number of acute care beds and high-technology medical equipment per capita are among the highest in OECD. The system performs well on some standard output indicators, like life expectancy, but not on others, like avoidable hospital admission rates. Life expectancy exceeds 80 years and has increased considerably. Citizens have become very attached to the existing health system, in particular its local delivery. However, maintaining the high level and quality of public health care will be a major challenge in the future, when a higher share of older people increases demand for health care services while reducing contributions to finance them. Against this backdrop, new national policy efforts to put public finances on a sustainable path put on the agenda a long disregarded question: are the large public resources dedicated to health being employed fully and adequately, and would it be possible to durably bend the growth of public health spending without undermining the quality and effectiveness of services?

The health care system is organised along supply-side considerations

The Austrian health system is organised to deliver good quality and easily accessible services, but does not have clear mechanisms to optimise spending and service provision on a cost-benefit basis in order to achieve the best outcome for the population. This may be mainly due to the fact that it is a supply driven system. Social partners are in charge of the sickness funds and medical chambers with compulsory membership regulate the access to the system in outpatient care and pharmaceutical reimbursement. *Länder* are in

Figure 9. **Large resource commitments and strong outcomes**



1. Arithmetic average of other small European high income economies: Denmark, the Netherlands, Sweden and Switzerland except the Netherlands in Panel B.
2. Arithmetic average over OECD countries excluding: – Panel B: Chile, Ireland, the Netherlands, Portugal and Slovak Republic; – Panel C: Austria, Chile, Denmark, Germany, Greece, Luxembourg, Mexico, Norway, New Zealand, Portugal, Switzerland, Turkey and the United Kingdom.

Source: *OECD Health 2010 Database* and OECD calculations.

StatLink http://dx.doi.org/10.1787/888932458957

charge of hospitals – without full cost responsibility. In contrast, the federal government finances a large share of costs without exerting any influence on the utilisation of the funds. This segmented financing structure weakens incentives for optimisation and perpetuates the dominance of service providers in the functioning of the system.

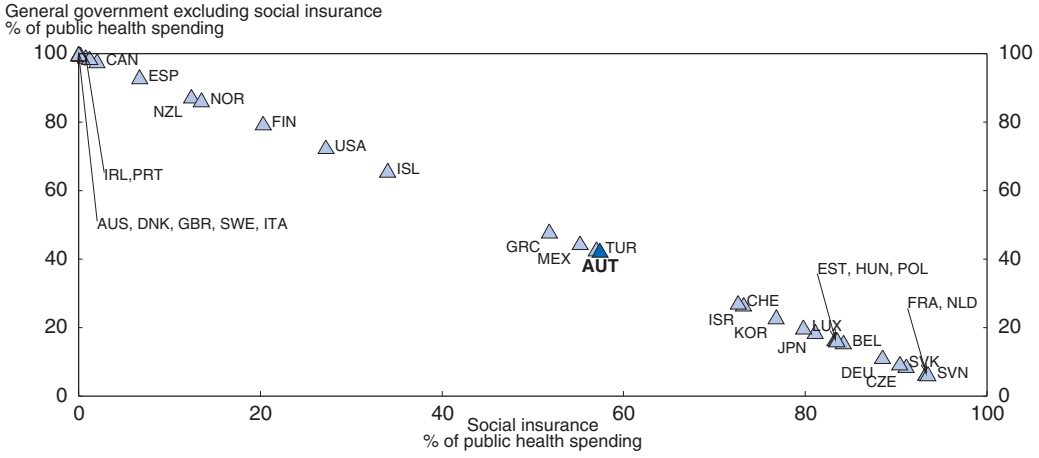
Entry and competition are *de facto* limited in markets for publicly-funded health services and goods. Most hospitals, particularly in less populated areas, are local monopolies. Ambulatory services by independent physicians are offered by "contracted networks" of generalists and specialists, which are co-managed by their respective professional associations, which exert monopolistic power. Pharmaceutical and other medical goods producers operate under restrictive regulatory frameworks which reduce competition. This may be one of the reasons behind the relatively limited, even though now rising, share of generic pharmaceutical products.

As a consequence of its supply-driven focus the Austrian health care system suffers from: *i)* a high degree of fragmentation; *ii)* an expensive "delivery-mix" with an overly strong focus on hospital services; *iii)* an overly large variation of outcomes; and *iv)* uneven quality control.

The institutional design of the system is too fragmented

Public health spending is divided between general government (42%) and social insurance funds (58%) (Figure 10). On the part of the government, federal, *Länder* and municipal levels are simultaneously involved, to fund mainly hospital services. Social insurance funds other spending components: outpatient care by independent physicians, pharmaceutical costs, and part of the hospital costs. Each resident is registered with one of the 19 "Sickness Funds", on basis of either region of residence or branch of employment. Funds offer somewhat different basic packages. There is only a rudimentary risk equalisation system between them (on basis of the age structure of membership) but no yardstick or direct competition. Funds are supposed to respect the budget envelope determined by revenues received from their members and contributions from central government.

Figure 10. **The fragmented funding and governance structure**



Source: OECD Health Data 2010.

StatLink http://dx.doi.org/10.1787/888932458976

The authorities are aware of these shortcomings, which reduce the responsiveness of the health system to policy objectives. The ultimate goal of a range of reforms introduced since 1997, and notably since 2005 and 2008, was to remedy some of the most severe institutional shortcomings and to make the health system more responsive to policy and market demands. Funding sources merged for better service purchasing. New payment mechanisms were introduced, emulating to some degree market signals, notably in the hospital sector (by directing funding for various services according to user demand). An important initiative is the endeavour to implement a detailed national capacity plan, which aims at remaining independent from existing supply structures, and means to anticipate future demand for services. These efforts have all been helpful, but do not seem to have altered the basic institutional flaws of the system. To address them, this *Survey* suggests that *public resources dedicated to health should be further consolidated and be given clear*

objectives, i.e. *performance, financing and spending responsibilities should be much more clearly assigned in the national health system. The national capacity plan for publicly-funded inpatient and outpatient care should be optimized and enforced under federal government authority, with the support of the* Länder *governments and Sickness Funds. This recommendation may face constitutional obstacles. In such instances, "joint funds" or "fund pools" consolidating resources from different general government entities may prove useful. To increase policy leverage, the high fragmentation of the social insurance sector should also be overcome. One possible step is to reduce the number of funds by merging them.*

The system remains too heavily centred on hospital services

The health system is heavily centred on inpatient services, which are mostly provided by hospitals and are expensive. As the costs of both inpatient and outpatient care provided by hospitals are largely funded by the government, Sickness Funds – which finance a variety of alternative services – have a distorted view of hospital costs, and no incentive to take them fully into account. At the same time, *Länder* governments have an interest in maintaining hospital capacity at high levels. Residents appreciate round-the-clock hospital services near where they live, and make intensive use of them.

The health system could provide quality care at lower cost by making greater use of family doctors, outpatient, inpatient, rehabilitation and long-term care. The prevailing fragmentation and firewalls in both funding and provision have hampered adjustment. There have been important *ad hoc* policy initiatives to develop integrated services and to better balance outpatient and inpatient services, and certain produced very good results – such as the disease management programme (DMPs) for diabetes – but they have not modified the inpatient focus of the system. An electronic health record infrastructure is being put in place (the so-called ELGA system) which is destined to help optimise patient-level care in the future. Other countries' experiences indicate that more supportive mechanisms for funding, contracting and paying for integrated services are important for more spontaneous and faster development of integrated care. This *Survey* suggests that the authorities should; i) *continue to back disease management programmes and diffuse best practices in all chronic care areas;* ii) *remove legal restrictions for group practices, and for the outpatient departments of hospitals which could become autonomous entities; and* iii) *authorise Sickness Funds to enter into "managed care" agreements with group practices and outpatient clinics. Policymakers should also continue to give high priority to the development of the individual electronic health record-based ELGA system.*

Access remains equitable but health outcomes differ across social groups

All indicators confirm that the degree of equity in accessing services is among the highest in OECD. In contrast, there is evidence that life-style choices and a lack of prevention are becoming significant sources of differentiation in health status across social groups and regions. In particular, gaps experienced in these areas by immigrant groups with a low level of education are important. Differences are also large across *Länder*. These gaps are particularly worrying concerning cases of overweight citizens and obesity, notably at younger ages, which have serious long-term health and cost implications. If these non-health care factors do not improve, health outcomes risk diverging more in the future than in the past, and overall performance will fall short of potential. *Austria should:* i) *set national health goals, and pursue them by a better balance between lifestyle improvement, prevention and curative care;* ii) *implement more effective public health programmes with respect to nutrition,*

smoking and alcohol consumption; iii) continue to develop "children's health" programmes which have positive life-long impacts; and iv) develop special programmes for vulnerable groups lagging behind in positive lifestyle choices and prevention, notably low education immigrant and resident groups.

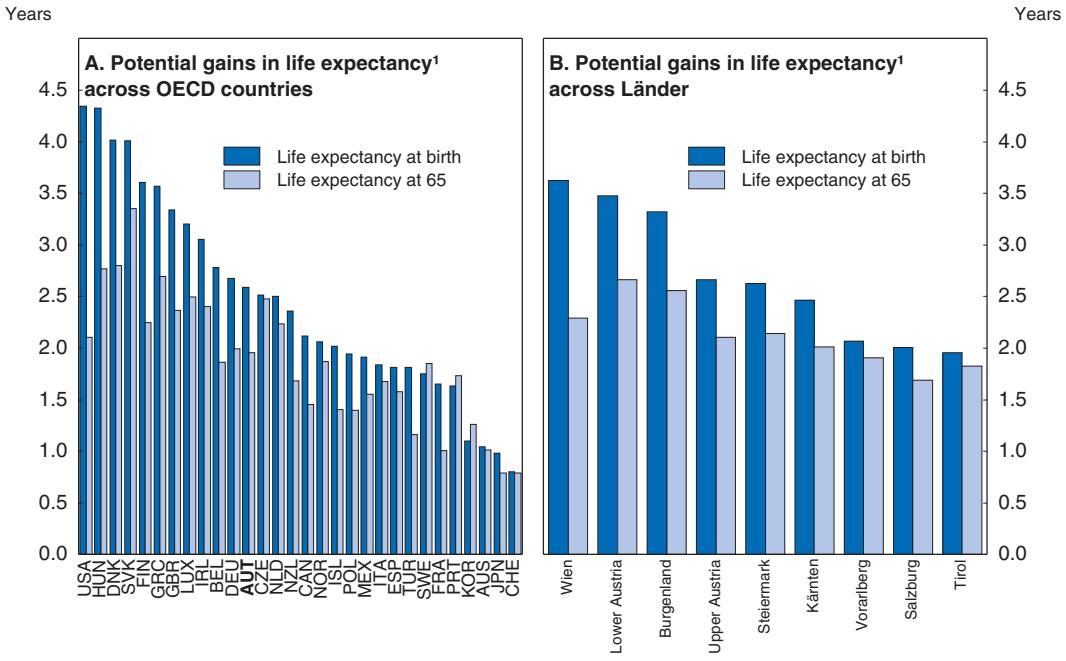
The quality of services should be made more transparent

There is a widespread perception that the quality of health services is very high and homogenous across the country. Health experts and government officials observe however that this assertion is not necessarily backed by objective criteria. Some international indicators indicate that Austria succeeded in reducing mortality rates from certain prevalent diseases to well below OECD averages, and below averages in other high-income countries such as Sweden, Denmark and Netherlands. In other areas outcomes are average. There are also matters where Austria has fallen short, such as standard vaccination procedures and related outcomes, including hepatitis incidence. Policymakers are aware of the need to considerably strengthen the monitoring of quality performance and introduced an "Austrian Quality Strategy" as part of a reform package in 2005. A *Federal Institute for Quality in the Health Care System* was created, inspired by the system of quality indicators successfully put in place in Germany. National quality reports were to be prepared on all sectors and professions according to uniform methods. This work was also to help improve quality outcomes by individual care providers. However, this project could not be implemented, and quality reporting as requested by Law has not yet come through. *The authorities should fully put in application the national quality strategy, if needed on the basis of a stronger legal and regulatory framework.*

There is large room for efficiency gains

A main policy objective is to enhance the economic efficiency of the system. Recent research helped document more clearly significant economic inefficiencies, *e.g.* services are not produced at the lowest possible input volumes and costs. International comparisons of health system efficiency, efficiency reviews in the hospital sector, and inter regional comparisons of resource utilisation in different *Länder* corroborate this diagnosis (Figure 11). The authorities basically concur with these analyses and have phased in initiatives to help raise efficiency. Additional planning objectives have been introduced to better align resources with service needs; hospital payments aim at tracking benchmark productivity and cost levels, a new health technology assessment system aims at better balancing costs and benefits in drug utilisation. The *Survey* suggests that policymakers should focus on the three main triggers of productivity improvement: financing services according to strict quality and cost criteria; relying more on competition; and, when services are provided by national or local monopolies – notably when negotiating with medical chambers – using strict cost benchmarks and yardstick competition. *They should: i) eliminate the firewalls between physicians' services and hospitals' outpatient wards and contract with both for ambulatory care (for more user choice and competition); ii) base fee negotiations with all ambulatory care providers on more innovative and cost-saving techniques (to make fees converge with benchmark cost levels); iii) fully implement the cost-based Diagnosis Related Group (DRG) system on all inpatient services, and, in a next step – after a fundamental change of financing structures –, make Sickness Funds pay the full costs of inpatient care; iv) close the loopholes which permit DRG payments to deviate from national cost benchmarks on a regional basis; and v) increase competition in the pharmaceutical market by submitting not only*

Figure 11. **There is important room for efficiency gains**



1. DEA efficiency calculations were performed with two inputs: health care spending per capita and a variable which is a composite indicator of the socio-economic environment (GDP per capita, educational attainment) and lifestyle factors (nitrogen oxide emissions, consumption of fruit and vegetables, lagged consumption of alcohol and tobacco – 1990 data).

Source: OECD calculations.

StatLink http://dx.doi.org/10.1787/888932458995

new but also the existing "stock" of drugs to health technology assessment, and by authorising additional generic products when possible.

Short-term spending savings are welcome but should be made more structural

All policy efforts in the area of health should remain compatible with broad economic and fiscal policies. As discussed above Austria has a compelling short-term fiscal consolidation task. Health and economic policymakers agreed to solicit the health system for immediate savings. In 2009, a sizeable saving package was agreed with Sickness Funds, entailing spending restraint for prescription drugs (negotiated with pharmaceutical manufacturers) and for ambulatory care (negotiated with medical chambers). Hospital care, which is the largest spending item but where governance and spending responsibility lies largely with *Länder* governments, was left out. Early evidence suggest that this saving package will reach and overperform its immediate targets, but there are some indications, in line with past experience, that savings may remain cyclical and spending could resume its trend growth when the economy recovers. *The authorities should aim at achieving less short-term and more structural savings, in particular in hospital care.*

The medium-term fiscal outlook of the health system needs to become more prominent

Public health spending faces major long-term pressures. As in other OECD countries, they arise from the ageing of the population, technological progress and associated health care opportunities, and increases in the relative prices of medical goods and services. However,

they are compounded by three features of the national health system: *i)* the wider scope of the legally-guaranteed health package, and its openness to state-of-the-art goods and services; *ii)* the system's commitment to take responsibility for the disability care needs of dependant persons, irrespective of their financial means, and *iii)* health price increases which have been steeper to date than in other countries. As a result, existing public health spending projections vary markedly, and reach up to 2 percentage points of GDP of further public health spending by 2020, and 5 percentage points of further spending by 2030. In this environment, a common framework of medium-term fiscal scenarios, and outlook, between health policymakers and economic policymakers would be very useful.

This *Economic Survey* suggests: *i) to make the official health and long-term care spending projections (presently produced under the aegis of the European Commission) more nationally visible; ii) integrate better the "health care" and "long-term care" components; iii) to produce national spending scenarios, with a the full range of hypotheses on the impact of technological change and future demands for new services; iii) set a medium-term (10-15 years) path for public health spending at general government level; and v) consider making public health spending at general government level a policy target associated with the multi-year budget framework which accompanies the annual budget law.* These initiatives would help implement health policies in full congruence with the Austrian government's economic policy goals, including fiscal sustainability and growth.

Box 2. **Summary of health policy recommendations**

Tighten the institutional design of the health system

- Performance, financing and spending responsibilities should be much more clearly assigned.
- The national capacity plan for publicly-funded inpatient and outpatient care should be optimized and enforced under federal government authority, with the support of the *Länder* governments and Sickness Funds.
- This recommendation may face constitutional obstacles. In such instances, "joint funds" or "fund pools" consolidating resources from different general government entities may prove useful.
- The fragmentation of the social insurance sector should be reduced.
- The Federation of Sickness Funds (*Hauptverband*) should continue to centralise functions where there are economies of scale.

Mobilise performance-based payment mechanisms to improve productivity

- Eliminate the firewalls between physicians' services and hospitals' outpatient wards and contract with both for ambulatory care. Base fee negotiations with all ambulatory care providers on more innovative cost-saving techniques. Aim at gradually expanding the cost-based hospital payment DRG system into outpatient care.
- Fully implement the DRG system on all inpatient services and close the deviations of DRG payments from national cost benchmarks.
- Increase competition in the pharmaceutical market by submitting also the existing stock of drugs to health technology assessment, and by authorizing additional generic products when possible.

Box 2. **Summary of health policy recommendations** *(cont.)*

Emphasise national health and quality goals

- Set national health goals including quantified targets. Pursue them by a better balance between lifestyle improvement, prevention and curative care.
- Make public health programmes more effective. Continue to develop "children health" programmes.
- Develop special programmes for vulnerable groups which lag behind in lifestyles and prevention.
- Implement fully the national quality strategy in the entire range of health services, if necessary on a stronger legal and regulatory basis.

Promote better-balanced integrated care

- Continue to back disease management programmes, especially in all chronic care areas.
- Remove legal restrictions for group practices, and for the outpatient departments of hospitals which could become autonomous entities.
- Authorise Sickness Funds to enter into managed care agreements with polyvalent group practices and outpatient clinics.
- Continue to give high priority to the individual electronic health record-based ELGA system.

Make the medium-term fiscal outlook of the system more prominent

- Focus the post-crisis spending saving measures on structural areas, also in the hospital sector.
- Make health and long-term care spending projections and scenarios more nationally visible.
- Integrate better the "health care" and "long-term care" components of projections.
- Set a medium-term (10-15 years) path for public health spending at general government level.
- Consider making public health spending at general government level a policy target.

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ANNEX A1

Box A1.1. **Cross-border prudential policy**

The Austrian banking sector will remain exposed to strong credit cycles in catching-up economies in the CEE region. Prudential policy will therefore play an important role in enhancing banks' resilience and limiting the build-up of associated risks. A framework for orderly and swift crisis management and resolution will be needed to make it possible for banks to fail without destabilising the financial system in order to avoid moral hazard. However, high cross-border exposures, including to non-EU countries complicate the conduct of prudential policy by Austrian authorities. Foreign subsidiaries are supervised by host country authorities and cross-border supervisory co-operation can be at times difficult – due to differences in the interests of home and host supervisors or imperfect information exchange. Moreover, while crisis management and resolution is already difficult at the national level, it is particularly problematic in the context of systemically important cross-border institutions as problems of the cross-border supervision tend to be magnified in a financial stress situation (OECD, 2010b). An effective prudential policy and crisis management are therefore possible only if there is a close and continuous supervisory co-operation with neighbouring countries. Encouragingly, the cross-border supervisory and crisis management frameworks available to Austrian authorities were improved as part of the response to the global financial crisis:

- At the regional level, the crisis management platform was provided by the Vienna Initiative/European Bank Coordination Initiative (VI/EBCI). This platform launched by the Austrian Ministry of Finance, the European Bank for Reconstruction and Development and the International Monetary Fund at the height of the financial crisis, brought together all key players with a stake in the financial stability in the CEE region: home and host country authorities, international financial institutions, the European Commission and international banks (Nitsche, 2010). While the VI/EBCI participants have never agreed on a general framework of burden sharing and division of tasks, the platform was effective to negotiate comprehensive country-specific solutions involving important commitments from all stakeholders. It played a crucial role in the cases of Romania and Serbia, and an important role in the cases of Bosnia-Herzegovina, Hungary and Latvia. In this way, the VI/EBCI helped preventing a systematic breakdown of the regional banking sector. Currently, two VI/EBCI public private working groups remain in operation focusing on absorption of structural funds and the development of capital markets. The VI/EBCI platform might remain helpful also in the future, in particular in case of co-operation with non-EU countries that would not be part of emerging European crisis prevention and crisis management frameworks.

Box A1.1. **Cross-border prudential policy** *(cont.)*

- At the European level, the establishment of new supervisory authorities should facilitate cross-border supervisory co-operation between Austrian and host-country authorities within the EU. The European Systemic Risk Board (ESRB) has a strong mandate to monitor systemic risk, issue warnings and recommendations to EU and national authorities, and monitor their implementation within specified timelines. The European Banking Authority (EBA) will have strong tools to improve co-operation within supervisory colleges and to provide binding mediation to cross-border supervisory disputes. In an emergency situation, the EBA will actively facilitate and, where deemed necessary, co-ordinate any actions undertaken by the relevant national supervisory authorities, and ensure a smooth exchange of information. It will be empowered to require national supervisory authorities to take specific actions to remedy an emergency situation, and even to adopt decisions addressed to individual financial institutions. However, no decision adopted by the EBA may impinge in any way on the fiscal responsibilities of countries, weakening its effectiveness in the emergency situation, while a comprehensive EU crisis management framework is still in the making. Unfortunately, the emerging new European supervisory architecture will not have a direct impact on supervisory co-operation with authorities in countries outside the European Union, where Austrian banks are also operating.
- At the international level, the Basel III capital requirements framework, to be transposed into the EU Capital Requirements Directive, introduces, among other capital strengthening measures, a counter-cyclical capital buffer that operates on the principle of jurisdictional reciprocity. While capital add-ons applicable to counterparties/borrowers in each jurisdiction are decided by the respective authorities, they are binding for all lending banks irrespective of their country of residence. This ensures that the buffer add-on will create a level playing field for banks from different countries active in a host country, and may help to limit situations when banks are pressured to take excessive risks in order to gain market share.

Box A1.2. **The relationship between unemployment and GDP in Austria**

The negative relationship between movements in the unemployment rate and real GDP is referred to as Okun's law, following Okun (1962) who originally estimated for the United States that a 3 percentage point decline in output is typically associated with a 1 percentage point rise in the unemployment rate. Studies typically find that the Okun coefficient differs across countries and over time with differences and changes in labour market institutions (such as EPL) having a large influence (IMF, 2010). In general, the Okun coefficient is found to have increased over time as labour markets have become more flexible.

There are several ways to estimate Okun's law (Knotek, 2007): in the static difference approach, the change in unemployment is regressed on the contemporaneous change in real GDP. The dynamic approach instead takes into account the fact that unemployment tends to react with a lag to changes in output. Estimations along these lines mostly include also lags of the dependent variable in order to eliminate serial correlation in the error terms.[1] The standard specification for this approach, which is applied here, is:

$$\Delta unr_t = \alpha + \sum_{s=0}^{\infty} \beta_s \Delta gdp_{t-s} + \sum_{i=1}^{\infty} \gamma_i \Delta unr_{t-i} + \varepsilon_t \text{, Okun coefficient} = \frac{\sum_{s=0}^{\infty} \beta_s}{1 - \sum_{i=1}^{\infty} \gamma_i}$$

with *unr* being the unemployment rate and *gdp* the log level of real GDP.

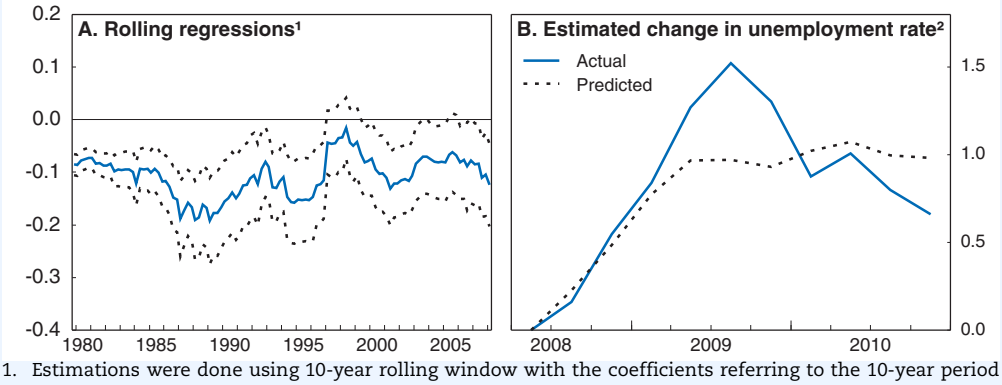
Box A1.2. **The relationship between unemployment and GDP in Austria** *(cont.)*

The sample period covers 1970 to 2010 at a quarterly frequency and the optimal lag lengths according to the Akaike criterion was 1 for both GDP and the unemployment rate. When estimated over the whole sample period, the Okun coefficient is calculated at –0.11, *i.e.* a one percentage decrease in GDP growth is associated with a 0.11 percentage point increase in the unemployment rate.

This point estimate, however, can mask significant changes over time in the Okun relationship. To analyse the time-variability of the Okun coefficient, rolling regressions using a ten-year window were estimated (applying the same specification as above). The left hand side of Figure A1.1 indicates that the Okun coefficient for Austria is very stable over time (Sögner, 2001). Taking the last decade prior to the onset of the crisis the Okun coefficient was only slightly higher with –0.12 than the average. Taking these estimates, the right hand side of Figure A1.1 compares the actual with the predicted development of the unemployment rate. This suggests that the actual evolution of the unemployment rate during the crisis (between 2008q2 and 2010q4) was slightly higher than what would have been predicted based on the historical relationship between GDP and the unemployment rate in Austria.[2]

The previous analysis treated upswings and downswings symmetrically. It might be the case, however, that the relationship between GDP and unemployment differs between recessions and booms. In Figure 1 of the main text the Okun coefficient of the current recession is compared with that of previous recessions. The Figure suggests that the reaction of the Austrian labour market to the current crisis was very similar or slightly more pronounced than during previous recessions. Furthermore, the Okun coefficient is relatively small in international comparison.

Figure A1.1. **Estimated Okun coefficients and actual *versus* predicted change in the unemployment rate**



1. Estimations were done using 10-year rolling window with the coefficients referring to the 10-year period just prior to the date marked on the x-axis.
2. Estimations based on estimated Okun coefficient and constant over the last 10-years prior the crisis.

Source: OECD calculations.

StatLink http://dx.doi.org/10.1787/888932459014

1. Another option is to estimate the relationship in levels, *i.e.* relating the level of the unemployment rate to the output gap.
2. It should be noted, however, that these results slightly change when national unemployment data are used instead of internationally comparable labour force survey data. While the Okun coefficient over the entire sample is only slightly higher using national data (–0.14**)**, the difference is more pronounced when only the ten years prior to the crisis are investigated. In this case the Okun coefficient using national data is estimated to be –0.26 and a slightly stronger and more prolonged reaction of the unemployment rate would have been expected than actually occurred.

ANNEX A2

Progress in structural reform

This table reviews recent action taken on recommendations from previous *Surveys*. Recommendations that are new in this *Survey* are listed in the relevant chapter.

Labour market recommendations	
Recommendations of the previous *Survey*	**Action taken**
Re-examine the new tax-benefit position of low-income workers, taking into account all ongoing changes in the tax-benefit system, with a view to ensure that their incentives to join or stay in the labour force are maximised.	From 1 July 2009, a modified in-work benefit (Kombilohnbeihilfe) was introduced. It is targeted at older workers (> 50 years), handicapped persons and parents with unemployment spells longer than six months. The new in-work benefit is granted in form of a monthly wage top-up of € 300 (full-time) or € 150 (part-time) as an incentive to take up low-paid employment. With the introduction of a new, federally harmonised social assistance in 2010, there is an allowance of 7% to 17% of the minimum income that is not counted towards the assistance for at least the first 18 months of employment. The exact details are laid down by the Länder.
More substantial reductions in employer social security contributions for low-income workers should be considered, to reduce their employment costs. These cuts should be funded by other permanent sources.	No action taken.
Continue to strengthen the up-skilling and requalification programmes for low-skilled workers. Evaluate the results and concentrate resources on the most effective schemes.	In 2010, 43.9% out of the 273 968 participants in PES (Public Employment Services) courses were offered very high-quality training measures leading to an acknowledged certificate (+4.3% year-on-year). By the end of 2010, 22 189 low-skilled persons had been trained to become skilled workers (+18.7% year-on-year) within the regional "skilled worker initiative" (Regionale Fachkräfteausbildung). In 2010, almost € 79 million were spent on this initiative, up from € 46 million in 2009.
Furthermore, PES integration measures for immigrants have been stepped up with a specific focus on the lesser-skilled (orientation measures, professional qualification, language courses, etc.).	
Ensure that high-quality up-skilling programmes are also available for workers presently in the "shorter working time" (Kurzarbeit) scheme.	Short-time work benefits or "subsidies for skills training" can be awarded for periods of training during hours not worked since the STW reform in 2009. The STW benefit rates applicable to periods of skills enhancement include a 15% supplement to provide additional incentives. In 2009, around 8 000 persons (out of 67 000 affected by STW) participated in a training measure during the STW period. Subsidies for skills training were granted for approximately 3 100 persons in 2009 and for more than 1 100 persons in 2010.
Fully implement past pension reforms. The transition period to the new system should not be extended, and the conditions of this transition should not be relaxed further.	There is no intention of the Austrian government to go behind the last pension reforms. In contrary, the access to early retirement regimes such as the special retirement scheme for people with a long period of contributions (Hacklerregelung) and the disability retirement scheme were further restricted at the beginning of 2011.

Labour market recommendations	
Recommendations of the previous *Survey*	**Action taken**
Continue to develop high-quality and low-cost early child care services to support working parents.	A total of € 45 m was spent during the years 2008-10 to further develop the child care facilities in Austria. The results of this measure will be evaluated in 2011. At the end of May 2011, the coalition partners decided on seven work packages and agreed to continue the expansion of childcare facilities – especially for children aged up to three years – via a mix of in-kind and monetary spending. It is aimed to create about 5 000 additional childcare places. p.a. in the years 2012-14 at an average annual cost of € 15 m (see below).
Prepare for the full integration of the labour market with the new EU members from 2011.	During the past seven years, the labour market has been gradually opened for EU8 citizens in line with labour demand. Access for several occupations was eased by special regulations, *e.g.* for top managers, scientists and researchers, key employees, qualified personnel in health and care professions. By means of the so-called "Fachkräfteverordnung", skilled workers in 67 professions with labour shortages were admitted preferentially.
	Workers from the new member states were granted unrestricted labour market access after having been employed continuously for one year. Until the end of January 2011, more than 76 000 "Freizügigkeits-bestätigungen" (certificates of entitlement to free movement) had been issued for NMS (New Member States) citizens.
	Additional measures are taken within the new "Lohn- und Sozialdumpingbekämpfungsgesetz" (Act to fight wage and social dumping) as of 1 May 2011. By enhancing inspections and tightening sanctions, this new law is to ensure fair working conditions for all persons working in Austria as well as fair competition for employers.
Financial market recommendations	
Recommendations of the previous *Survey*	**Action taken**
To secure financial stability plans should be ready in the event that the financial crisis worsens in one or more CEE countries.	The Vienna Initiative/European Bank Coordination Initiative (VI/EBCI) is an informal forum. It was launched by the EBRD, the IMF and the Austrian Ministry of Finance at the height of the systemic financial crisis in late 2008/beginning 2009. The aim was to provide the missing setting where all relevant stake holders for crisis management in vulnerable Central- South- and East European Countries (CESEE) could meet, and to initiate joint crisis response.
Depending on developments, further cross-border initiatives with the CEE region and the international financial community may be called for.	Based on ECOFIN conclusions and the roadmap on an EU-wide framework for crisis prevention, management and resolution Austria is preparing the establishment of a regional Cross Border Stability Group (CBSG) for the big four Austrian cross border banks operating in the CESEE region. The main tasks of the CBSG would be to provide a platform for exchange of relevant information for crisis management, discussion of systemic relevance (on the basis of the MoU 2008 "Heat Map"), discussion of stress scenarios, preparation and conduct of crisis simulation exercises as well as development of a joint crisis communication strategy.
	The supervisory authorities as well as the MoF of the member states Bulgaria, Slovenia, Czech Republic, Romania and Hungary have been invited to participate. The first meeting will take place in June 2011.
Medium-term growth recommendations	
Recommendations of the previous *Survey*	**Action taken**
Product markets	
Facilitate the opening of sheltered service sectors to domestic and international competition, while preserving service quality and consumer protection.	According to Art. 77 para 5-9 of the Trade Act, a permission – which was granted only under certain restrictive conditions in order to avoid danger for the supply in town centres – was required for retail stores of a surface more than 800 sq.m. These provisions have been abolished on 1 January 2011 (*Federal Law Gazette* No. I/111/2010).

Medium-term growth recommendations	
Recommendations of the previous *Survey*	**Action taken**
Fully implement the EU directives relating to services. In particular, sectoral regulators and the FCA should closely monitor market structures, behaviour and prices in electricity, gas, rail passenger transportation, postal services and telecommunications.	At the end of 2009 the operational business of the PSC (Point of Single Contact) started in line with the implementation of the Services Directive 2006/123/CE. Further improvement of the PSC – in particular concerning the electronic procedures – will be elaborated in the next months. Vorarlberg initiated the Weblink Länder model in compliance with the EU services directive.
	No such market surveys (in the legal sense of the competition act – Wettbewerbsgesetz) have been conducted. Nevertheless, the FCA had to examine these industries in several merger cases and in subsequent specific complaints. An investigation into the green electricity surcharge (Ökostrom-Zuschlag) may serve as an example.
Reduce barriers to competition in professional services	The Crafts, Trade, Service and Industry Act was amended in 2008 to facilitate entry in several professions. EU directives concerning professional qualification certificates have been transposed.
Carry out in full the planned thorough evaluation of competition policy and its institutional framework.	An evaluation of Austrian competition law is currently being carried out. In November 2010 the social partners presented a study on the future of Austria's competition policy. Working groups consisting of the relevant stakeholders in competition policy are now discussing suggestions derived from this study. By the beginning of 2012 the competent federal ministries will put forward their legislative proposals.
Pre-school education	
In addition to the already-decided introduction of one year compulsory pre-school on a half-day basis, enhance participation in full-day pre-school education from age three onwards, with a particular focus on children from age three with weak socioeconomic and immigration backgrounds.	Due to the federal structure of Austria the Länder are in charge of pre-school education and each Land has its own regulation. At the federal level, compulsory pre-school education on a half-day basis was introduced in September 2010. Effects will be evaluated by October 2011.
	Examples of *Land*-level measures, taken in Vorarlberg: Pre-school education plan (*Kindergartengesetz* und Kindergartenbildungs- und -erziehungsplan);
	one year compulsory pre-school education on a half-day basis – free of charge – from age five onwards (Gesetz über eine Änderung des Kindergartengesetzes);
	compulsory pre-school education on a half-day basis from age four onwards for children with deficits in speech and language (Gesetz über eine Änderung des Kindergartengesetzes).
	As regards raising the number of pupils – especially with migration backgrounds – several measures have been taken, *e.g.* introduction of the one-year compulsory pre-school education, information, networks, and pedagogical handouts. Measures are taken in close co-operation with the Länder under the so-called "15a Directive" (15a Vereinbarung). Additionally, the federal ministry has supported training institutions in order to increase their capacity for initial education and training.
Set and implement quality standards in pre-school education, concerning physical facilities, class sizes and teacher qualifications.	The initial training of pre-school teachers is organised on the federal level and thus guarantees compliance with quality standards.
Improve co-operation between federal, Länder and municipal governments to agree on future objectives of coverage and quality in pre-school education.	A first step towards a comprehensive approach was the set up of "A framework of education for pre-school educational institutions in Austria supported by the federal level and the Länder" (Bundesländerübergreifender BildungsRahmenPlan für elementare Bildungseinrichtungen in Österreich; *www.sprich-mit-mir.at/paedagoginnen/bildungsplaene*) in 2009. If measures are taken on the federal level, they will be implemented in close co-operation with the Länder. This specific measure is also to be seen in connection with the work on the "Language Promotion Plan" (included in the education plan for pre-school educational institutions for 5 year-old children), which is individually implemented in each institution.
Make the development of pre-school education a fiscal priority, with explicit performance objectives.	In May 2011, the federal government decided to create additional 5 000 ECEC (Early Childhood Education and Care) units each year in the years 2012-14; an investment of € 55 m (€ 10 m in 2011 and € 15 m per year in the years 2012-14).

Medium-term growth recommendations	
Recommendations of the previous *Survey*	**Action taken**
Primary and secondary education	
Integrate national academic standards into the primary and secondary school curriculum, and testing and assessment practices.	A legal framework for educational standards which defines competence levels in mathematics, English and German was adopted in 2009. It will be implemented step by step with a first test-phase in mathematics for the 8th grade in 2012 and for the 4th grade in 2012/13.
Overcome the overly early streaming of students, notably by encouraging the development of "comprehensive schools" (Neue Mittelschule), which requires equipping them with adequate teaching resources and curricula.	Since 2009, the comprehensive school model "Neue Mittelschule/ NMS" has been implemented in 320 schools. By fall 2011, 117 additional schools will enter into the new NMS model. By 2015/2016 all lower secondary schools will be conveyed to "Neue Mittelschulen"
Address with specific policy measures the very large gaps between academic achievements of students who speak and do not speak German at home.	In 2006/2007, a legal framework regarding the introduction of language courses in German to support ex-matricular pupils was established. This was extended to all schools of the lower secondary and pre-vocational level in 2008/2009. By 2010/2011 the lower level of secondary academic schools will also be included. For a maximum of two years ex-matricular pupils receive up to 11 hours of German classes a week.
Equip teachers to identify weaker students and students of foreign origin encountering language difficulties, to diagnose better their difficulties, and individualise instruction accordingly. This may require additional resources for schools with more children at risk.	The offer of support classes in the student's mother tongue was extended and support classes in 22 different languages are part of this initiative. In Austria, 400 teachers are involved in this initiative to help pupils with a mother tongue other than German to follow the curriculum.
	Additionally, "Didactics in Coaching" for teaching staff in multilingual classes is a project that started in 2010. It supports teachers of all disciplines to identify pupils with linguistic problems in order to implement individually targeted support measures. These training measures for teachers will help to better diagnosing children at risk.
Further the autonomy and leadership of headmasters and teachers to adapt curricula and classroom practices to student populations.	As regards the role of headmasters, Austria is working on a legal amendment to define the role and the tasks of school leaders. Furthermore a "management structure" to support schools leaders will be implemented in 2011.
Continue to support the development of assessment and evaluation practices, including assessment tests at school level that will eventually help improve quality and accountability.	Currently, a reform of teacher's initial education and training is underway. A quality management system which concentrates on individualisation, competence orientation in teaching and learning will be legally adopted in 2011. Better co-operation between federal and Länder levels is also envisaged.
	The initiative "25plus – individual learning and teaching" (25plus-individuell lernen und lehren) includes initial training measures for teachers as well as quality management and the development of course materials which are continuously refined
	E.g.:
	Peer reviews on "Teaching and Learning" at University Colleges of Teacher Education.
	"Train the trainer" offers for teachers at University Colleges of Teacher Education.
	Further development of external support and guidance of schools.
	Quality in schools "Q.I.S. online" as a reporting tool to highlight "individual teaching".
Re-assess the present school infrastructure, class sizes and teaching personnel against demographic developments and urbanisation trends, and develop a rationalization plan.	No action taken.
Re-invest the resources freed by rationalisation into improving teaching quality, notably by developing in-service training for education professionals to carry out evaluation and assessment.	A legislative initiative has been launched to introduce a comprehensive system of quality management for all schools (as already implemented in vocational education). This includes a close co-operation between federal and Länder levels.
Develop co-operation between federal and Länder governments to achieve common objectives for rationalising school infrastructures and improving teaching quality.	At the moment, the federal ministry and the University Colleges of Teacher Education are working together to offer sustainable and more effective training measures in order to improve teaching quality.

Medium-term growth recommendations	
Recommendations of the previous *Survey*	**Action taken**
Make teaching and headmaster professions more attractive. Develop a national "teacher and headmaster policy" including recruitment, continuing education, periodical evaluation, geographical mobility, pay and reward standards.	At the moment, a new service law regarding pedagogical staff which includes a better remuneration scheme at the beginning of a teaching career is planned.
	The reform process on a renewed initial education for teachers was launched in 2009. Following the Bologna architecture, education will be harmonized for teachers of primary and secondary schools. In all pedagogic professions the completion of a tertiary education will be required.
	In addition to the reform of teacher's education, a differentiation and repartition of tasks within school administration is aspired. To increase the attractiveness of pedagogical professions, a new, more permeable recruitment system will be introduced.
	As regards additional training, headmasters, school administrators and mentors will benefit from extended training programmes.
Tertiary education	
Set objectives for the development of lagging tertiary education capacity.	In the last two years two special programmes offered public funding (€ 34 m for teaching and € 34 m for research infrastructure) in addition to the global budget for universities. Moreover, in 2011 and 2012 additional € 30 m will be spent each year for measures improving the teaching infrastructure in mathematics, informatics, natural sciences and techniques, as well as for an extension of places at universities.
Clarify public and private responsibilities in funding tertiary education and draw fiscal implications.	There is still fewer private spending in the Austrian tertiary system than in other countries. In March 2011 Austria adopted a comprehensive strategy for research, technology and innovation (Strategie der Bundesregierung für Forschung, Technologie und Innovation). The strategy also includes different measures to improve and clarify the financing of public universities. The Federal Ministry of Science and Research is currently analysing new funding mechanisms for public universities to increase transparency and efficiency in tertiary education funding.
Allow universities to charge tuition fees, while avoiding socioeconomic segregation in university accession with the help of a state-of-the-art student grant and loan system.	The situation concerning tuition fees has not changed since 2009.
Develop a state-of-the-art student loan system following international best practices, covering not only study fees but also living expenses.	So far, no decision has been taken in this respect (see question above).
Allow universities to limit student registrations according to available teaching capacity.	In general, there is no access limitation at Austrian universities (see question on tuition fees). Entrance exams in order to adjust student numbers are limited to very few fields of study (*e.g.* medicine, veterinary medicine and psychology).
	Recently, Austria has taken the following actions:
	help for young people making the "right" choice in their course of study (*e.g.* awareness campaign; a special campaign promoting science, technology, engineering and mathematics).
	introduction of an entry phase for all studies: starting with winter semester 2011 there will be better information and orientation within the first semester.
	In order to be able to continue to study, students have to pass two exams in the first study year.
Make teaching quality, academic standards and labour market outcomes of individual tertiary education institutions transparent and public.	The implementation of the Bologna process is still ongoing; Austria is trying to optimise processes (*e.g.* "bologna reloaded", a programme including ten measures to be taken together with the institutions of higher education – to be finished in 2011).
	The new law on quality assurance for universities, universities of applied sciences and private universities is expected to come into effect in 2012. It will include several measures mentioned in the OECD recommendations.

Medium-term growth recommendations	
Recommendations of the previous *Survey*	**Action taken**
Continue to encourage governance and management reforms in universities and further develop "performance contracts" with the government.	In 2009 the federal ministry carried out negotiations concerning the performance agreements for the second time. The Austrian Science Council has evaluated the process and the results to help further develop this instrument of governance (see *www.wissenschaftsrat.ac.at*).
	In 2011 the next steps in developing these instruments will be taken. The federal ministry is preparing the so-called Hochschulplan, which is meant to become an ongoing process of governing the whole Austrian higher education system in a systemic process together with the institutions concerned.

ANNEX A3

Selected structural reform priorities of the Austrian government: road map 2011-13

In the end of May 2011, the Austrian federal government agreed on seven work packages (road map 2011-13) containing more than 90 measures. The implementation is expected to further reduce unemployment and strengthen economic performance. The road map forms the basis for the work of the federal government until 2013.

Education, science, research, culture and media

New comprehensive school (*Neue Mittelschule*): The new school model will be extended to 434 schools by autumn 2011 and all currently existing lower secondary schools will be transformed into the new model by autumn 2015.

Day care for school children: Day care facilities will be extended from currently 105 000 places to 210 000 by 2015.

Remuneration of teachers: An increase in entry-level salaries of teachers is foreseen to make the job more attractive.

Economy, labour, infrastructure and innovation

Small and medium enterprises: Innovation, investment and internationalisation will be promoted via grants and low interest credit.

New limited liability company: Changes in the legal form will reduce administrative burdens for small- and medium enterprises.

Research and technology: The focus on innovation-friendly public procurement, co-operation between science and industry, and excellence in research will be enhanced.

Health, long-term care and social affairs

Hospital and health-care reform: A cost-containment path in hospital care will be implemented and the financing and organisation of the hospital sector will be reformed.

Pension system: Long-term monitoring of pension costs is foreseen to guarantee the sustainability of the pension system. The objective is an increase in the effective retirement age.

Sickness funds: A binding cost containment path for sickness funds is expected to generate savings of EUR 1.7 billion in the period 2010-13.

National health objectives: An expert proposal is expected by mid-2012.

Family, society, opportunities and women

Early childcare: Childcare facilities will be expanded by 5 000 places a year for better reconciliation of family and work.

Return to work: In co-operation with the private sector, flexible working time arrangements and high-quality part-time employment shall be promoted.

Energy, environment and agriculture

Renewable energies: The use of renewable energies to achieve independence from nuclear energy by 2015.

Energy efficiency: Thermal improvement of buildings will be promoted via subsidies and grants.

Gas market: Competition and consumer protection will be increased to ensure uninterrupted service and to promote investment.

Public sector effectiveness and public finances

Reduction of administrative burdens: 330 reform proposals, out of which 40 have already been implemented in 2011, will improve public sector efficiency.

Chapter 1

Public sector inefficiencies have become less affordable

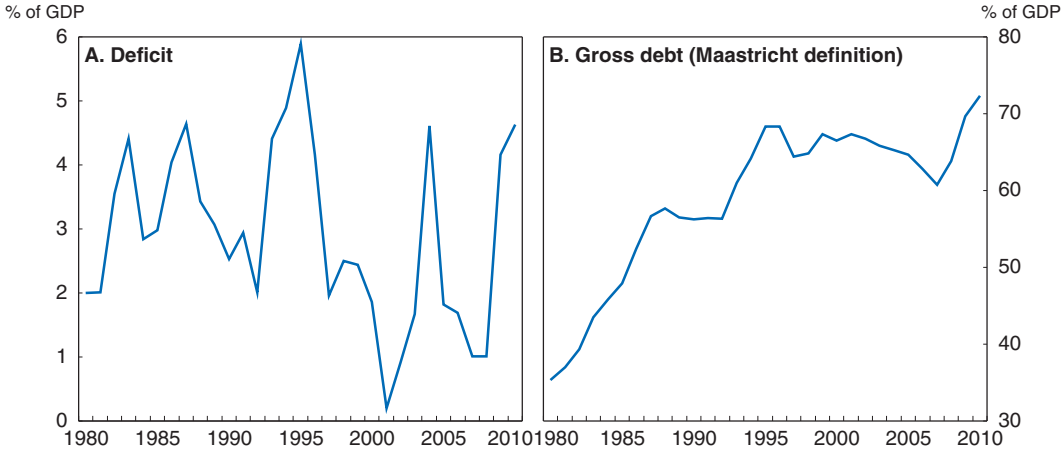
Performance of fiscal policy, while good in international comparison, is not sufficient to prepare for future ageing related spending increases. Given favourable macroeconomic conditions, the pace of consolidation could be more ambitious than currently planned, with a view to reducing the debt burden below 60% of GDP by 2020. Austrian fiscal policies have tended to be pro-cyclical in upturns, mainly because spending was not adequately kept in check. Stronger fiscal rules and a reform of inter-governmental fiscal relations could help contain expenditure dynamics. Efficiency-raising reforms in key spending areas such as pensions and other social expenditures, health, and education are also highly needed to reduce spending and ensure the provision of high-quality public services at lower cost. In this regard, Austria should make full use of the performance budgeting framework it plans to introduce from 2013. Higher potential growth could also take off some of the pressure on public finances. There remains significant room to rebalance the tax structure towards less distortive sources of revenue, thus supporting employment and growth.

Public finances after the crisis

Austria's public finances worsened markedly in the course of the economic and financial crisis, with the deficit increasing from 0.9% of GDP in 2008 to 4.6% of GDP in 2010. The deterioration was driven by discretionary stimulus measures – injected principally via cuts in personal income tax – and the operation of automatic stabilisers. The discretionary fiscal boost totalled 1.5% of GDP in 2009 and 1.8% of GDP in 2010 and was largely in line with the European Economic Recovery Plan. Public debt rose from 63.8% of GDP in 2008 to 72.3% of GDP in 2010 and is set to increase further through to 2013. Part of the increase in the debt ratio (2.4 percentage points) is due to government support to the banking sector and bilateral loans to Greece. Support for Greece and other euro area countries (Ireland, Portugal) within the architecture of the European Financial Stability Facility (EFSF) will lead to further temporary increases in the debt ratio in the period 2011-13. Even so, Austria still compares favourably with the EU or OECD average.

The deterioration of the deficit and debt figures also reflects a comprehensive revision of government data in March 2011. A tightening of the criteria for private sector entities by Eurostat forced the re-incorporation of the deficit and debt of the Austrian railway company and public hospitals into government balance sheets. The public sector thus assumed additional debt of 2.2 percentage points of GDP in 2009 and a further 1.2 percentage points of GDP in 2010. Deficits turned out 0.6 percentage points and 1 percentage point higher in 2009 and 2010 respectively due to reclassifications. It is more transparent to account for such operations in the public sector, because repayment of these loans would have been unlikely without further public liquidity injections.

Figure 1.1. **Public deficit and gross debt**



Source: OECD Economic Outlook Database for public deficit and Statistics Austria for gross debt.

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Nevertheless, budget shortfalls in Austria have largely been structural in nature. Fiscal policy used to be countercyclical during downturns but pro-cyclical or at best neutral during upturns (Brandner *et al.*, 2009). For more than three and a half decades, budget deficits have been recorded irrespective of economic conditions, with the sole exception of the balanced budget in 2001. The last time the general government balance was in surplus was in 1974. Over the past three decades, the debt stock doubled from one third of GDP to more than two thirds. Interest expenditure on debt will consume almost 3% of GDP or close to 6% of public expenditures in the years to come (Schratzenstaller, 2010). The expected normalisation of interest rates would gradually drive up debt servicing costs.

Corrective action has begun

As the recovery takes hold, a comprehensive strategy is needed to reverse the increase in the deficit and debt ratio so as to regain budgetary room for manoeuvre and cope with emerging medium- and long-term challenges. High and rising debt burdens risk exposing countries to financial market volatilities, as bond markets have become increasingly wary about governments' ability to address unsustainable fiscal positions. Inadequate consolidation efforts may thus trigger interest rate hikes and a country may quickly find itself in an uncomfortable position. Empirical evidence also suggests that a high level of public debt may hamper long-term growth through the negative impact of higher interest rates on business investment. A debt level of above 90% of GDP has been found to reduce growth by about 1 percentage point per year (Reinhart and Rogoff, 2010).

On 2 December 2009 the Council of the European Union adopted a decision stating that Austria had an excessive deficit and recommended correction by 2013, with consolidation starting in 2011 and improving the structural balance by ¾ percentage points of GDP per year. In the event, the Austrian authorities have specified measures in the 2011 Budget which should permit the deficit to fall below 3% of GDP by 2013 (see Tables 1.1-1.3).

Table 1.1. **General government finances 2008-13**

% of GDP	2008	2009	2010	2011	2012	2013
General government balance	–0.9	–4.1	–4.6	–3.9	–3.3	–2.9
Structural balance	–1.8	–2.6	–3.2	–2.8	–2.4	–2.1
Total disbursements	49.3	53.0	53.0	52.2	51.6	51.0
Total receipts	48.3	48.8	48.3	48.3	48.2	48.2
Gross public debt (Maastricht)	63.8	69.6	72.3	73.6	75.0	75.5

Source: Statistics Austria; Federal Ministry of Finance, 2011a (figures for 2011-13 according to government plans).

Table 1.2. **Expenditure restraint central government 2011-14**

EUR million	2011	2012	2013	2014
Social expenditures	–734	–860	–970	–1 093
Pensions	*–356*	*–400*	*–469*	*–549*
Transfers to families	*–246*	*–278*	*–278*	*–278*
Others	*–132*	*–182*	*–223*	*–266*
Administration costs	–486	–791	–868	–963
Subsidies and transfers	–190	–330	–404	–458
Interest payments	–86	–229	–454	–712
	–1 496	**–2 210**	**–2 696**	**–3 226**

Source: Federal Ministry of Finance, 2011a.

Table 1.3. **Additional revenues general government 2011-14**

EUR million	2011	2012	2013	2014
Stability levy on banks	500	500	500	500
Fuel tax	417	470	470	470
Anti-fraud package	100	200	300	400
Capital gains tax	30	50	100	250
Tobacco tax	100	150	150	150
Corporate tax	0	200	200	200
Others	17	171	201	221
	1 164	**1 741**	**1 921**	**2 191**

Source: Federal Ministry of Finance, 2011a.

The main measures on the expenditure side are cuts in social spending (family and long-term care benefits), administrative costs, and subsidies and transfers, as well as restraints on pensions. Savings are also expected in the area of interest payments on government debt.[1] Measures on the revenue side include a "stability levy" on banks, an increase in fuel taxation, a flight ticket tax, an increase in tobacco taxes and changes in the taxation of capital gains and foundations (introduction of a withholding tax on financial assets). Moreover, policies to combat fraud are expected to generate additional revenues. Measures on the expenditure side account for nearly 60% of the total consolidation volume and are borne by the central government. The state and municipal levels benefit from new tax revenues and are embedded in the national consolidation strategy via the *Domestic Stability Pact*, which allows *Länder* (state governments) a deficit of 0.75% of GDP in 2011, 0.6% in 2012, and 0.5% in 2013-14, while municipalities are required to record balanced budgets.

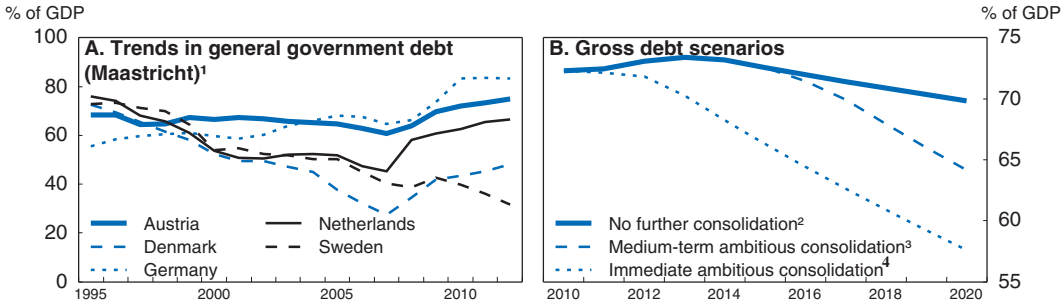
In addition to the measures in the 2011 Budget, the Medium-term Budgetary Framework Law 2012-15 of April 2011 specified a path for nominal central government expenditure growth at 1.8% of GDP on average per year. Under the assumption of nominal GDP growth of 4% per year and an unchanged revenue ratio, this is expected by the government to gradually reduce the expenditure ratio and bring down the fiscal deficit to 2% of GDP by 2015.

Debt consolidation has to continue in the medium term

Given favourable macroeconomic conditions, the pace of consolidation could be more ambitious, with a view to reducing the debt burden to sustainable levels and accommodating future fiscal pressures. Under the current medium-term fiscal consolidation plan, the budget deficit will decrease to 2% of GDP by 2015. However, without a further improvement in the budget stance, this would not be sufficient to bring down debt rapidly enough. Extrapolating the deficit of 2% in 2015 through to 2020 and assuming a constant nominal growth rate of 3.7% after 2012, the debt-to-GDP ratio would remain above pre-crisis levels until 2020 (Figure 1.2, Panel B). By contrast, an immediate, ambitious and front-loaded consolidation programme, which aims at reducing the deficit to 1% of GDP in 2013 and 0.5% in 2014, similar to the German debt brake, and leaving the deficit at this level thereafter, would reduce the debt-to-GDP ratio below 60% by 2020. A medium-term ambitious consolidation scenario, foreseeing a further decline in the deficit by 0.5 percentage point of GDP after 2015 until a balance of –0.5% of GDP is reached, would not bring down the debt-to-GDP ratio below 60% until 2020.

The fiscal position is vulnerable to higher interest rates, which have been relatively low for some time. Higher interest rates would raise debt-servicing costs and thereby

Figure 1.2. **Gross debt ratios and scenarios**



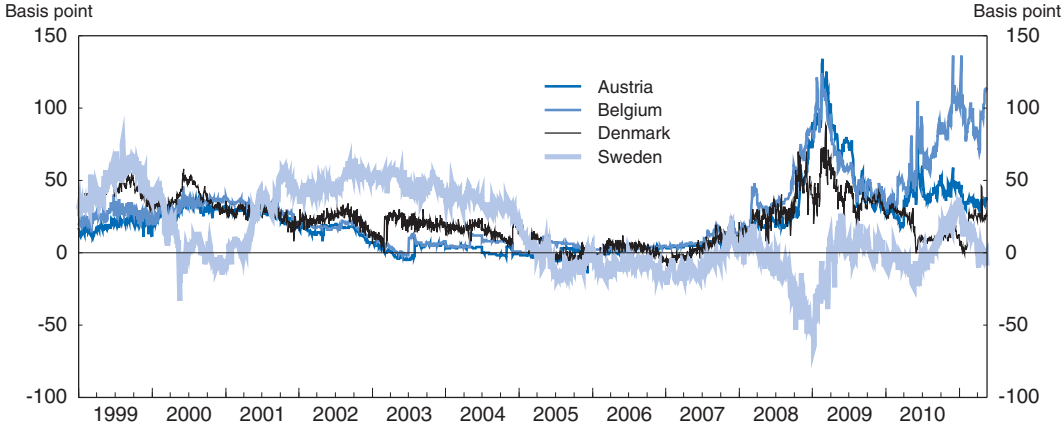
1. Data after 2010 are projections.
2. Nominal GDP growth of 4.7% in 2011 and 3.7% thereafter, and a budget deficit of 3.7% of GDP in 2011 with a gradual reduction to 2% of GDP by 2015 and no further consolidation thereafter is assumed.
3. Same assumptions as in (1), but further consolidation of 0.5 percentage point is assumed after 2015 until a budget deficit of 0.5% is reached.
4. Same nominal GDP growth assumptions as in (1) and (2), but the deficit is gradually reduced from 4.6% of GDP in 2010 to 0.5% of GDP by 2014 and held constant thereafter.

Source: OECD, *OECD Economic Outlook Database*; OECD calculations based on data from *OECD Economic Outlook*.

StatLink http://dx.doi.org/10.1787/888932458273

increase pressure to cut non-interest spending to reach the deficit target. The eventual normalisation of financial conditions and policy rates is likely to involve a general increase in long-term interest rates. In addition, an increase in the debt-to-GDP ratio could translate into a larger premium on Austrian sovereign debt, which is now relatively small, at 40 basis points over German rates. The threshold at which Austrian risk premia could begin to rise cannot be predicted with certainty.[2] However, the risk that high and rising government debt may add upward pressure on long-term government bond yields and depress growth should be factored into budget planning.

Figure 1.3. **Interest rate differentials *vis-à-vis* Germany**



Note: The interest rate differentials *vis-à-vis* Germany are based on 10-year government benchmark bonds; latest available data as of 18 May 2011.

Source: Datastream.

StatLink http://dx.doi.org/10.1787/888932458292

Medium- and long-term fiscal challenges

A reduction of the current debt-to-GDP ratio is all the more important as future spending pressures increase. A forward-looking assessment of public finances must

consider implicit liabilities of the public sector not reflected in government deficit and debt figures. These are commitments to the public pension scheme and loan guarantees to infrastructure companies,[3] the banking sector, and other euro area countries under the EFSF. The latter are contingent liabilities, *i.e.* costs the government would have to incur in the event of a borrower's default. The probability of such an event is uncertain, but its impact on public finances would nevertheless be significant.

Population ageing adds considerable pressure to public finances

Austria's population is projected to age rapidly. The number of elderly persons aged 65 or above will increase markedly, while the working-age population between 15 and 64 will decline as from 2020 onwards. The European Commission (2009) projects the old-age dependency ratio (*i.e.* the ratio of people aged 65 or more to the population aged 15-64) to double from 25% in 2008 to 51% in 2060. Austria would thus move from having 4 persons of working-age for every person aged over 65 to a ratio of only 2 to 1. The largest shift in the old-age dependency ratio is expected to occur in the period between 2020 and 2030, and costs for the public sector will be highest between 2040 and 2050.

Demographic developments will put considerable strain on public finances. Based on projections by the European Commission (2009), the government expects that population ageing will add an extra 3.1 percentage points of GDP to public spending in the period up to 2060 (Table 1.4). Most of the projected increase is due to higher costs for health care, followed by rising expenditure on long-term care, and then pensions. The projected increase in age-related expenditure is less than in other EU countries, but Austria's starting position is higher as it currently spends an above-average share on pensions and health and long-term care (13.5% of GDP and 8.5% of GDP respectively). According to the European Commission (2009), Austria is a "medium risk" country in terms of sustainability of public finances under the pressures of population ageing.[4]

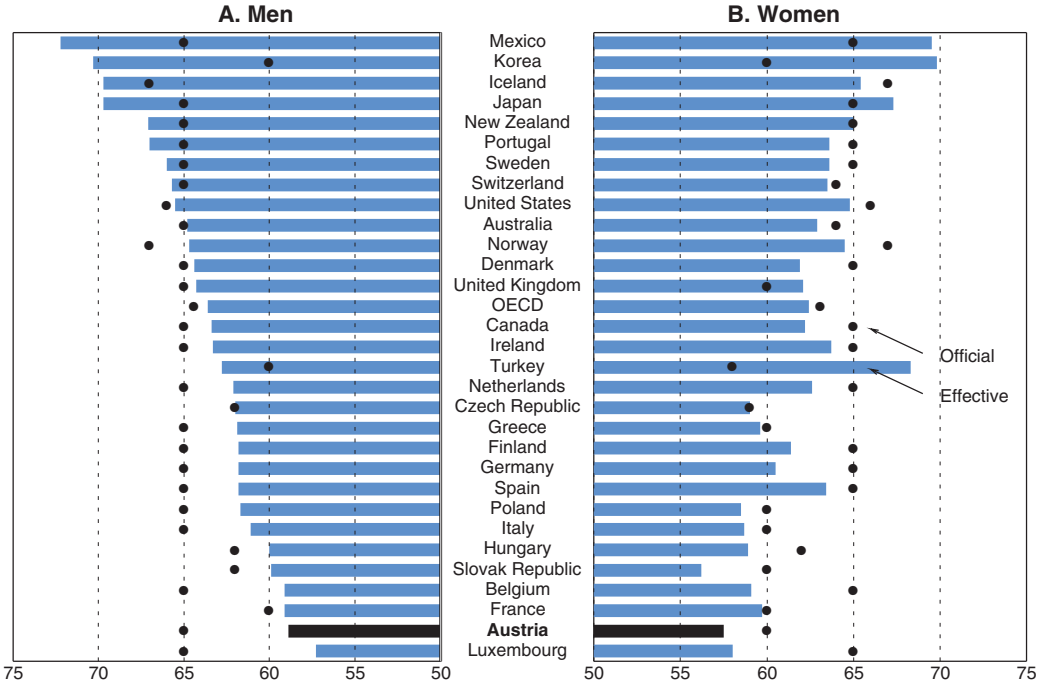
Table 1.4. **Projection of age-related expenditure 2010-60**

% of GDP	2010	2020	2030	2040	2050	2060
Age-related expenditure	27.6	27.8	29.4	30.2	31.0	30.7
Pensions	13.6	13.7	14.5	14.6	14.7	14.3
Health care	7.1	7.5	7.9	8.3	8.6	8.5
Long-term care	1.4	1.5	1.8	2.1	2.5	2.6
Education	4.8	4.4	4.5	4.5	4.5	4.6

Source: Federal Ministry of Finance (2011a), update of European Commission 2009.

However, these projections involve risks, particularly with regard to pension expenditures. They assume that average pensions relative to wages fall markedly over the projection horizon, even though over the past few years, average pensions grew more than average wages.[5] It is also assumed that people will retire later in the future. Some progress in this area has been made recently, but the retirement age remains very low. Austrian male workers exit the labour market at age 59 on average and females at age 57, the second lowest in the OECD after Luxembourg (Figure 1.4). Strong financial disincentives to continue work at older ages have kept the effective retirement age in Austria low (see below). According to a recent report by the OECD (2011, pp. 44-46), if only demographic changes as the main driver of pension expenditures are considered, pension expenditures would rise by more than 9 percentage points by 2060 to 23% of GDP – one of the highest shares in the OECD.[6] This implies that significant efforts are needed if pension expenditures are to be contained.

Figure 1.4. **The average effective retirement age is too low**



Note: Effective retirement age shown is for five-year period 2004-09; pensionable age is shown for 2010.

Source: OECD, *Pensions at a Glance 2011: Retirement-Income Systems In OECD and G20 Countries*, Figure 2.3, p. 43.

StatLink http://dx.doi.org/10.1787/888932458311

Projections of health and long-term care costs are also subject to large uncertainties, mainly because of non-demographic factors such as developments in health technology and rising relative prices of health and long-term care. According to evaluations in Chapter 2 of this *Survey*, cost increases may be more than 4 percentage points higher up to 2030.

Off-budget liabilities may influence fiscal outcomes in the medium-term

Public enterprises reported EUR 27.5 billion in outstanding debt in 2010 (9.6% of GDP), with more than half of it accounted for by the Austrian railway company and another significant share by the road company/ASFINAG (see Table 1.5). These liabilities are estimated to increase further in 2011. In addition, there are debts accrued by off-budget entities such as infrastructure companies at municipal level, amounting to about EUR 12.6 billion in 2010 (4.4% of GDP) (Federal Ministry of Finance; Government Debt Committee, 2010). Guarantees to the banking sector and other euro area member states have risen considerably in the course of the crisis. Most relevant are federal guarantees to commercial banks, which reached EUR 29 billion in 2009 (Aiginger *et al.*, 2010). Moreover, guarantees of some state governments, such as *Kärnten's* guarantee for the bank group Hypo Alpe Adria AG, reached significant amounts, but are expected to diminish gradually and expire in 2017 at the latest.

Public finance management needs further strengthening

The institutional background for budgetary planning has improved with the introduction of a 4-year fiscal framework as part of a comprehensive budget law reform. Since 2009, legally binding expenditure ceilings have been in place for five main expenditure categories, covering about 75% of central government outlays. The new

Table 1.5. **Liabilities of public enterprises**

EUR billion	2005	2006	2007	2008	2009	2010
Federal level						
Austrian railway company	5.8	7.1	9.3	11.1	12.5	14.4
Road company/ASFINAG	9.3	8.6	9.2	8.4	8.8	10.0
Federal facility management company	3.3	3.3	3.3	3.1	2.7	3.0
Others	0.6	0.3	0.2	0.1	0.1	0.1
	19.0	**19.3**	**22.0**	**22.7**	**24.1**	**27.5**
of which included in government debt	*4.1*	*3.5*	*3.6*	*4.4*	*5.0*	*6.0*
States						
Hospitals	0.6	0.8	1.0	1.3	2.2	2.9
of which included in government debt	*0.6*	*0.8*	*1.0*	*1.3*	*2.2*	*2.9*
Municipalities						
Communal infrastructure companies	11.7	12.1	12.2	12.5	12.5	12.6
Total	**31.3**	**32.2**	**35.2**	**36.5**	**38.8**	**43.0**
of which included in government debt	*4.7*	*4.3*	*4.6*	*5.7*	*7.2*	*8.9*

Source: Federal Ministry of Finance.

budgetary framework also created saving incentives for line ministries by allowing the carry-over of unspent funds from one year to the next. Some flexibility in central government spending is allowed for business cycle-sensitive areas, with variable ceilings that oscillate around defined parameters to ensure the working of automatic stabilisers. Other applications of variable ceilings are expenditure related to reimbursement from the EU, expenditure directly related to revenue (*e.g.* shares of value-added tax for hospital financing), and expenditure for guarantees (Steger, 2010).

Preliminary experience with the new expenditure framework is good and raises the credibility of the central government's budget plans. In particular, the ceilings exerted discipline over spending and the carry-over of unused funds successfully avoided "December fever". Line ministries were cautious about committing all available resources and built considerable reserves. As a result, in 2011, they have about EUR 1.4 billion in addition to their budgetary appropriations, which they can use to finance special projects not foreseen at the time the expenditure framework was passed. It remains, however, to be seen whether the possibility to carry forward reserves will lead to a macroeconomically relevant loss of control over effective fiscal performance.

However, the expenditure framework covers only about 40% of total general government outlays. Sub-central governments have so far resisted the implementation of the budget law reform, and social security funds are also not subject to the ceilings. Thus the risk of expenditure overruns has not yet been fully contained.

Fiscal federal relations continue to hamper consolidation

Fiscal relations between the three layers of government – the central government, the states, and the municipalities-are characterised by fragmented taxing and spending powers. Sub-federal government levels spend almost one third of total outlays but have only limited tax competences, to some extent because of own decisions. Resources are assigned to them via transfers, co-financing and shared taxes, based on a weighted population key and with a view to reducing inequalities among regions.

Two instruments are in place to govern fiscal relations: the *Domestic Stability Pact* and the *Fiscal Equalisation Act*. While the former sets annual deficit targets for the three levels of

Box 1.1. **Off-budget operations of the Austrian government**

In the run-up to monetary union, many EU countries used one-off measures and "creative accounting" to bring general government deficit and debt figures in line with the Maastricht ceiling of 3% of GDP and 60% of GDP respectively. Examples are corporatisation of hitherto public entities such as hospitals and infrastructure providers, sale and lease-back operations, classification of capital injections into public enterprises as financial transactions instead of capital transfers, above-the-line treatment of privatisation operations, and changes in the calendar for tax payments. More stringent fiscal rules and decentralised budgets have been found to make recourse to such operations more likely (Koen and Van den Noord, 2005).

Austria employed this type of procedures mainly in the form of reclassification from the public to the private sector. For example, the road company/ASFINAG, founded in 1982, was restructured in 1997. Besides, hospitals in four states and communal infrastructure providers were moved off-budget. Reclassification operations were estimated to have improved the budget balance by 0.5% of GDP and the debt ratio by 5.2% of GDP in the period 1996-97 (Schratzenstaller, 2010, p. 155). A second wave took place in the early 2000s, when the federal facility management company expanded its business and hospital providers in the other five states were moved off-budget. At the same time, there was a change in hospital financing, with some state governments resorting to granting loans rather than injecting capital, thereby reducing deficits. These measures are estimated to have improved the budget balance by about 0.5% a year over the period 2001-04 (*ibid.*). In 2006, however, Statistics Austria decided that the new accounting practice with regard to hospital financing is not in line with ESA accounting principles and retroactively revised deficit figures accordingly.

Reclassification does not *per se* improve fiscal sustainability. In contrast to privatisation, the government retains influence in some form or other on the entity and thus carries operational risk. If the government incurs implicit liabilities for the debt of reclassified units and continues to finance their deficits, this is a pure accounting operation and the true public finance position remains unaffected. However, the information value of common fiscal indicators can be reduced considerably, as proceeds, costs and accumulated liabilities vanish from government balance sheets. The debt ratio in particular may lose significance as an indicator of long-term sustainability when there are sizeable off-budget liabilities (Prammer, 2009).

The long-term impact of reclassification on government finances has to be assessed against the viability of the entities concerned. Austria is one of the countries in the OECD with the highest share of government subsidies and transfers to business, amounting to above 5% of GDP. More than half of this money goes to public enterprises outside the government sector and to hospitals. Even excluding for the purpose of international comparison the share allocated to health care units (1.5% of GDP in 2008), transfers to businesses and public entities remain well above the level in other countries (4% of GDP as compared to 2.3% of GDP in the OECD; data for 2008). On the other hand, government investment has come down significantly, from more than 3% of GDP in the early 1990s to a low of 1.1% of GDP in 2008 (as compared to 3.3% in the OECD), as most investment is now carried out by firms outside the government sector (Prammer, 2009; Pitlik *et al.*, 2010).

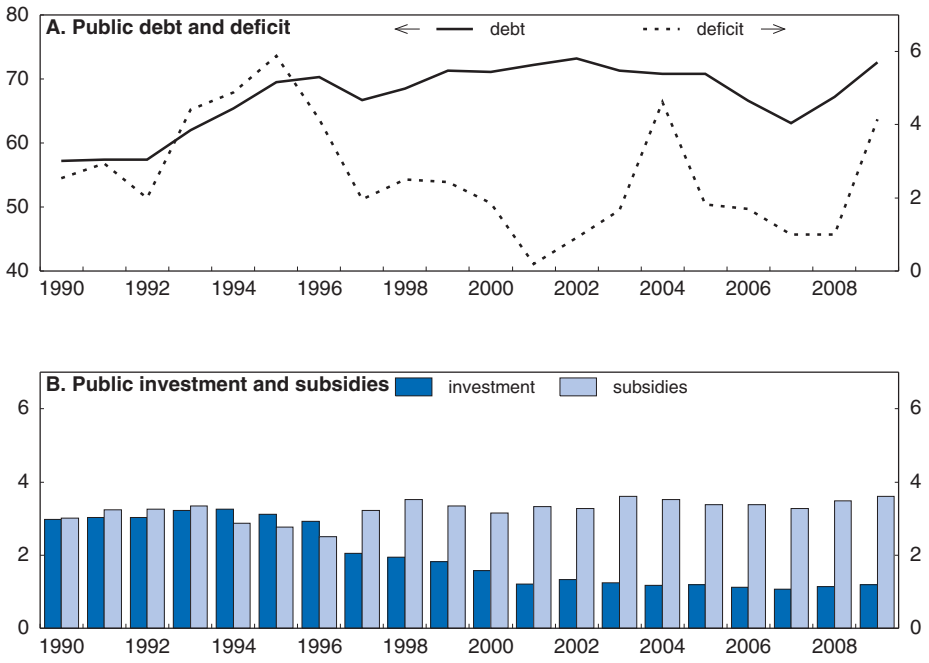
There is also a risk that hitherto implicit liabilities could re-enter public balance sheets as explicit liabilities, as has already happened to some extent in March 2011. One of the criteria for qualification as a "market producer" under the European System of Accounts (ESA 95) is that sales cover more than 50% of production costs. Discussions for tightening the criteria are currently underway, and chances are that some reclassified units in Austria

Box 1.1. **Off-budget operations of the Austrian government** *(cont.)*

no longer meet the requirements. The Austrian railways, for example, receives more than a third of sales revenues from the government in the form of compensation for infrastructure maintenance, social pricing and environmental measures. The facility management company could also be affected by more restrictive criteria and be forced back on government balance sheets.

Figure 1.5. **Public debt and deficit, investment and subsidies**

% of GDP



Source: OECD, *OECD Economic Outlook Database*.

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government, the latter determines the allocation of revenues between them. Both are renegotiated periodically, usually in connection with each other. The current arrangements were agreed in early 2011 and are in place until 2014. States are required to gradually reduce their deficits from 0.75% of GDP in 2011 to 0.5% of GDP in 2013 and 2014, while municipalities have to achieve balanced budgets. The central government is responsible for ensuring that general government deficit targets as set out in the Stability Programme are met.

There are no limits to the debt ratio in the *Domestic Stability Pact*, but all administrative levels committed to set ceilings for liabilities (*e.g.* guarantees to banks, public enterprises or hospital operating companies) and they are now also obliged to report newly created off-budget entities to the national statistical agency, thus increasing transparency. However, the effectiveness of the guarantee ceilings remains to be seen, in particular because their level can be decided autonomously by individual governments. Nevertheless, this marks progress, because the hitherto exclusive focus on the deficit had encouraged states and municipalities to move spending off their books, thus reducing the integrity of fiscal indicators without necessarily improving fiscal positions.

Sanctioning mechanisms in the case of non-compliance with deficit targets have been reinforced recently. Since the first *Domestic Stability Pact* was adopted, some states have consistently failed to adhere to the budgetary targets. Fines would have been possible in theory but no attempt has ever been made to apply them, because the set-up of the sanctioning mechanism (unanimous agreement to start an internal excessive deficit procedure, including by the state that breached the deficit target) rendered it a mere hypothetical tool. New arrangements will make the *Domestic Stability Pact* a more effective instrument to address the risk of budget shortfalls at sub-central levels of government:

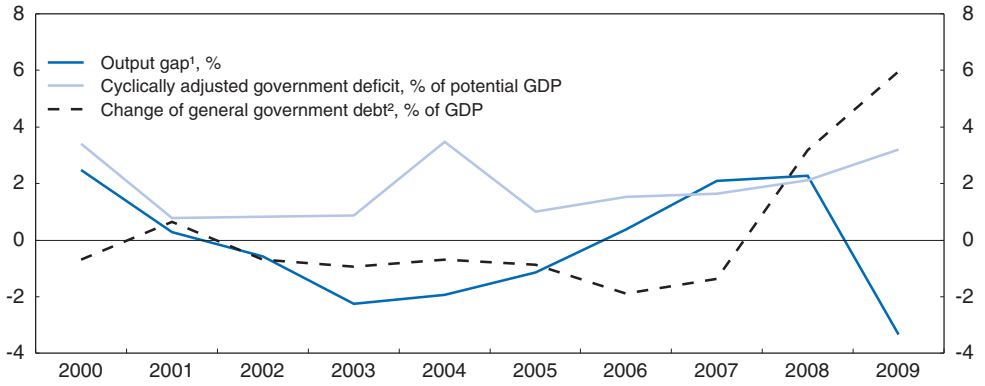
- In case of negative deviations from deficit targets, if the violation of the deficit target is confirmed by an *ex officio* report of the Court of Audit, an arbitration committee will be installed. The committee consists of representatives of the central government and the administrative level concerned (the "peers"), but the state or municipalities in breach of the deficit target have no say.
- Agreements can now also be reached in the absence of one of the negotiating parties. If the committee decides that the *Domestic Stability Pact* was violated, the state or municipality concerned is demanded a deposit equal to 15% of the deficit overrun. The deposit will be returned if the overrun is corrected within the next fiscal year, but is lost in case of repeated failure to adhere to the budgetary targets.

Despite these improvements, pro-cyclical elements in the design of inter-governmental fiscal relations remain a problem. Sub-federal governments receive a constant proportion of mostly cyclically sensitive tax revenues such as personal income tax, corporate tax, and value added tax, while their deficit targets are fixed as a percentage of GDP for a 4-year period and thus unresponsive to changes in economic conditions. With no room for manoeuvre on the revenue side, little incentive to build reserves and governed by nominal deficit targets, spending at sub-federal levels tends to be raised during boom periods and reduced during downturns (see Brandner *et al.*, 2009). The recently adopted *Domestic Stability Pact* takes into account new tax revenues of the consolidation package and the economic outlook.[7] However, the current outcome of the negotiations between the federal and local governments about the distribution of consolidation burdens raises the question why only the federal level makes savings on the spending side, despite a now more favourable economic outlook. Additional tax revenues allocated to states and municipalities in case of a stronger than predicted upswing may thus be expected to be spent fully. Instead these should be used to further reduce the general government deficit – at the federal level the expenditure framework guarantees such a further consolidation. With improved budgetary rules, budgetary policy at state and municipal level could better support fiscal policy objectives at the national level.

Fiscal targets need strengthening

Existing fiscal rules such as the medium-term target of a balanced budget over the business cycle as spelled out in the Austrian Stability Programme have proven too weak. A budget rule of balance over the cycle should have produced a secularly declining debt ratio, but the debt ratio remained on average 5 percentage points above the Maastricht threshold of 60% of GDP during the decade preceding the crisis. Austrian net lending, like in many other OECD economies, has been subject to pro-cyclical movements (see Figure 1.6). Brandner *et al.* (2009) provide evidence that fiscal policy in Austria has tended to be pro-cyclical in upturns, principally because spending was not adequately kept in check. Discretionary policies tended to offset the effects of automatic stabilisers during upturns

Figure 1.6. **Austrian government debt remained high**



1. Output gap of the total economy.
2. General government gross financial liabilities according to Maastricht definition.

Source: OECD, *OECD Economic Outlook Database*.

StatLink http://dx.doi.org/10.1787/888932458349

but not during downturns. Another factor has been the tendency to resort to off-budget financing which eventually showed up on government balance sheets.

One option to contain spending pressures in periods of revenue windfalls would be to anchor consolidation efforts in a debt rule which specifies a path to reduce the debt-to-GDP ratio. This may be supplemented by a target rate of growth of real general government spending. The advantage of such an expenditure rule as compared to a deficit rule of balance over the cycle is that it is less sensitive to cyclical conditions, which may be difficult to assess and offer room for manipulation. Under an appropriately designed rule, revenue increases in upturns will automatically be saved, which is not the case with a deficit rule (OECD, 2010d).

The challenge Austria faces is how to further involve regional governments in the consolidation efforts. A reform of inter-governmental fiscal relations will be needed to strengthen containment of expenditure dynamics and further reduce pro-cyclical tendencies. Apart from applying the medium-term expenditure framework at all levels of government, the *Domestic Stability Pact* should be extended towards debt and spending targets.

Public spending needs to be substantially restrained

Containing public expenditure dynamics is the first best option to durably consolidate public finances and prepare for upcoming challenges related to demographic developments, climate change adaptation or additional education needs as well as other prioritisation needs. The ultimate goal should be to provide more and better public services with less public money. Governments are not only accountable for how much they spend, but also for what they achieve with a given amount of taxpayers' money. There is thus a cost-efficiency and a quality argument. To the extent that public services can be provided with fewer resources, taxes can be lowered or spending directed to other areas in the service of growth and welfare.

Improving public sector efficiency is particularly important given the above-average ratio of expenditures to GDP (53% of GDP in 2010, up from 49% before the crisis). Studies suggest that there is a sizeable savings potential, especially with regard to social transfers, health care, education, and business subsidies (see below), but also in public administration

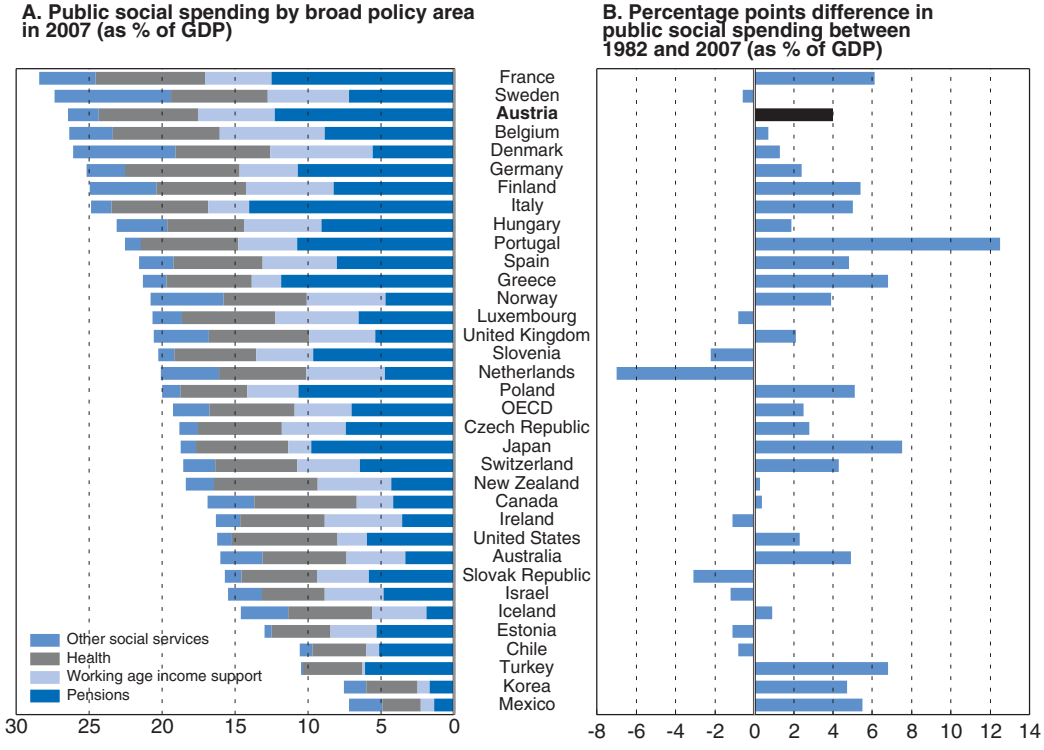
and public procurement. For example, strengthening public tendering processes and resorting to Public-Private Partnerships where they offer genuine efficiency gains can secure savings. Replacing only a fraction of retiring government employees seems to be the most effective way to reduce public wage costs. In general, the scope for raising efficiency appears to be large in areas characterised by fragmented responsibilities between different levels of government and at sub-federal levels (see OECD, 2005a; Fuentes *et al.*, 2006).

According to WIFO (2010), the short-term savings potential in the Austrian public sector amounts to EUR 1.8 to 2.8 billion for the consolidation period 2011-13. Similar conclusions have been reached by a recent IHS study (2010), which detects an efficiency savings potential of EUR 430 to 660 million per year as a lower bound estimate. The long-run savings potential from genuine public sector reform would be significantly larger. The main reasons for inefficiencies seem to differ between the central government and the states: whereas in the former, deficiencies in strategic planning (*e.g.* inadequate personnel management) appear to be the most important cause for inefficiencies, at state level resistance to reform and overcapacities seem to be most relevant (*ibid.*).

Social protection spending should be better targeted

Large spending items naturally also contain the largest potential for efficiency gains. Compared to other OECD countries, Austria spends an above-average share of GDP on social protection, reflecting societal preferences. The upward trend in spending over the past decade will slow down somewhat with the cuts applied to family and long-term care benefits in the 2011 Budget (Schratzenstaller, 2011).

Figure 1.7. **Austria is among the highest spenders on social programmes**



Source: OECD, *Society at a Glance 2011*.

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Savings could be made if social transfers were better targeted. A move away from universal benefits and increased use of means-testing will be hard to avoid if the generosity of benefits is not to be severely reduced. This would be facilitated if responsibility for social spending were concentrated on one governmental level. In the area of long-term care benefits, a reform proposal to this effect has been endorsed recently, together with the updated *Domestic Stability Pact*. In many other areas, however, the system continues to suffer from a fragmentation of competences and a lack of co-ordination between the various actors, which makes means-testing difficult to apply in practice. The government has taken a first step to improve transparency by setting up a database (see Box 1.2). Moreover, a working group on the future of the welfare state has been established to reassess social benefits and transfers.

Housing subsidies, a sole competence of the *Länder*, are one example of social spending which could be better targeted. While means-tested benefits play a limited role, considerable amounts are spent on a housing promotion scheme *(Wohnbauförderung)*, which benefits higher income earners more than lower ones, as the former are more likely to invest in home ownership than the latter (Albacete and Wagner, 2009). In addition, housing is indirectly subsidised because: *i)* imputed income from owner occupied housing is not taxed, and *ii)* interest payments on housing loans are deductable from income tax up to a certain income level.

Box 1.2. **Transparency database**

Since 1 January 2011 a federal law is in force to establish a so-called transparency database, with the main aim of increasing transparency of all benefits and services provided by the public sector to natural and legal persons; to reduce the interaction costs between citizens and benefit granting authorities; and to enhance the effectiveness of public transfers. Access to the database is under the current law only granted to the recipients of benefits, however, the federal government can request aggregated and non-personal data. The database is scheduled to be operational by 1 January 2012 and the set-up costs are estimated to be around EUR 1.6 million with additional running costs of about EUR 2.5 million per year.

The transparency database is intended to provide a comprehensive list of all benefits including social security benefits, monetary transfers, subsidies, tax expenditures and benefits in-kind in order to enhance information availability and raise the awareness of the amount of public transfers. In the case of benefits in-kind, such as publicly subsidised access to child care facilities or the educational system, information on the average cost per beneficiary will be provided. However, under the current law, only federal benefits are covered and for the database to include benefits from states and municipalities, separate laws on the state level have to be enacted. A treaty between the federation and the states is currently negotiated with the outcome being unpredictable at the moment.

Besides informational purposes, the transparency database can be used to facilitate the interaction between natural/legal persons and benefit granting authorities. For instance, in order to apply for an additional benefit, it might be necessary to provide evidence of benefits already received. A list of these benefits can be readily obtained from the database and transferred to the authorities. This in turn enables the granting authority to easily verify the conditions for entitlements and reduces the risk of granting double-benefits.

Box 1.2. **Transparency database** *(cont.)*

The government can use the transparency database for controlling and evaluation purposes. Based on aggregated and non-personal data, the government obtains an overview over the instruments of state aid and their amount. In addition, analyses on the eligibility conditions for entitlements and how well they are aligned can be conducted. This may help to co-ordinate different benefit instruments and target them to specific groups. Access barriers for the government are high, however. Each request requires a unanimous vote of the council of ministers. Furthermore, the purpose of assessing the effectiveness of state aid might be particularly limited in the case of subsidies. Subsidies are generally granted with the aim of influencing incentives and behaviour. Thus to properly assess their effectiveness, information on outcomes would be necessary. While such an extension is currently not envisaged, the database would provide a first step by establishing the necessary infrastructure.

Scope for efficiency gains needs to be identified sector-wise

International benchmarking of public expenditure efficiency suggests that Austria is among the less efficient countries in terms of value for money from health spending (European Commission, 2008). The reasons for inefficiencies and the savings potential are discussed at length in Chapter 2 of this *Survey*. The analysis shows that the below average productivity/cost performance in the health sector may be partly related to the complexity of governance based on the fragmentation of decision making and financing between the different levels of government. A better alignment of performance, financing and spending responsibilities would thus seem to be an essential step forward in the health domain. In respect of health spending, however, the contribution of better management to budget control will be more in containing the effects of growing future demands rather than freeing up resources for alternative use or deficit reduction.

Austria is also lagging with respect to the efficiency of education spending (OECD, 2009a). One estimation (Sutherland *et al.*, 2007) suggests that compared with international best practice, Austria could save a considerable amount of real resources and still achieve the same educational outcomes. Looking at educational outcomes as measured by student attainment at age 15 in the OECD *Programme for International Student Assessment* (PISA), Austria is close to international norms in terms of educational attainment but commits an above-average amount of resources. These efficiency gains in education could be achieved by reducing teacher inputs and pursuing institutional reforms. In particular, greater decision-making autonomy at the school level tends to be associated with higher levels of efficiency, while small school sizes and residence-based selection is associated with inefficiency. However, one finding from international benchmarking exercises is that teacher pay is positively related to outcomes, so here, as perhaps elsewhere in the government sector, downward relative pressure on wages could have a negative long run cost in terms of the quality of outputs.

Expenditure on higher education is a different matter. Higher-education grants comprise a relatively high proportion of public spending on education, while there is an absence of tuition fees. The absence of tuition fees is in contradiction to the progressivity which characterises other mainstream aspects of the Austrian fiscal system and should be reviewed. Overall, the warranted policy objective of increasing tertiary education attainment rates, together with the necessity to develop a comprehensive grant and

income-contingent loan system will put additional pressure on the share of public education spending in GDP, rather than reducing it, reinforcing the need for realising efficiency reserves.

Spending on business subsidies and transfers claims twice as many resources as in other OECD countries. Again, fragmented responsibilities between different levels of government and social security bodies, a lack of co-operation between them and insufficient reporting, especially at sub-federal levels, seem to be the main reasons for inefficiencies. WIFO estimates that Austria spends 1.5 times the amount of subsidies that would be required according to structural factors (Pitlik *et al.,* 2010). The transparency database has the potential to provide for the first time a consistent compilation of all subsidies and transfers granted by different institutions, on the basis of which a comprehensive evaluation against quantitative and qualitative performance objectives could be undertaken.

There are also efficiency reserves in the administration of the tax system and the collection of general government receivables. Several taxes, such as income taxes and social security contributions, are collected on related tax bases. If these were better integrated, synergies could be exploited and help reduce administration and compliance costs and improve efficiency of enforcement.

Progress with public sector reform is sluggish

Discussions about public sector reform have a long tradition in Austria. Successive governments have taken initiatives over the past decades aimed at increasing transparency, efficiency and service quality. The most significant reform was undertaken in the area of security policy. Between April 2003 and June 2005, Austria reformed its police force by merging several previously separated police units into one law enforcement body. The previously 45 regional police headquarters were reduced to 9, one for each *Land*, and about 990 administrative and low- and middle-management positions were cut and relocated to strengthen the executive branch. In addition, bureaucratic processes were harmonised, streamlined and computerised to boost efficiency.[8] Another example of a successful reform is the widespread application of information technology in administrative processes – Austria is leading with e-government applications. States and municipalities have improved customer orientation by establishing one-stop-shops.

However, many key areas of the public sector have been highly resistant to reform. In February 2009 the government embarked on a new initiative and established a high-level working group on "consolidation and administrative reform", comprising the Federal Chancellor, the Minister of Finance, state governors and experts from the Court of Audit and research institutes. As of now, sub-committees have been set up to develop practical solutions on 6 out of 11 work packages and 2 sets of recommendations have been finalised and presented to the working group. The first set of recommendations of May 2009 relates to school organisation and proposes a better alignment of spending and financing responsibilities, orientation towards strategic objectives, external monitoring and school autonomy. The second set deals with the alignment of pension systems of states and public enterprises with the general pension scheme and was presented in February 2010.

In practice, progress in the working group has been slow and a lot of impetus has been lost in the preparatory committees, where diverse interests narrow down the scope of discussion and reaching consensus has proven difficult. No decision has so far been taken

on issues involving a shift in power structures between the three levels of government or even between states.

Performance budgeting should help improve efficiency

Increasing the use of performance information in the budget process is an important step away from the traditional input-orientation towards outcomes and results. With the adoption of the budget reform law in 2009, Austria has made a commendable first step in that direction. The traditional budget doctrine of being economical, thrifty, and useful was transformed into four principles to be applied by 2013: *i)* outcome orientation; *ii)* efficiency; *iii)* transparency; and *iv)* true and fair view (Steger, 2010). Performance budgeting is one of the main elements to be introduced in the second stage of the budget reform process scheduled for 2013. Thus the new budget framework can act as a key institutional driver to improve public sector efficiency.

The challenge is now to develop appropriate performance indicators and establish a framework for using them in the budgeting process. OECD experience suggests this is not an easy task. Despite widespread introduction of performance information in the budgeting process over the past 15 years, OECD countries continue to struggle to make appropriate use of it. A clear procedure on how to employ performance indicators in the budgeting process, the quality of information and the institutional capacity of Finance Ministry and line ministries have been found to be important success factors (Curristine *et al.*, 2007).

In order to get the most out of the reform, performance budgeting should also be implemented at sub-federal levels of government. Fiscal relations between the federation and the states must ensure that incentives to deliver cost-efficient and effective public services exist at all administrative levels. Genuine public sector reform requires the co-operation of states and municipalities, especially because they play an important role in the provision of some of the services where the largest gaps in terms of quality and cost-efficiency have been detected.

Towards a more growth-friendly tax structure

Taxes affect employment, welfare, and economic growth through their impact on the decisions of households and firms with regard to labour supply and demand, the level and composition of investment and production, and the choice of savings channels. What matters for these decisions is not only the level of taxes but also the way in which different tax instruments are designed and combined. Empirical evidence suggests a "tax and growth ranking" with recurrent taxes on immovable property being the most growth-friendly, followed by consumption taxes and other property taxes as well as environmental taxes, personal income taxes and corporate income taxes (Johansson *et al.*, 2008; Arnold, 2008). Recognising this, many OECD countries have undertaken structural reforms of the tax system with a view to creating work incentives, encouraging investment and entrepreneurship, and reducing tax-induced distortions (OECD, 2010a).

Austria enjoyed some success in reducing the overall tax burden from 2000 to 2007. Attempts have also been made to improve the growth-friendliness of the tax structure, reducing taxation of labour and corporate income:

- Recent reform measures reduced the labour tax burden by EUR 2.1 billion and were implemented in 2008/2009 as part of the economic stimulus package. The package

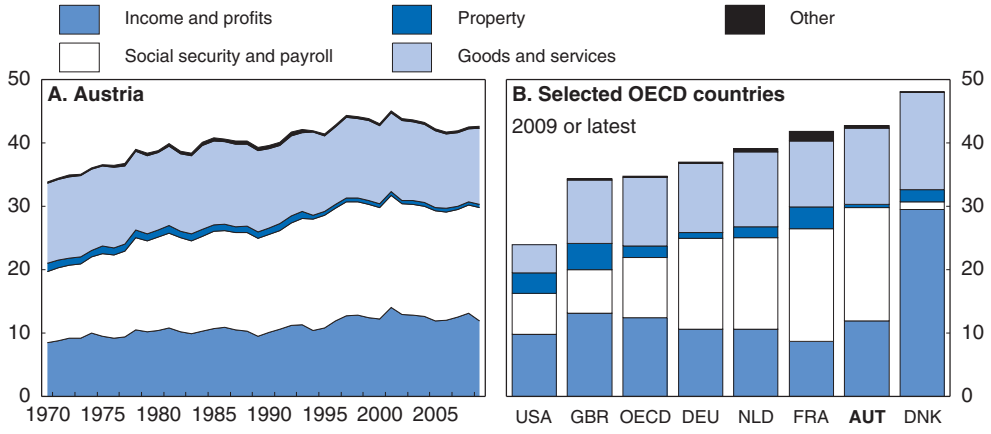
included: *i)* an extension of the zero tax threshold and an upward shift of the top income bracket; *ii)* rate cuts in the second and third income brackets (from 38.3% to 36.5% and from 43.6% to 43.2%); *iii)* an up to 3 percentage points reduction in unemployment insurance contributions of low-wage employees; and *iv)* measures to support families with children, such as an increase in the tax credit for children, the introduction of a tax allowance for children and tax deductibility of childcare costs. The earlier 2004/2005 income tax reform reduced the number of tax brackets from five to four, increased the standard tax credit, simplified the phasing-out rules of the standard tax credit, and introduced a child tax credit for sole earners and lone parents.

- An Act to promote small- and medium-sized enterprises came into effect in 2007, introducing a tax allowance for reinvested profits in certain assets. The 2009 tax reform expanded the tax allowance to all firms under income tax law and softened the reinvestment criteria, while eliminating the preferential taxation of non-distributed profits and stock options.

Despite these recent improvements, there remains significant scope to further increase the growth-friendliness of the tax structure. Figure 1.8 shows the composition of tax revenues by major tax category. Compared to the OECD average, direct taxes on income and social security contributions are relatively important, while the proportion of taxes on property and consumption is lower. Over time, the share of growth-friendly taxes was reduced at the expense of more distortive ones. Austria now funds one of the largest public sectors in the OECD, while at the same time largely foregoing opportunities to raise revenue in a non-distortive way.

Figure 1.8. **The tax structure is biased towards distortive taxes on labour**

As % of GDP



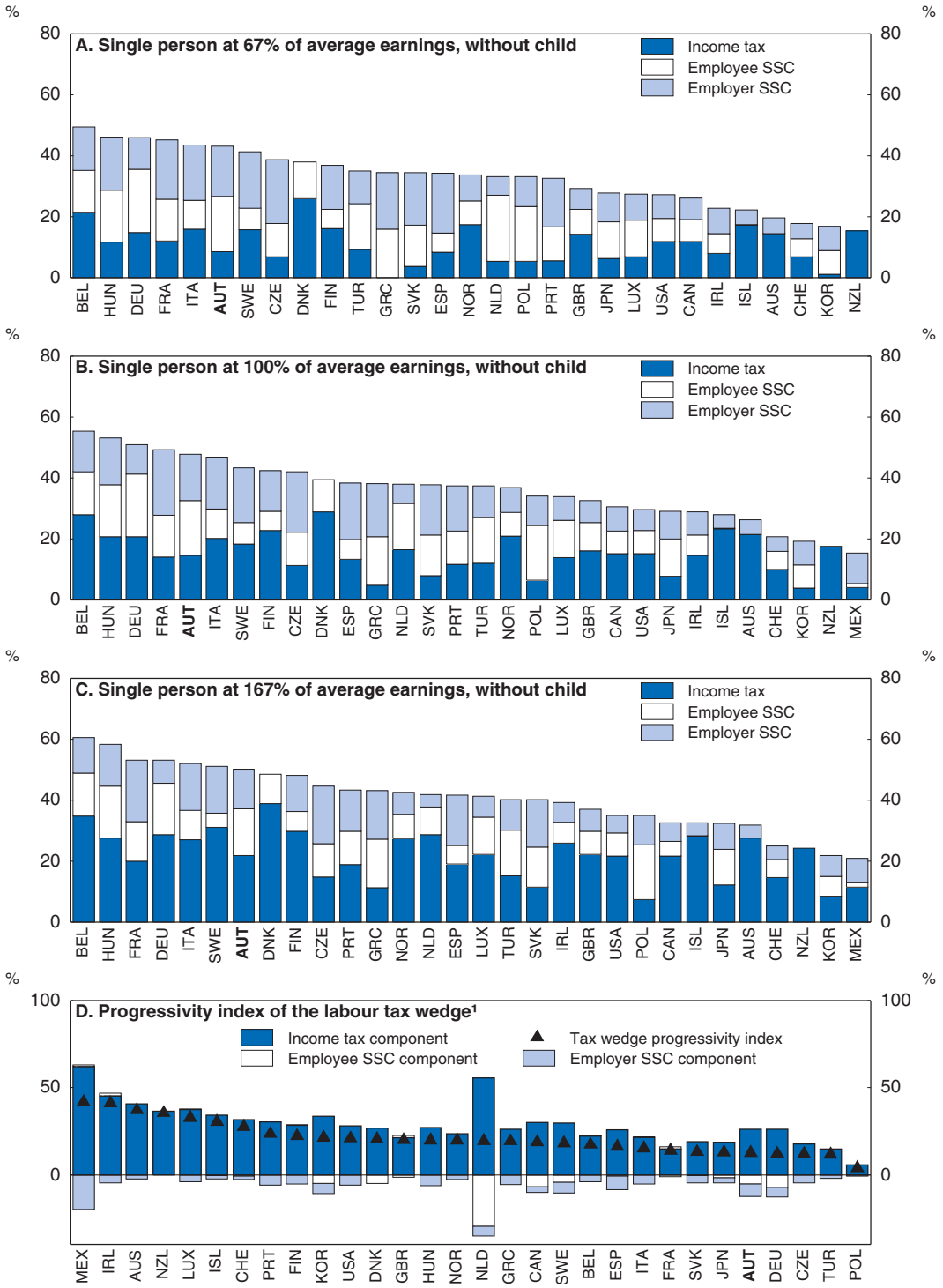
Source: OECD, *Revenue Statistics Database.*

StatLink http://dx.doi.org/10.1787/888932458387

Austria is among the countries in the OECD with the highest tax wedge on labour income, at 48% for the average earner.[9] Empirical evidence suggests a high tax wedge between gross wages paid by employers and workers' take home pay reduces employment (OECD, 2007b). Other things being equal, a higher tax wedge reduces the net financial gain from work and thus tends to depress labour supply. Opportunities for undeclared work reinforce this effect.

Figure 1.9. **Labour tax wedges are among the highest in the OECD**

% of labour costs, 2009



1. The progressivity index of the tax wedge is calculated as (TW167 – TW67)/TW167, where TW167 and TW67 is the tax wedge for workers at 167% and 67% of average wage, respectively. The index here is calculated for a single person with no children.

Source: OECD, *Taxing Wages Database*.

StatLink http://dx.doi.org/10.1787/888932458406

The Austrian labour market performs well with low unemployment and an above-average employment rate, but a considerable performance gap exists between the core of the labour force (men and women between 25 and 54 years with at least upper secondary education) and some vulnerable groups (see OECD, 2009a), who could be helped by reducing the fiscal burden on them:

- Older workers: The employment rate of workers aged 55 to 64 remains among the lowest in the OECD, despite some progress in recent years. In 2009, it stood at 42% (52% for men and 32% for women), up from 33% in 2005 (43% for men and 24% for women), but still far below the OECD average of 57%.
- Female workers: The labour market potential of women is not fully exploited, even though progress has been made in increasing the employment rate to 66% in 2009, up from 62% in 2005. The increase was however driven by a rise in part-time work, which approached levels far above the OECD average. In 2009 44% of employed women worked part-time, as compared to 39% in 2005 (Statistics Austria). This contrasts with just 9% of male part-time employment and 26% of female part-time employment in the OECD.
- Low-skilled and migrant workers: The gap between employment rates of low-skilled workers as compared to workers with intermediate or higher education is higher than in other OECD countries, suggesting that there is room for improvement. Migrant workers are unemployed twice as often as native-born workers.

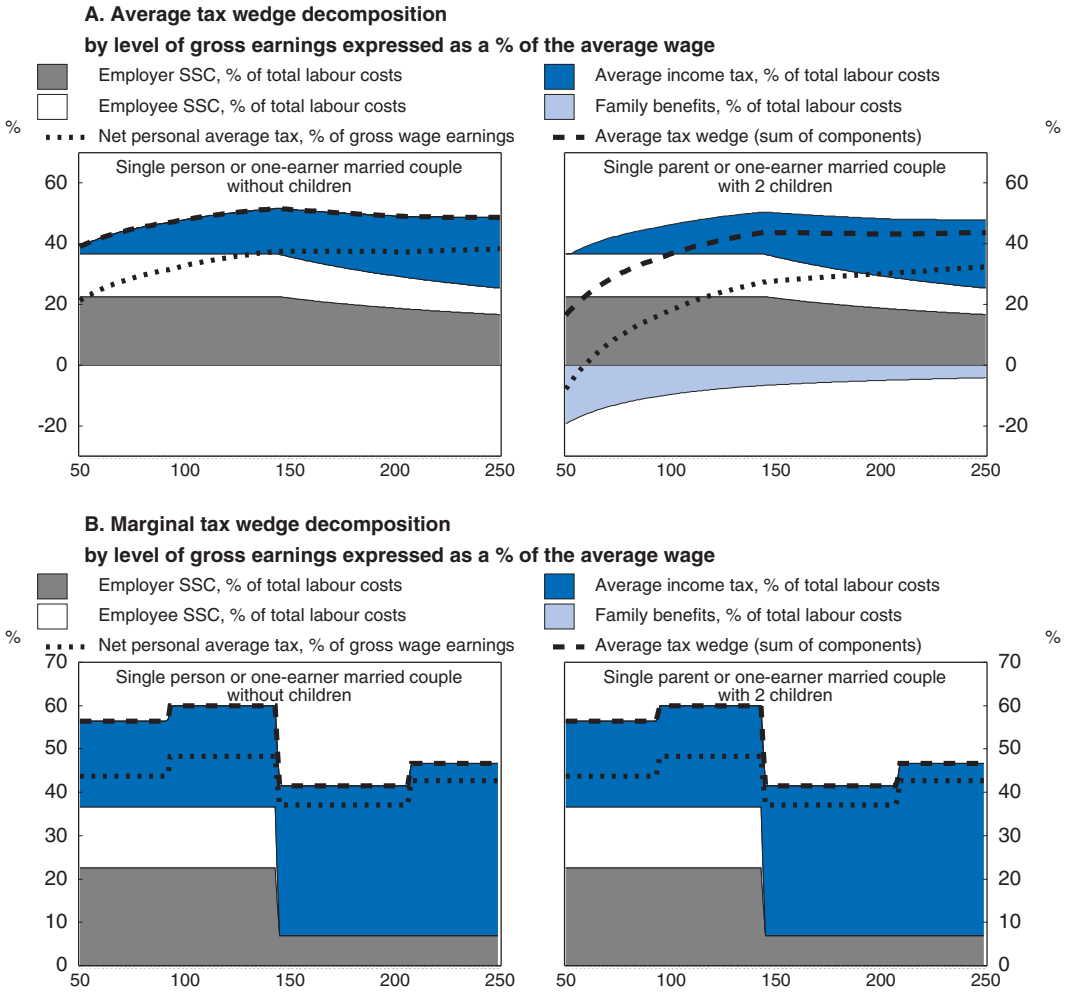
Reforms should target low-income groups

Periodic efforts to reduce the tax burden on labour income have focused on the income tax, which is the relatively less important part of the total labour tax wedge (see Figure 1.10 and Box 1.3). The reductions were not sustained, because "fiscal drag" effects quickly neutralised the effects of reform. Tax brackets are not indexed to inflation so that over time nominal income growth pushes more and more taxpayers into higher tax brackets even tough real earnings may not have increased. The 2009 income tax reform, for example, reduced the tax rate of an average earner by 1.3 percentage points, but the tax rate was still 1.8 percentage points above the level in 2000 (OECD, 2010b). The reforms have also failed to address workers at the lower end of the earnings distribution, whose taxable income does not normally exceed the tax free threshold, while however, being fully subject to social security taxation.

While average tax rates are high for almost all workers, marginal tax rates are particularly high at low income levels, due to the interaction of social security contributions, personal income tax and the benefit system (see Boxes 1.3 and 1.4). This reduces incentives for transition from inactivity to employment and from part to full-time employment. High marginal tax rates also negatively affect incentives to invest in skill-upgrading, reducing the amount of training and education among the group of workers that would be most in need of it. There is thus a risk of locking the low-skilled into "low-wage traps", when the financial returns of higher work effort are too low to be considered a sufficient return relative to remaining on a benefit programme.

The fiscal burden tends to be stronger for women for two main reasons. First, for married couples with children there is a "joint element" in the tax system in the form of the sole earner's tax credit (EUR 494 per year plus EUR 175 for the second and EUR 220 for the third and every additional child), granted as long as the spouse's income does not exceed EUR 6 000 per year. Thus there is a jump in the tax rate as the second earners' employment goes beyond a marginal job. And second, working hours of second earners have been found

Figure 1.10. **Average and marginal tax wedges decomposition**



Source: OECD, *Taxing Wages 2010*.

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to be more responsive to taxation than that of principal earners, thus the economic distortion of high marginal taxation tends to be stronger for women (Causa, 2009).

Several OECD countries with high labour income taxation have responded to the challenge of increasing employment rates of low-skilled workers by granting rate reductions or exemptions. Austria has made a first step into that direction by reducing unemployment insurance contribution rates for low-wage workers. Measures have also been taken to increase incentives for employers to hire low-skilled workers, including an in-work benefit scheme for specific age cohorts in low-wage jobs *(Kombilohn)* and subsidies for recruiting long-term unemployed *(Eingliederungsbeihilfe)* (see OECD, 2009a).

Childcare costs and the availability of childcare institutions also play a role in parents' work decisions. For parents with limited earnings potential, the costs of childcare might reduce the financial reward of full-time employment and therefore make reconciling work and family obligations expensive. Austria has recently introduced half-day free of charge childcare for 5-year olds, and some *Länder* have gone beyond that by offering free half- or

Box 1.3. **Main taxes on labour income**

Social security contributions are levied at a rate of about 40% on all earnings exceeding EUR 374 per month and up to a cap of EUR 4 200 (about 140% of the average wage; data for 2011). They are shared between employers (22%) and employees (18%) and both the lower and upper thresholds are adjusted annually. Since 2008 up to 3 percentage points lower rates have been applied to low incomes. Social security contributions are the largest tax by volume, yielding 35% of total tax revenues in 2009. Their effect is regressive and hurts low and average incomes disproportionately.

Income taxation is progressive with four tax brackets and a tax-free threshold of EUR 11 000 on gross wages less social security contribution. Most of the progression is taking place at relatively low income levels, with the marginal tax rate increasing from zero to 36.5% at around 50% of the average wage. A special tax rate of 6% is applied to the so-called Christmas and leave bonuses of dependent wage income recipients to the extent that their sum does not exceed 1/6 of annual income. The latter benefits higher income earners, who also gain disproportionately from tax allowances for children, childcare costs, and work related expenses, thus decreasing the maximum effective marginal income tax rate to 44% (from the statutory rate of 50%) and reducing the progressive element in the system. Income tax on wages yielded 18% of total revenues in 2009.

Payroll taxes other than social security contributions are levied on all private sector wage incomes exceeding EUR 1 460 per month. They include the contribution to the Family Burden Equalisation Fund (4.5%), the Community Tax (3%), and the contribution for the promotion of residential building (0.5%). In addition, all private sector workers contribute to the Labour Chamber (about 0.5%). Payroll taxes accounted for 7% of tax revenues in 2009 and add another proportionate element to the labour tax burden.

Labour income taxation (wage tax, social security contributions and payroll taxes) is characterised by high total marginal and effective taxation at below average income levels, whereas progression flattens out at higher earnings. For low and average earners (67% and 100% of the average wage respectively), the total marginal tax rate is among the highest in the OECD (44% and 48% respectively), while for high income earners (167% of the average wage) it is significantly below the OECD average (37%). High incomes experienced a decrease in the marginal tax rate over the past decade, whereas low and average incomes faced a 3 to 7 percentage points increase. Total average tax rates are 27%, 33% and 37% for low, average and high income earners respectively and have increased over the past decade by 1 percentage point at the lower and upper ends and by 2 percentage points at the average income level (OECD, 2010b). Over time, the labour tax system has become less progressive and today's structure resembles in many aspects a flat tax system with a relatively large basic tax allowance, also due to numerous tax deduction possibilities of a multitude of saving vehicles.

full-day care also for younger children. It remains to be seen whether these measures are sufficient to facilitate full-time labour force participation of low-skilled women. The tax allowance for childcare costs introduced in 2009 fails to appropriately address this group of workers, as their taxable income may not exceed the zero tax zone. Low enrolment rates of children below age three in formal childcare (less than 20%) also suggest that there is an undersupply of good-quality childcare facilities for the very young. More often than in other high-income OECD countries, labour market availability of women is held back because of care responsibilities (Budimir *et al.*, 2010). Investment in high-quality childcare

Box 1.4. **Social benefits and effective taxation of labour income**

Withdrawal of unemployment or social assistance benefits can significantly reduce the financial incentives for taking on a job or transiting from part-time to full-time employment. For someone considering a move into employment, the relevant question is how much this adds to available income. An analysis of employment incentives would thus be incomplete without giving due consideration to the availability of out-of-work social assistance.

Policy makers try to accomplish three main goals when designing benefit systems: support the living standard of low-income families; encourage work; and keep the costs for taxpayers low (OECD, 2007a). Austria fares well as regards the first goal, with poverty rates below the OECD average. There remains however room for improvement as regards work incentives. A high level of social protection is not necessarily in conflict with high labour market participation and employment, as the Scandinavian model of high taxes, high social protection and high total hours worked shows (see Causa, 2009). Rather it is the pattern of government spending and revenues, together with the enforcement of work availability rules, which matters. Negative employment effects are stronger in the case of lump-sum transfers but can be largely avoided if the size of the transfer depends on the amount of labour supplied. A low tax and contribution burden or in-work benefits that top up earnings might be best suited to improve work incentives while at the same time avoiding poverty traps.

Unemployment insurance benefits are paid out for up to one year and to a maximum of 55% of previous net earnings, subject to work availability. There is a supplement for people with low net earnings, but replacement rates generally do not exceed 60% in the case of no dependents and 80% with dependents. After exhaustion of unemployment insurance benefits, needs-based unemployment assistance *(Notstandshilfe)* to the amount of 92% of the previous unemployment insurance benefit (95% for low-income groups) is available. Benefit recipients can earn up to EUR 374 per month *(Geringfügigkeitsgrenze)* with the benefits remaining unaffected. In the case of unemployment assistance, there is a limit to what spouses can earn before benefits are withdrawn. A new needs-based basic income scheme *(Mindestsicherung)* was introduced as of September 2010, replacing the former social assistance, which differed between *states* as regards eligibility conditions and payment rates. Support is provided to households with earnings below the social assistance threshold of currently EUR 744 for sole persons and EUR 1 116 for couples. There are top-ups for children which vary between states but are at least EUR 134 per child.

Given that wages of low-skilled workers in a number of occupations such as commerce, tourism, or the publishing industry are not much above EUR 1 000 per month (35% of the 2009 average wage), yielding net earnings of around EUR 850, there often appears to be little financial gain from employment. Such low earnings also do not benefit from tax credits or tax allowances, though negative tax is possible upon application. Single persons without dependents are paid out up to EUR 240 per year in the following year, and for sole earners/sole parents with children, the amount increases by the respective tax credit (EUR 494 per year plus EUR 175 for the second and EUR 220 for the third and every additional child). However, for a sole earner with two children taking up work at a wage level of EUR 1 000 per month hardly pays. The annual net income from employment would be around EUR 12 700, whereas income from social assistance would amount to EUR 12 150.

institutions is therefore crucial to increase full-time labour force participation of women. This could be financed partly by better targeting monetary spending for families.

A cut in the labour tax wedge could lead to sizeable employment gains

Estimates by the OECD suggest that a cut in the average labour tax wedge could lead to sizeable employment gains. According to Bouis and Duval (2011), the employment rate in Austria could be raised by 2.4% within 10 years following a reduction of the average labour tax wedge to the level observed in the six OECD countries with the highest employment rate. Shifting progressivity in the labour tax system upwards would help alleviate adverse employment incentives at low income levels. This would also be consistent with equity goals, given that the wage differential has increased over the past decade, with losses up to the third quintile of the earnings distribution and gains for the fifth quintile (Guger and Knittler, 2008). Cuts in the tax burden for low-income workers have also been recommended by the OECD as a way to boost consumption, as this group is more likely to spend rather than save additional net earnings (OECD, 2009b).

Wage flexibility at the lower end of the earnings scale has been considered one of the strengths of the Austrian economy. However, high marginal effective taxation of transition to employment risks locking people into "unemployment traps" or "inactivity traps", if the net income gain is too low to "make work pay" (OECD, 2007a). Reducing social assistance benefits might not be a politically viable option to encourage work, because it conflicts with poverty and income distribution goals. Measures should therefore be taken to reduce the effective tax burden at low earnings levels or introduce in-work benefits that top up wages. The government should also consider providing more in-kind benefits in the form of childcare facilities for children below age three to allow for more continuous female work careers and facilitate a decrease in the gender wage gap in the medium- to long-term. Better targeting of social transfers to needy parents would limit the strain on government budgets while addressing barriers to work for those who are most likely to respond to stronger work incentives. The quality of enforcement of work availability rules continues to be important to keep beneficiaries in the labour market.

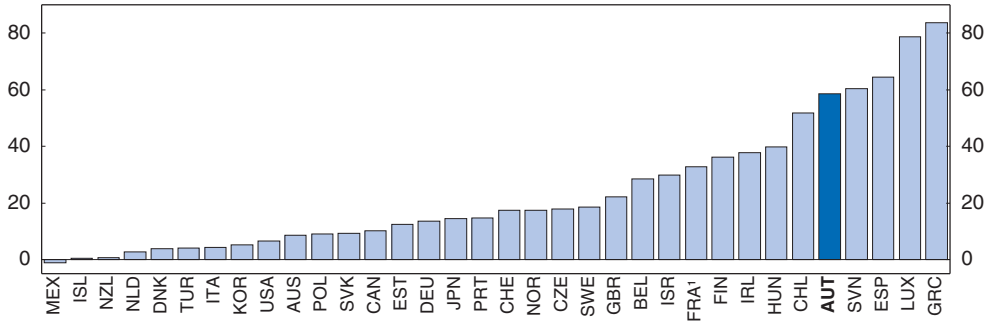
Fiscal disincentives are depressing employment at older ages

The employment rate of older Austrians is among the lowest in the OECD. More than two thirds of workers withdraw from the labour market before reaching the statutory retirement age (65/60 for men/women, with women's retirement age increasing to that of men between 2024 and 2033) and many even before reaching the early retirement age (62/57 for men/women, with a gradual increase to 65 for men and 60 for women until 2017). On average, male Austrians retire at age 59 and females at 57. Only 28% of new pensioners[10] in 2010 took the regular route to old-age pension, whereas 31% were granted disability pension and 41% benefitted from other early retirement schemes [67% of which from the special early retirement scheme for long-term contributors (*Hacklerregelung*)] (Federal Ministry of Labour, Social Affairs and Consumer Protection). Excess inactivity of older workers poses a heavy toll on the economy and the sustainability of the social system. An extension of work careers would not only curb age-related spending, but also raise economic growth and generate higher tax revenues.

A key summary indicator of retirement incentives is the implicit tax on continued work, which represents the balance between economic costs (in terms of foregone benefits and contributions paid) and benefits and captures the effects of eligibility ages and the

benefit level. Austria is among the countries in the OECD where such implicit taxes on continued work are highest, reaching almost 60% of average earnings. Adverse work incentives for persons aged 55 to 64 have been reduced over the past decade, but strong disincentives to continue work at older ages remain. Estimates suggest that the gains from reforming retirement schemes in terms of an increase in the employment rate would be particularly high (Bouis and Duval, 2011).

Figure 1.11. **Average implicit tax on continued work at older ages**
2009, percentage of average worker earnings



Note: Implicit tax on continued work in early retirement, average for 55 and 60-year-old workers.
1. For France, year 2010.

Source: OECD calculations based on Duval (2003),"The Retirement Effects of Old-Age Pension and Early Retirement Schemes in OECD Countries", *OECD Economics Department Working Papers*, No. 370.

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Pension benefits are more generous than in most other OECD countries. The net replacement rate (individual net pension entitlement divided by net pre-retirement earnings) in Austria varies between 78% (blue collar workers) and 85% (white collar workers) depending on the duration and steepness of the income career (Federal Ministry of Labour, Social Affairs and Consumer Protection) – significantly above the OECD average of 70%. Penalties for early retirement are limited and so are benefits from continued work. Pensions are adjusted by 4.2% for each year the pension is claimed early or late, but deductions and increments are capped (deductions at 15% and increments at around 12%) and exemptions exist for some early retirement schemes, with no discount whatsoever in the case of the "*Hacklerregelung*" (see below) and a reduced discount for "corridor pensions". Other countries such as US, Canada, the Czech Republic, Japan and Spain impose a much higher early retirement penalty of 6% per year or more. The adjustment that would be needed for actuarial neutrality, *i.e.* neither subsidisation nor penalisation of retirement at different ages, has been calculated at around 7.5% by the OECD and at about 6% by Austrian experts (OECD, 2005b; Federal Ministry of Labour, Social Affairs and Consumer Protection, on the basis of Brunner and Hoffmann, 2010).

The statutory retirement age is in line with OECD practice but undermined by the availability of generous early retirement and disability schemes:

- A special early retirement scheme *("Hacklerregelung")* is in place for persons with a long contribution history, granting entitlement to undiscounted pension benefits from 60/55 years for men/women subject to 45/40 contribution years (40/40 contribution years in the public sector). The scheme has become the most common way into early retirement and

is particularly popular among public sector employees. A law was passed in 2010 which will tighten access to the scheme from 2014 onwards and is expected to halve the inflow.

- The pension system allows for the retroactive purchase of up to 9 contribution years for secondary and tertiary education after age 15. Making use of the provision has become three times more expensive for prospective pensioners as of 2011 and it is planned to be phased out in 2014. Up to then, however, it remains an attractive option and comes at a high cost for the social system. The provision is inherently regressive because it benefits better educated workers with more school and university years.
- Eligibility criteria for invalidity pensions continue to be generous in international comparison. Given that the health status of the Austrian population is above average in the OECD (see Chapter 2), the high rate of incapacity among the working age population does not appear to be justified. Contrary to OECD practice, disability is assessed against one's own occupation *(Berufsschutz)*, implying that some workers can claim disability benefits even though they might be able to work in other occupations. Invalidity pensions may therefore constitute an alternative pathway into early retirement. As of January 2011, eligibility to disability pension has been tightened, with rehabilitation now being mandatory before a pension can be claimed. The government has also implemented a programme for early identification and prevention of work-related health problems based on best practice examples in Finland and the Netherlands, which aims to increase the average effective retirement age by 1 year within 5 years.

It is often argued that encouraging people to work longer will deprive younger workers of jobs. A recent OECD report (2011) however demonstrates that the idea that policy can re-shuffle jobs between workers of different ages is not true. Employability problems of older workers should be addressed via better education, life-long learning and retraining opportunities. OECD comparison shows that Austria has room for improvement in this area. The age gap in training is particularly large; older Austrians are less likely to take part in training compared to their younger colleagues than in most other OECD countries (*ibid.*).

Income from capital is taxed unevenly

A notable feature of personal income taxation has been the non-taxation of capital gains, except for speculative gains. The treatment of capital gains differs widely among OECD economies, with varying impact. On the one hand, omitting to tax capital gains means that a feature of the Austrian tax system has been that it has not led to artificial revenue buoyancy during times of asset booms: the fact that OECD country deficits have been affected by fluctuations in asset prices, via the sensitivity of asset-related taxes to such movements, distorts underlying budget trends in some countries. There are thus advantages in terms of yield stability and predictability. National autonomy over capital tax rates may be diminished where capital is internationally mobile – a factor which prevents corporation tax from being a revenue-raising base – but in the case of capital gains tax the usual effect of taxing capital gains at a lower rate than ordinary income is that there is a conduit for tax avoidance. No evidence exists on this for Austria, but in Norway, for example, there is.

From 2012 onwards realised capital gains will be taxed evenly at a rate of 25%. This new capital gains tax applies to profits from the sale of shares, bonds, funds and derivatives.

Table 1.6. **Tax treatment of capital gains and interest deductibility for individuals**

2010, Resident taxpayer

	Residential property		Shares	Rate and regime	Mortgage interest deductibility
	Principal residence	Other			
Austria	Not included in taxable income, except speculative gains = disposal within 2 years for immovable property	Not included in taxable income, except speculative gains = disposal within 10 years for immovable property	Not taxable until 2011 ex. speculative gains, since 2011 subject to a 25% withholding tax	Normal income tax rate on speculative gains on immovable property; 25% withholding tax on shares	Deductable up to a certain income level; subsidised savings plans and generous housing subsidies
Belgium	Not taxable except on sale of undeveloped immovable property within 8 years and developed immovable property within 5 years		Not taxable except speculative transactions	Normally zero; 33% on speculative transactions; 16.5% on short-term immovable property gains	Deductible up to € 2 770 for first ten years and € 2 080 thereafter
Denmark	Exempt	Taxable as capital income	Taxed as income from shares	28/43/45% above ceiling	Deductible from capital income
Germany	Not taxable until 2010, ex. speculative gains: 1 year for shares and 10 years for immovable property			Normally zero; speculative gains taxed at income tax rates	Not deductible
Netherlands	Not taxable			Zero	All interest payments deductible for 30 years
Sweden	Tax deferrable if new permanent residence purchased	22/30ths taxable	Included in income from capital	Flat rate tax on capital income: 30%	Deductible from capital income
Switzerland	Subject to a real estate gains tax declining with period of ownership		Exempt except for professional share dealing	Cantons set their own tax rates	Deductible with limits

The property tax base is eroding

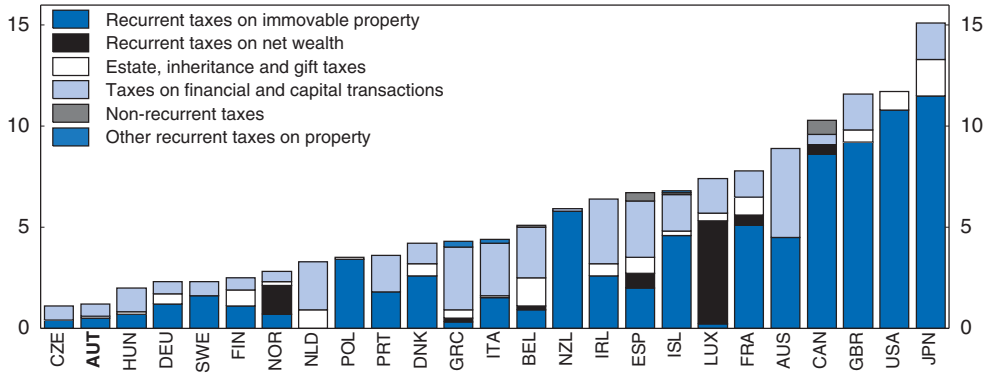
A further aspect of the uneven taxation of capital, which is potentially of even greater significance, relates to real estate. The share of property taxes is very low by international standards (Figure 1.12), mainly because the assessed values of land and buildings *(Einheitswert)* have hardly been adjusted over the past decades. The last assessment *(Hauptfeststellung)* was carried out in 1972, and updates since then have raised valuations by only 35% as compared to an increase in consumer prices by about 250% (Böheim *et al.*, 2010). In 2009, the government generated only 0.6% of GDP or 1.3% of total revenues from property taxes, as compared to OECD averages of 1.8% and 5.4% respectively.

Raising the share of property taxes in GDP to the OECD average would yield extra revenues of EUR 3 billion per year. This would be a relatively efficient way of reducing the burden on more growth-hampering revenues. Such taxes have an advantage over income taxes because they are less distorting and levied on a relatively immobile tax base.[11] Moreover, where they are low or absent, investment incentives may be biased towards property investment, to a degree which may be amplified or offset by not taxing capital gains or allowing tax relief against mortgage interest. No national house price index exists in Austria to be able to assess the effects. Nevertheless, it is recommended that revenues from real estate taxes be increased, which would require upgrading outdated valuations of real estate and land.

Other taxes on property include inheritance and gift taxes, which are also negligible in Austria, while other high-income OECD countries raise up to 0.5% of GDP from this source. In fact, the Austrian reform process has pushed towards the relaxation of capital taxes: the inheritance and gift taxes were allowed to expire in 2008 after the assessment of the tax base was ruled unconstitutional by the Constitutional Court. International practice differs greatly, but the reinstatement of these taxes should be considered, within the wider context of a review of capital taxation in general.

Figure 1.12. **Taxes on property are very low in international comparison**

2008,[1] % of total fiscal revenues



1. 2007 for Australia, Greece, the Netherlands and Poland.

Source: OECD calculations based on *OECD Revenue Statistics 2010*.

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Table 1.7. **Inheritance, estate and gifts taxes**

	Estate/ Inheritance	Gift	Weight in total tax revenues %[1]
	RS4300		
	Tax imposed (Y) or not (N)		
Austria	N (from Aug. 08)	0.0	
Belgium	Y	N after 2 years	0.9
Denmark	Y	Y	0.5
Germany	Y	Y	0.4
Netherlands	Y	Y	0.7
Sweden	N	N	0.0
Switzerland	Y[2]	Y[3]	0.9

1. Period average.
2. In the case of non-registered accounts, capital gains are recognised and become taxable on the final return of the deceased, prior to inheritance.
3. No at federal level, but most cantons levy such taxes.

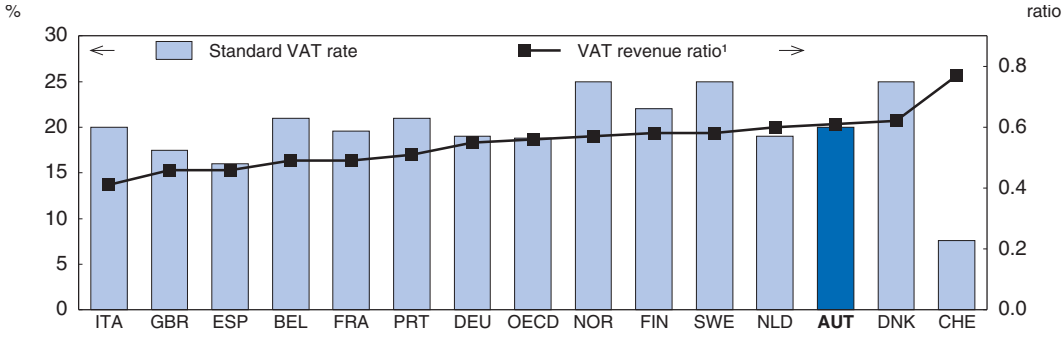
Source: European Tax Handbook; national sources.

Taxes on consumption could be better exploited

Taxes on consumption are likely to be much less damaging to growth than taxes on labour, especially if they are broad based and operate on a destination principle, like VAT. In practice most OECD countries have kept their standard VAT rates constant for long periods of time and the OECD average has remained at just under 18% for over a decade. However, the revenue effectiveness of the VAT also depends on the number of reduced rates and exemptions allowed. In that respect the 20% standard rate is significantly reduced in effective terms by the reduced rate of 10%. Austria is also among the group of OECD countries which exempts new building from VAT. To the extent that Austria lags behind the most VAT-efficient OECD countries a review of the revenue effectiveness of the VAT would be warranted.

Figure 1.13. **Efficiency of the VAT system**

2008



1. The VAT revenue ratio is defined as the ratio between VAT revenue and the theoretical revenue raised if the VAT was applied at the standard rate to total final consumption. VRR = VAT Revenue/(Consumption × Standard VAT rate) – VAT Revenue) where Consumption corresponds to final consumption expenditure.

Source: OECD (2011), *Consumption Tax Trends 2010*.

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Box 1.5. **Fiscal policy recommendations**

Develop a more forward-looking fiscal agenda

- Achieve more upfront consolidation in the next few years to bring the debt-to-GDP ratio below 60% by 2020. Medium- to long-term fiscal projections should be more instrumental in guiding front-loaded policy action.
- Increase transparency with regard to off-budget entities and contingent liabilities of the public sector. Evaluate the medium- and long-term fiscal impact of putting government programmes into off-budget vehicles.

Strengthen the fiscal framework at all levels of government

- Reinforce the current fiscal rule with a debt objective. In this context, specifying a target rate of growth of real general government spending would help.
- Reform the *Domestic Stability Pact* and the *Fiscal Equalisation Act* with a view to implementing the major elements of the federal budgetary reforms and avoiding pro-cyclical spending at sub-federal levels. The new sanctioning regime should be vigorously applied.
- Performance budgeting should be applied at all levels of government. Key policy objectives in the main public spending areas need to be defined, adequate performance indicators developed, and a clear procedure on how to use them in the concrete budgeting process has to be set out.

Restrain public spending

- Reduce public wage costs by replacing only a fraction of retiring government employees.
- Seek efficiency gains in all major public spending areas, notably in the education and health care sectors. Make full use of performance budgeting to this effect.
- Strengthen tendering processes in public procurement. Use Public-Private Partnerships when there is a genuine efficiency gain.

Box 1.5. **Fiscal policy recommendations** *(cont.)*

Better target social and pension transfers

- Eliminate all subsidised avenues into early retirement. Merge the special early retirement scheme in an actuarially neutral pension scheme. Eligibility criteria for disability pensions should be further tightened and the own-occupation based assessment of disability abolished if necessary.
- Fully harmonise the pension schemes of civil servants of states and municipalities and accelerate their incorporation into the general pension scheme.
- Increase the targeting of social transfers.

Make the tax structure more employment and growth friendly

- Rebalance the tax system with a view to increasing work incentives, encouraging investment and entrepreneurship, and reducing tax-induced distortions.
- Reinforce work incentives for low income workers by reducing social security contributions or introducing in-work benefits.
- Support women's full-time labour force participation by partly replacing monetary transfers to families with in-kind spending on childcare facilities.
- Review the taxation of capital to make it less uneven. Valuations of real estate and land should be brought to market values and the reinstatement of inheritance and gift taxes considered.
- Improve tax administration efficiency by better integrating the collection of similar taxes.
- Increase the efficiency of the VAT system.

Notes

1. The assumption is that interest payments decrease as a result of a smaller debt stock compared to a "no policy change" scenario.
2. There is tentative evidence that when gross government indebtedness passes a threshold of 75% of GDP long-term interest rates increase (decrease) by 4 basis points for every additional percentage point increase (decrease) in the government debt-to-GDP ratio (OECD, 2010d).
3. The reclassification decision of March 2011 moved only a comparatively small part of the debt of public enterprises back on government accounts, so that the bulk of liabilities incurred by public service providers remains off-budget. However, the reclassification covered a substantial part of the deficit of off-budget-entities between the years 2007-10.
4. The "sustainability gap" measures the size of the budgetary adjustment required to ensure that the 60% threshold for the debt-to-GDP ratio as prescribed by the Maastricht Treaty is reached by 2060. Based on the budgetary position for 2009, the required adjustment of the primary balance has been calculated at 3.8 percentage points of GDP. Under the assumption of a favourable initial position (*i.e.* budget balance and the debt-to-GDP ratio in line with the 3% of GDP/60% of GDP thresholds according to the Stability and Growth Pact), an improvement in the primary balance in the order of 2.2 percentage points of GDP is needed to cope with the fiscal cost of population ageing as estimated by the European Commission.
5. The decreasing path of this ratio is foreseen by enacted legislation (*e.g.* through the on-going shift of employees from the civil service scheme to the private sector insurance scheme; through the extension of the assessment period, which is phased in gradually by 2028; and through the introduction of individual pension accounts, which are also subject to a phase-in period due to parallel accounting with the old schemes).

6. Already enacted legislation, if fully implemented, is expected to decrease the generosity of the system and raise the effective retirement age. Along with increasing participation rates, this should mitigate the rise in pension expenditures.
7. In the period 2011-14, states are required to improve their budget balance by 0.25% of GDP, from –0.75% of GDP to –0.5% of GDP, while municipalities are required to record balanced budgets in all years. The share of additional revenues from the consolidation package allocated to sub-federal levels amounts to 0.1% of GDP in 2011 with a gradual increase to 0.2% of GDP by 2014.
8. A systematic assessment of the efficiency gains is not possible due to a lack of output measures of the old organisation.
9. The tax wedge combines the effect of in-work taxes and out-of-work benefits, *i.e.* personal income taxes and social security contributions on the one hand, and social benefits and entitlements on the other hand. It is defined as average income taxes plus employee and employer social security contributions minus cash transfers as a percentage of total labour costs.
10. Excluding survivor pensioners.
11. Recurrent taxes on residential property may have a long-term impact on a country's or region's attractiveness as a location for residential investment.

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Chapter 2

Reforming a highly regarded but costly health system

The highly regarded Austrian health system delivers good quality and easily accessible services, but is costly. Its governance and funding structure is highly fragmented and it makes too much use of inpatient care in hospitals. Entry and competition opportunities are de facto limited in most health markets. The system operates therefore on a supply-driven basis, and does not have clear mechanisms to optimize spending on a cost-benefit basis. Population lifestyles are also not supportive of good health outcomes and suffer important differences between social groups, raising risks for the future. This Chapter reviews Austrian authorities' responses to these challenges, and makes recommendations based on OECD countries' experiences. The suggested priorities are: i) more clearly assigning the performance, financing and spending responsibilities in the system, ii) enforcing a national capacity plan for publicly-funded inpatient and outpatient care, iii) introducing performance-based payment mechanisms in all services, iv) promoting the transition to "integrated care" by better balancing preventive, outpatient, inpatient, rehabilitation and long-term care, and v) better clarifying the medium-term fiscal outlook and scenarios of the system.

Introduction

Austria dedicates very large public and total resources to health. The share of total health spending in GDP at 11% is among the highest in OECD, mainly due to high public spending (8.5%). Health accounts for about 16% of total general government spending. The number of physicians and the number of hospital beds and high-technology health equipment per capita are among the highest in OECD. The system performs well on standard output indicators. For example, life expectancy improved drastically over the past 30 years, and exceeded 80 years in 2008, still below best performing countries but among the highest among European countries. Living conditions for the old have considerably improved, and became healthier. As a result Austrian citizens have become rather ardently attached to the existing health system, and in particular to its dense local delivery infrastructure.

There is growing evidence at the same time that the large resources engaged in the health system are not efficiently used. Due to a complex institutional structure, a strong bias formed toward curative inpatient care, while lifestyles and preventive behaviour in large segments of society have remained insufficiently supportive. This suggests that more efficient resource use in better optimized services, supported by more helpful lifestyles could help improve the health status of the population at less rapidly growing public costs.

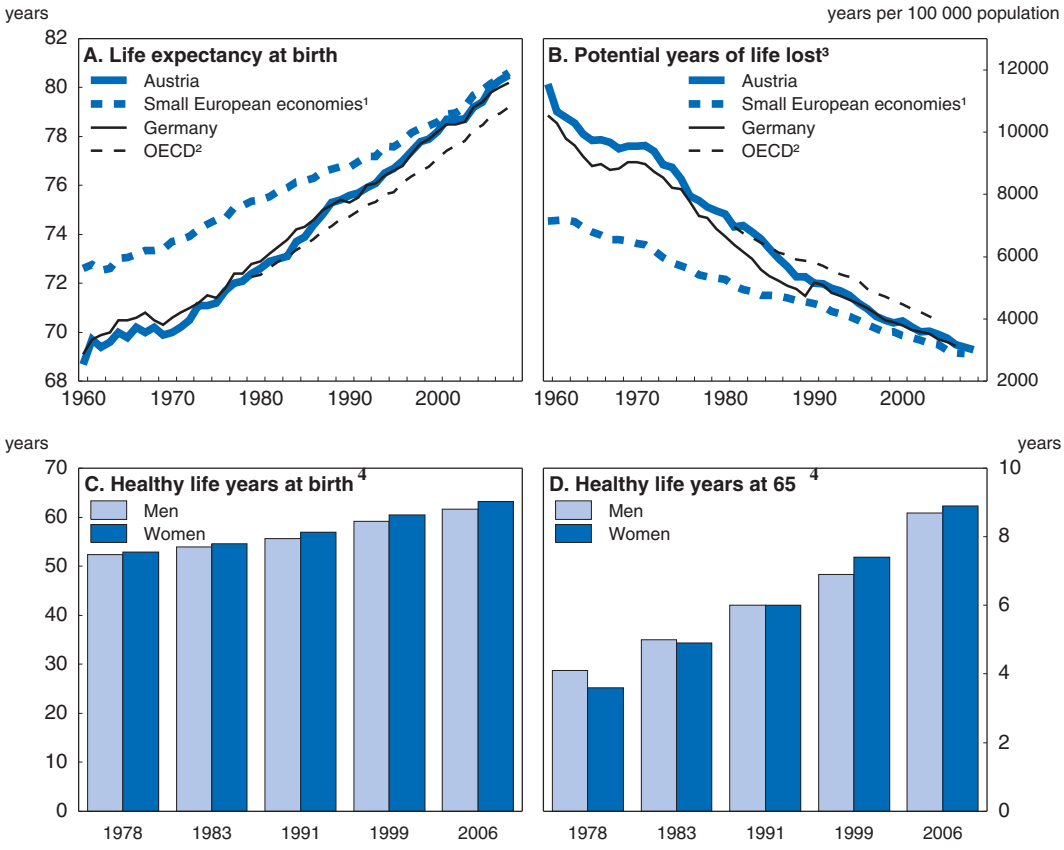
Reforming the health system is crucial in the context of the national policy efforts to put public finances on a sustainable path. Health policymakers also want to make sure that the health system can respond to the evolving care and service needs under more stringent fiscal constraints. This Chapter overviews this agenda by discussing Austria's combination of good health outcomes and costly health institutions, the short- and long-term fiscal challenges pending and the existing room for efficiency gains. It reviews the ongoing reform efforts and makes recommendations on the basis of other OECD countries' experiences.

The health system performs well but is excessively fragmented and costly

Health outcomes have considerably improved on the back of large resources

Austria's system is one of the successful examples of ambitious public health policies put in place in OECD countries in the past half-century. It has contributed importantly to the improvement of the health status of the population. Life expectancy at birth has increased by 12 years since 1960, exceeding 80 years in 2008. Gains in older ages have also been important: an Austrian woman aged 65 is expected to live an additional 21 years today (a difference of 6.4 years over 1960), and a man an additional 18 years (an improvement of 4.7 years). Living conditions at old ages have improved and have become healthier (Figure 2.1).

Figure 2.1. **Health outcomes have considerably improved**



1. Arithmetic average of other small European high income economies: Denmark, the Netherlands, Sweden and Switzerland.
2. Arithmetic average over OECD countries excluding Turkey in Panel B.
3. Arithmetic averages between males and females. Potential years of life lost is a summary measure of premature mortality which provides an explicit way of weighting deaths occurring at younger ages, which are, *a priori*, preventable.
4. Healthy life years indicator measures the number of remaining years that a person of a certain age is expected to live without disability. It is actually a disability-free life expectancy.

Source: *OECD Health Data 2010* and Eurostat, *Structural indicators on health*; and OECD calculations.

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The system is complex and costly

At the same time, the Austrian health system is much more complex and fragmented than in other OECD countries. Constitutionally, the federal government is in charge of all areas of the health care system but delegates an important part of its responsibilities to the 9 provinces (*Länder*), and another part to the social insurance funds (Sickness Funds).[1] The *Länder* are in charge of developing and maintaining an adequate hospital infrastructure, without funding it from their own tax revenues. Transfers from the federal government agreed under five-yearly "constitutional agreements" fulfil this purpose, under relatively flexible rules open to political bargaining. The federal government therefore finances a substantial share of costs without exerting any influence on the utilisation of the funds. The 19 Sickness Funds are in turn delegated the task of contracting for ambulatory care, pharmaceutical products and medical devices, that they fund from the employer and employee contributions that they collect. Sickness Funds also participate to the funding of

hospitals by transferring a fixed share of their resources (35%) to *Länder*' hospital funds.[2] This highly segmented funding structure weakens incentives for optimisation and makes providers the key drivers of the system. The provision of inpatient services is mainly assured by *Länder* owned hospitals, and of outpatient services mainly by independent physicians permanently contracted by Sickness Funds through their "regional physician chambers" (Box 2.1).

A comprehensive review of national health systems by OECD helped highlight the institutional specificities of the Austrian health system in international comparison (OECD, 2010a). This review confirmed that, as a result of the fragmentation discussed above, Austria's system is highly decentralized toward sub-central authorities and social health insurers, even though not consistently. As a result, there is limited room for strategic prioritization and priority-setting, while budget constraints are not managed actively and explicitly. Also, price signals do not play an important role and there is no gate-keeping function. In this environment, public health spending has grown more rapidly than in most other OECD countries and the share of public health spending in GDP reached one of the highest levels in OECD. On the other hand, the degree of user information on the quality and prices of services remains relatively limited and user choice among alternative providers is limited in parts of the system (Figure 2.2 and Box 2.1).

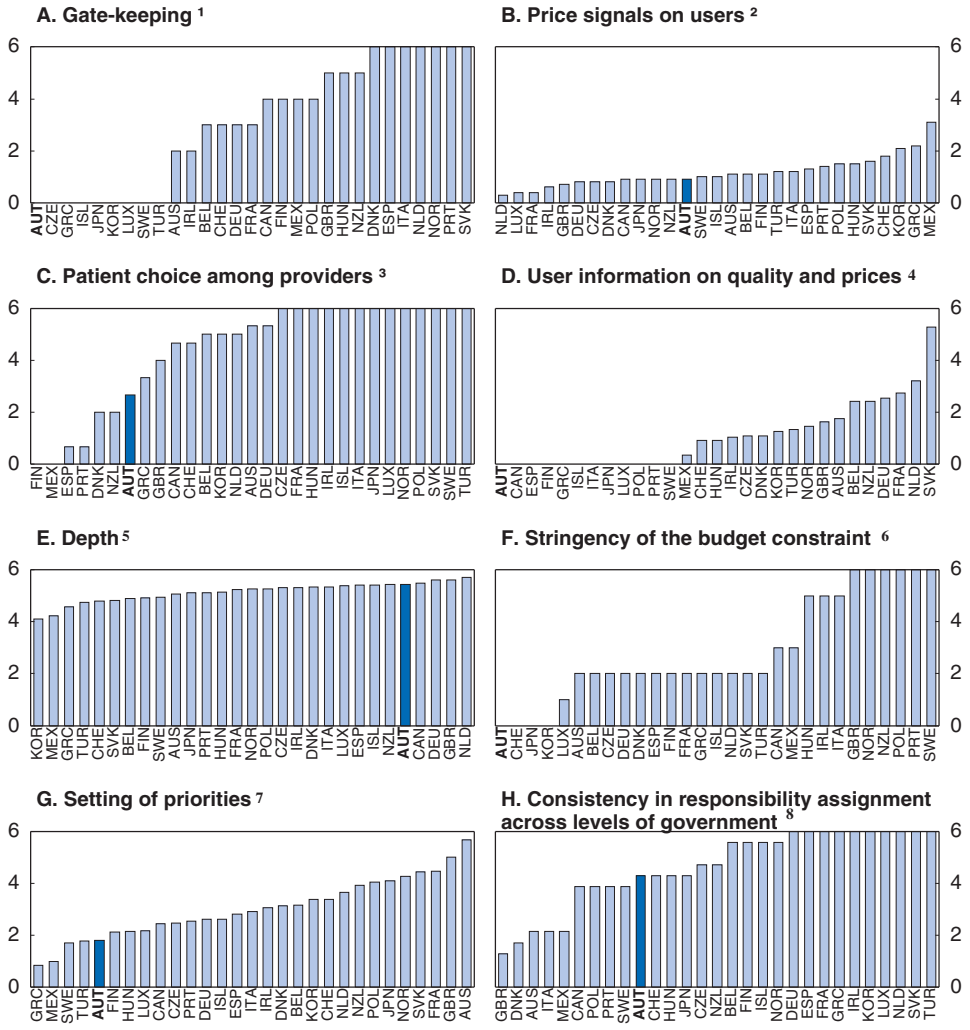
This complex system covers the whole population (98.7%) and provides access to "all necessary services".[3] The standard functions of public health insurance are available at particularly high reimbursement rates.[4] Austria is indeed one of the two OECD countries where the publicly funded insurance package is defined in relatively open-ended ways. The package has expanded through time, in response to technological developments and societal demands. For instance, psychotherapy and *in vitro* fecondation have been introduced in the 1990s. Access to new vintages of pharmaceuticals is also rather generously provided.

As a consequence of this broad coverage of public health needs, Austria ended up dedicating more fiscal resources to public health than other high-income European countries such as Sweden, Denmark, Netherlands and Switzerland. The share of total health spending in GDP, at about 11%, and the share of public health spending in GDP, at 8.5%, are now among the highest in OECD.[5] These levels were reached after a long period of stronger growth of spending than in other OECD countries (Figure 2.4).

Consequently, large human and technical means are mobilised in the health system. The number of acute care beds per population is one of the highest in the OECD and so is the number of acute hospital admissions. The number of generalist and specialist physicians and the rate of high technology diagnostic and treatment equipment per capita have become very high.[6] The consumption of pharmaceuticals registered one of the fastest growth rates in the euro area.[7] Austria has also experienced the largest increase in the number of medical students in the 2000s (also as a result of an inflow of foreign students, notably from Germany). This large resource base underpins a more intense health activity than in other OECD countries (Figures 2.5 and 2.6).

However, the link between such a resource concentration in the health system and actual health outcomes remains at first sight not strong in international comparison. The recent OECD overview positioned countries in terms of the amount of resources that they dedicate to health and the results that they obtain (proxied in a first stage through the average life expectancy of the population). This, and other indicators of efficiency are

Figure 2.2. **Austria's health institutions in international comparison**



1. A "0" score is attributed to countries where patients face no obligation or incentive to register with a General Practitioner (GP) and to obtain referral to access secondary care.
2. The score corresponds to the share of "out-of-pocket" payments in total health expenditure, rescaled from 0 to 6.
3. A "0" score is attributed to countries where patients face severe limitations when choosing a primary care physician, a specialist and a hospital.
4. A high score is attributed to countries where information on the quality of care and on price allows patients and/or purchasers to discriminate among providers.
5. The depth of coverage represents the level of the costs covered for key goods and services included in the basic benefit package and the actual level of coverage by health insurance (public and private).
6. A "0" score is attributed to countries with a soft budget constraint.
7. The scores reflect whether a health benefit basket is defined, criteria taken into account to define it, the definition and monitoring of public health objectives.
8. The lower the score, the lower the consistency in responsibility assignment across government levels.

Source: OECD (2010), *Health Care Systems: Efficiency and Policy Settings*.

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reviewed later in the chapter, yet this first hint suggests that serious efficiency shortcomings may be characterizing Austria's complex and resource-intensive health institutions (Figure 2.7).

Box 2.1. **Austria's fragmented health institutions**

This fragmented pattern of the governance and funding structure of the Austrian health system was already reviewed in the 1997 and 2005 *OECD Economic Surveys of Austria*. There are four sources of fragmentation rooted in the institutional design of the system, making Austria's health sector overly supply-driven, with limited incentives and capacity to respond to the demands of policymakers and market forces (OECD, 1997 and 2005):

- First, public health spending is divided between general government (42%) and social insurance funds (58%) (Figure 2.3). On the part of the government, Federal, *Länder* and municipal levels are simultaneously involved, to fund mainly hospital services. Social insurance finances other spending components such as outpatient care by independent physicians, pharmaceutical costs, and part of the hospital costs. In this setting, no party plays the role of a "principal", to strategically steer the system. An illusion is also created, notably among local policymakers and populations, that health services are free and the health sector can ultimately operate outside economic constraints.
- Second, each resident is registered with one of the 19 "Sickness Funds", on basis of either region of residence or branch of employment. Funds offer somewhat different basic packages. There is only a rudimentary risk equalization system between them (on basis of the age structure of membership) but no yardstick or direct competition**.**
- Third, there is a very strong bias in the health sector in favour of hospital services. As the costs of both inpatient and outpatient care provided by hospitals are largely funded by the government, Sickness Funds have a distorted view of hospital costs, and no incentive to take them fully into account. At the same time, *Länder* governments have an interest in maintaining hospital capacity at high levels. Residents appreciate round-the-clock hospital services near where they live, and make intensive use of them.
- Fourth, entry and competition are *de facto* limited in markets for publicly-funded health services and goods. Most hospitals are local monopolies. Ambulatory services by independent physicians are offered by "contracted networks" of generalists and specialists, which are co-managed by their respective professional associations, which exert monopolistic power. Pharmaceutical and other medical goods producers operate under restrictive regulatory frameworks which reduce competition. This may explain the relatively low share of generic pharmaceutical products.

The supply of various health services and products is indeed organised through different arrangements:

i) inpatient care is provided by a majority of *Länder*-owned and a minority of private non-profit hospitals, with funding from the federal government and Sickness Funds;

ii) generalist and specialist outpatient services are provided by physicians contracted by Sickness Funds, through collective regional contracts with regional medical chambers, and, by the outpatient wards of hospitals;

iii) drugs and medical aids are listed (referenced) by the federal government, with relatively few generic products authorized; and

iv) long-term care is provided by *Länder* governments, in regulated institutions. A new "long-term care fund" (*Pflegefonds*) is now being put in place at the federal level to contribute to the financing of services.

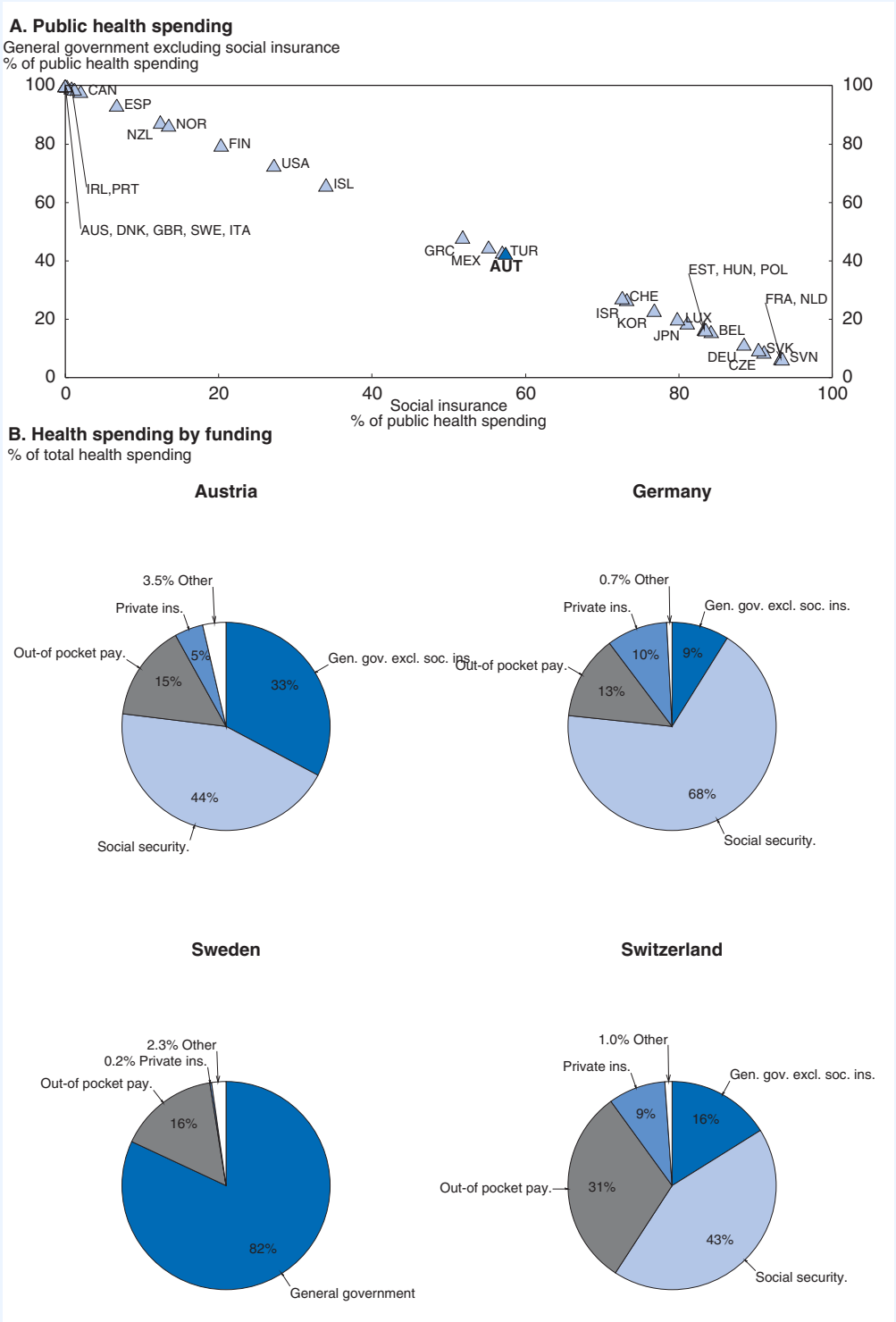
This segmentation in the organisation of supply creates firewalls between different types of services. In each area, provider groups (notably through their professional organisations) gain a high influence on the types of services provided and their prices.

The structure remains heavily centred on hospital services. Austria tops OECD countries for the number of acute care beds per capita (after Japan and Korea). There were 183 acute care hospitals in 2006, providing 52 894 beds. 92% of this capacity is in *Länder*-financed hospitals; 64% of the capacity is in directly *Länder*-and-municipality owned hospitals; 17% in three university hospitals; 8% in invalidity and work accident hospitals; 16% in institutions ran by religious congregations and 6% in private profit making hospitals. The majority of beds are *acute* care beds and there is no gate-keeping filtering access to them.

Box 2.1. **Austria's fragmented health institutions** *(cont.)*

Figure 2.3. **The funding structure is very fragmented**

2008 (or latest available)



Source: OECD Health Data 2010.

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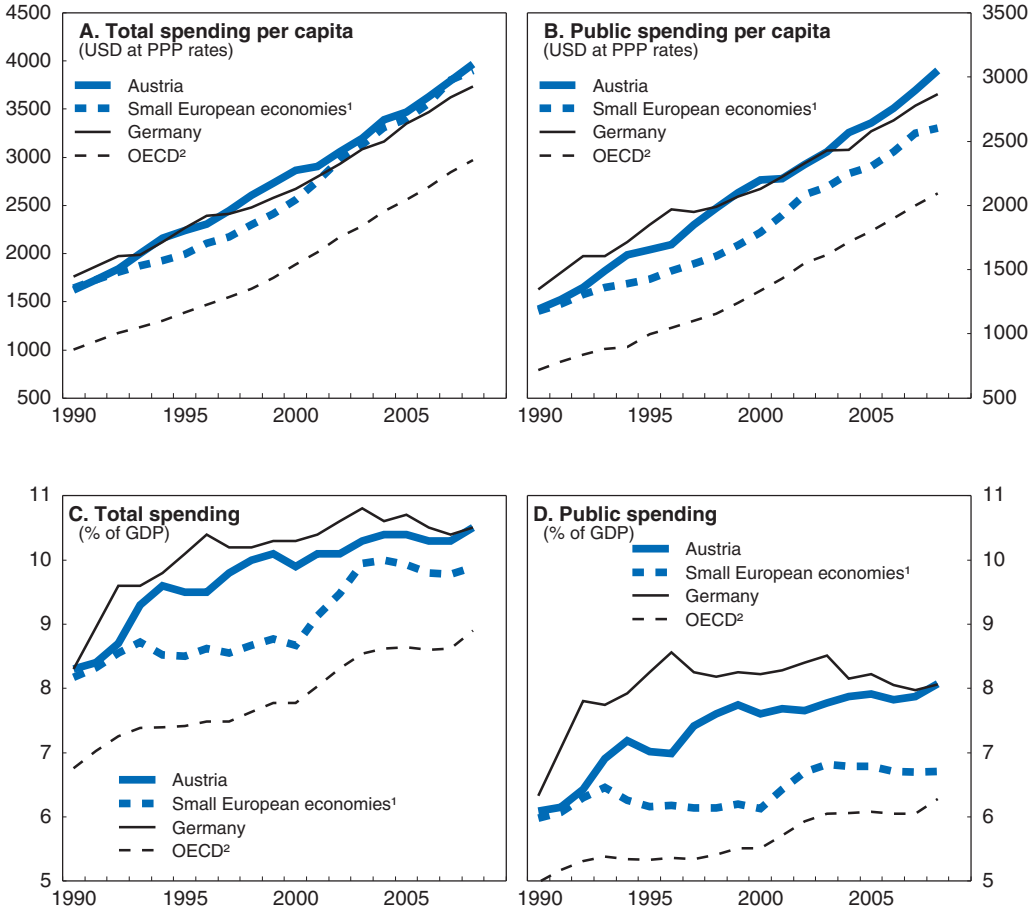
Figure 2.4. **Health spending has grown at a strong pace**



1. Arithmetic average of other small European high income economies: Denmark, the Netherlands, Sweden and Switzerland.
2. Arithmetic average over OECD countries.

Source: *OECD Health Data 2010* and OECD calculations.

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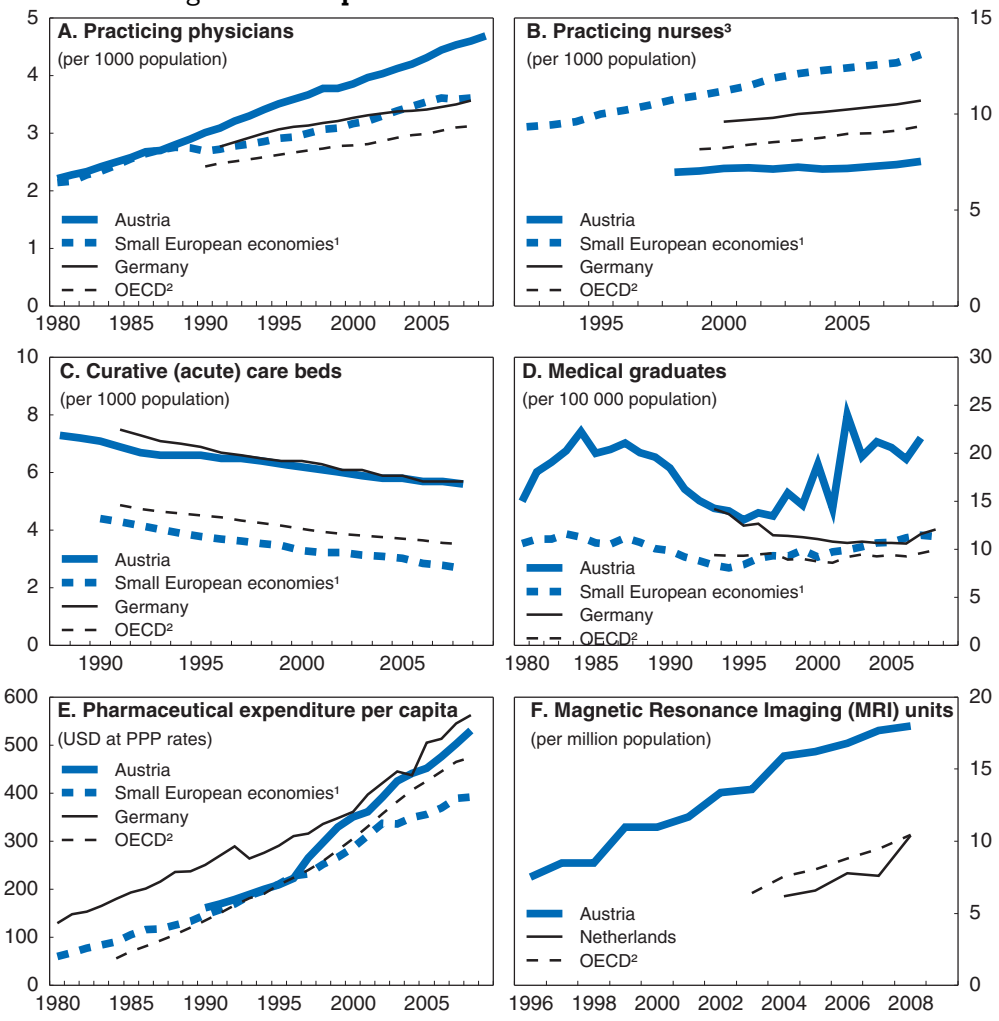
It enjoys the support of the population

Nonetheless, this density of resources helped Austria achieve a very high degree of equity of access to services. All the main international indicators of equity in health care confirm this achievement: *i*) only 2% of the population at the lowest income quintile report any difficulty of access to health services); *ii*) differences in contracted physician density across Territorial level 2 regions are very small; and *iii*) differences between women in different wealth quintiles in using cervical and breast cancer screening are very low (OECD, 2009). These outcomes are obtained despite private payments playing a relatively large role in financing (Figure 2.3), thanks to a system of exemptions which helped avoid inability to pay to impeach access (Box 2.2).

As a result, the population shows a very strong attachment to the existing health institutions and infrastructures as reiterated by successive cohorts of opinion surveys[8] (Annex 2.A1).

Figure 2.5. **Important technical means are mobilised**



1. Arithmetic average of other small European high income economies: Denmark, the Netherlands, Sweden and Switzerland except the Netherlands in Panel A.
2. Arithmetic average over OECD countries. The number of countries included in the OECD aggregate varies between 20 and 30 according to panels, depending on data availability.
3. International comparisons of nurse numbers suffer from definitional differences, and in certain instances only hospital nurses are reported. However, there is agreement that there is an undersupply of nurses in the Austrian health system.

Source: OECD Health Data 2010.

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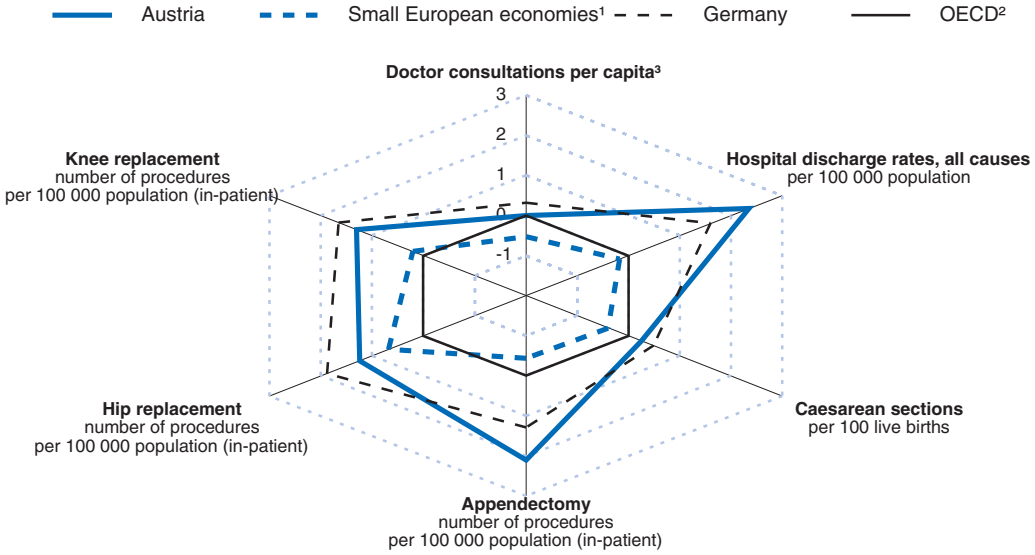
Important fiscal challenges lie ahead

Austria has a compelling short- and long-term fiscal consolidation task, as reviewed in Chapter 1. As public health is one of the largest single public spending items (amounting to about 16% of total general government spending) it is essential to exploit any available room for savings existing in the health system. This Chapter argues that room exists for savings – and started to be exploited by the authorities – while longer-term spending pressures are also serious. Beyond immediate savings associated with the post-crisis

Figure 2.6. **Health activities are intense**

Standardised deviations from OECD average, 2008 or latest available



1. Arithmetic average of other small European high income economies: Denmark, the Netherlands, Sweden and Switzerland except Sweden for caesarean sections.
2. Arithmetic average over OECD countries except Chile and also excluding – for doctor consultations: Ireland, Italy and Norway; for caesarean sections: Greece, Japan and Sweden; for appendectomy: Czech Republic, Japan, Korea and Turkey; for replacement of hip: Czech Republic, Italy, Japan, Slovak Republic and Turkey; and for replacement of knee: Czech Republic, Estonia, Greece, Japan, Norway, Poland, Slovak Republic and Turkey.
3. Detailed and more regularly updated data on doctor consultations is available in Austria, based on electronic (e-card) records.

Source: OECD Health Data 2010.

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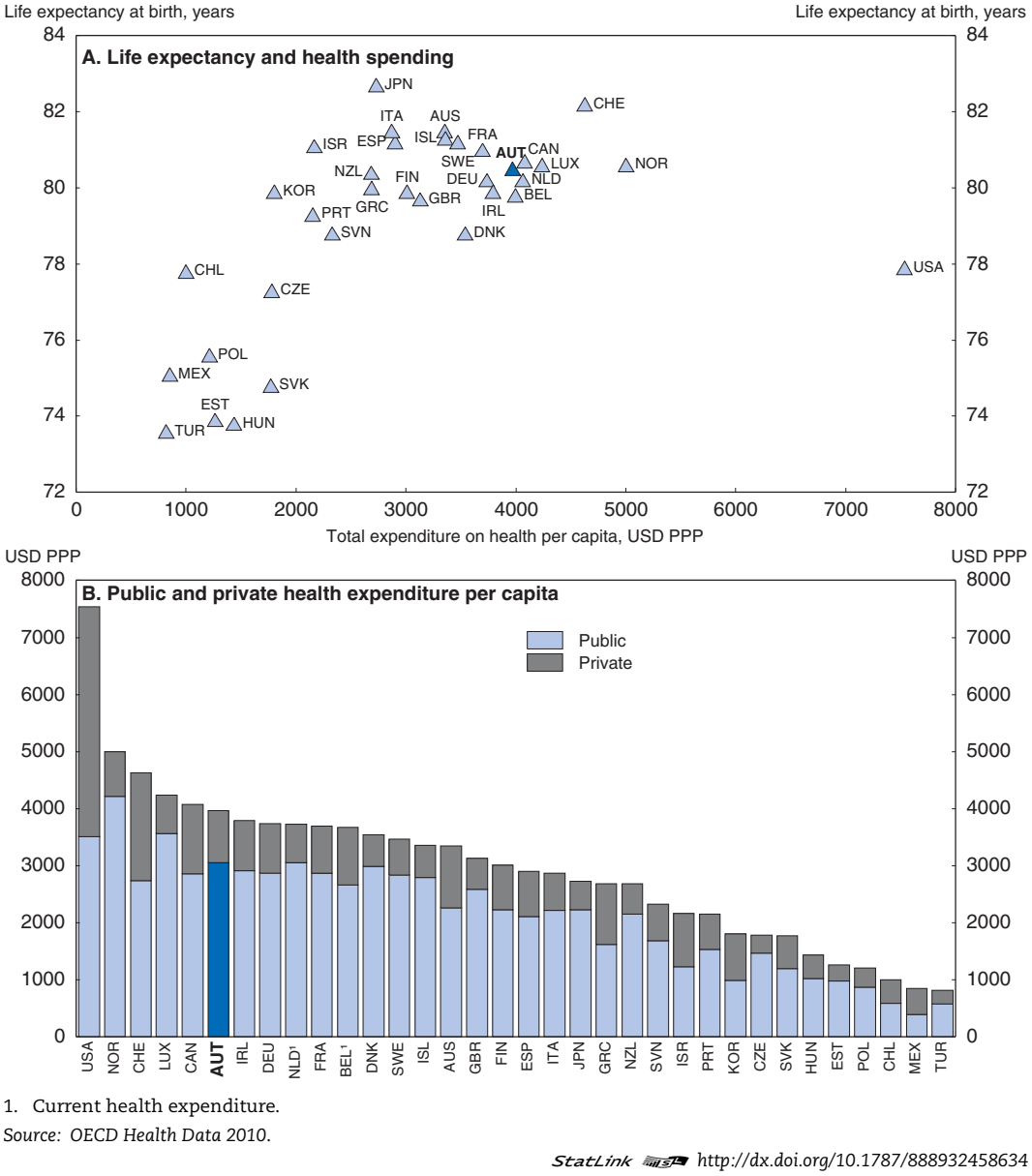
consolidation, structural reforms delivering breaks in spending trends are necessary to make these short-term savings sustainable.

Post-crisis spending savings should be made permanent

The 2008-09 economic crisis affected the finances of the Austrian health system mainly by slowing down the revenues of Sickness Funds. As most of these funds' expenditures are independent from cyclical conditions, several of them faced financial strains and accumulated debt.[9] Federal authorities responded by taking the lead in orchestrating a saving programme and offered some financial incentives for its implementation. After in-depth negotiations with the multitude of actors which co-fund and co-manage the system, a package was finalized. It left out the hospital sector for which spending responsibility remained with the *Länder* (Box 2.3).

Early evidence on the enforcement of the 2009 saving plans suggests that targets will have been attained in 2009 and 2010. However, there are also concerns that pent-up spending pressures remain in the system, and might unfold from 2011. According to the estimations used by the authorities, Sickness Funds' aggregate spending (which represents about 50% of total public health spending) grew only by 2.3% in nominal terms in 2009, and by 2.1% in 2010. However, expenditure growth is projected to accelerate to 3.4% in 2011, 2.5% in 2012 and 3.3% in 2013. These tentative projections hint therefore at a risk for the 2009 Saving Package to be successful in its first phase of implementation, but, in the absence of additional structural reforms and measures, notably in the hospital sector, to

Figure 2.7. **The link between health care spending and outcomes is weak**



1. Current health expenditure.

Source: OECD Health Data 2010.

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stall against the more ambitious targets of subsequent years. The savings achieved in the crisis could be reversed when fiscal conditions improve.

This risk is corroborated by Austria's past experience with the cyclical pattern of public health spending (Figure 2.8). It appears indeed that total public health spending displays a much higher responsiveness to the macroeconomic cycle in Austria than in countries with similar fiscal structures such as Germany, Switzerland, Sweden and Denmark. This capacity of the system to adjust to fiscal circumstances is obtained through three genuine mechanisms: annual negotiations between Sickness Funds and doctors' and pharmaceutical producers' associations on prices and volumes; the budgeting system of hospitals which is based on cyclically-dependent transfers from the federal government

Box 2.2. **Private payments do not necessarily undermine equity of access**

The share of private contributions in the financing of health services was 23% in 2008 in Austria, above OECD and EU averages. They include out-of-pocket payments (*direct cost-sharing*), co-payments (*indirect cost-sharing*), and premia for private insurance. Exemptions however minimize exclusion risks:

- *Out-of-pocket payments* fund services which are not in the benefit catalogue of Sickness Funds. The main items are special medicines, comfortable rooms in hospitals, and fixed dentures. For patients *deserving social protection*, exemptions are granted.
- *Co-payments* are participations by patients to the cost of standard services that they use. They include payments to *independent* physicians without a contract with Sickness Funds. These physicians practice unregulated fees, and are reimbursed at four fifths of the normal fees of contracted physicians, the patient paying the reminder. Members of certain Sickness Funds (of civil servants, farmers, the self-employed and the employees of Austrian Railways) contribute a further co-payment for each physician visit. Everybody also contributes a limited fixed amount for each prescription and for each hospital stay, under a means-tested exemption. On top of these exemptions, a further cap was applied to pharmaceutical co-payments since 2008.
- *Private insurance* secures cash benefits during hospital stays (which is an essential source of guaranteed income for the self-employed). It also finances access to non-contracted physicians, and to better accommodation in hospitals. One third of the population have such complementary insurance – half of them being self-employed. The number of private insurance policies has been falling since the 1990s.

and from Sickness Funds, inciting them to manage spending pro-cyclically; and, finally, new funding opportunities created by the establishment of off-budget regional hospital companies, which may recourse to non-budget borrowing when fiscal resources dry up and reduce general government funding in accounting terms. These factors of pro-cyclicality may have been in play in the exceptional circumstances of the 2008-09 crisis and may have contributed to the success of the savings package. Yet, the very same pro-cyclicality suggests that, in the absence of structural reforms, spending could accelerate when the economy recovers.

Efforts to rein in pharmaceutical spending in mid-2000s illustrate this risk. An indicative annual growth ceiling of 3-4% was set for public pharmaceutical spending in 2005, in consultation with doctors' associations and pharmaceutical producers. However, after a first phase of compliance, pharmaceutical spending soared again when the economy recovered in 2007 and 2008, without any check. In the same vein, the pharmaceutical industry agreed to reduce profit margins voluntarily in the framework of the 2009 saving plan, to save EUR 200 million in pharmaceutical spending (6% of yearly pharmaceutical spending). A new law also required physicians to prescribe the most economical available drugs (*ökonomische Verschreibweise*), without, however, asking pharmacists to convert prescriptions to their cheapest equivalents as in some other countries.[10] This type of arrangements raise the issue of the sustainability of the savings obtained through such *ad hoc* consensual agreements.

Independently from cyclically-motivated consolidation needs, important medium-to-long term spending pressures loom on the Austrian health system. As in other OECD countries, they arise from three sources: *i*) the ageing of the population (*e.g.* growing share

Box 2.3. **The 2009 saving package**

During a special retreat in February 2009 after the new government took office in December 2008, coalition partners pledged to safeguard the budget balances of the Sickness Funds in the crisis, provided that they commit to achieve savings.[1] The support package was to offer cash subsidies to Sickness Funds, and a government commitment to write-off gradually their recently built-up debt.

A so called *Structural Fund for Health Insurance* was created in September 2009 to manage the scheme. A *Debt Forgiveness Law* was also adopted. The package was innovative as, for the first time, it strengthened federal government's leverage on the social insurance sector. Federal authorities allocated subsidies of EUR 100 million per year to Sickness Funds, and committed to write off EUR 150 million of their debt per year between 2010 and 2012. The two measures amounted together to about 1.7% of Sickness Fund's aggregate annual budget. In the 2011, confronted with further fiscal constraints, the government reduced direct subsidies by more than half, to EUR 40 million per year, but committed to maintain this allocation until 2014.

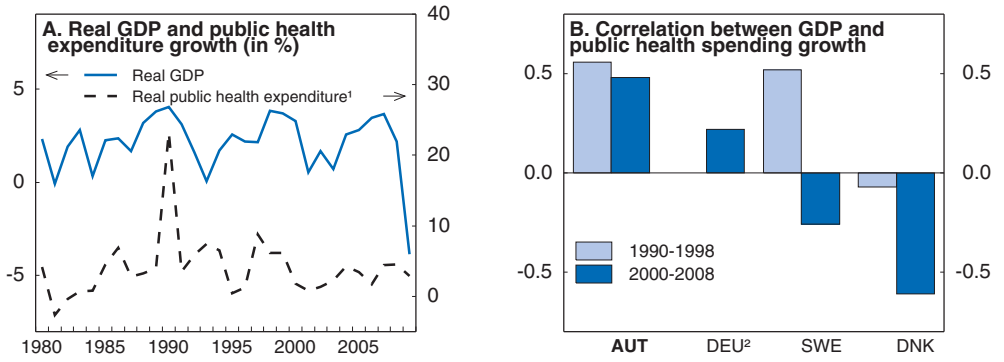
In return, the Federation of Sickness Funds (*Hauptverband*) promised to submit a road map for cost containment (*Sanierungskonzept*). This scheme was to be negotiated with the suppliers of services, in particular with the doctors' professional association (the medical chamber). The finalized roadmap stipulated cost savings amounting to EUR 1.7 billion between 2010 and 2013. Savings of 197 million were to be achieved in 2010 (1.4% of annual Sickness Fund spending), 361 million in 2011, 510 million in 2012 and 657 million in 2013. To make targets stringent, shifting savings between funds and across years was banned.[2]

Early outcomes of this package appear promising. In the first year of the *Structural Fund*'s implementation, 2010, the Ministry of Health reported that cost savings exceeded expectations by as much as 50%. The Federation of Sickness Funds reports that out of a total health insurance sector budget of EUR 14.6 billion, they expect a surplus of EUR 175 million. Before the saving package it was projected that funds' combined deficit would reach EUR 376 million. This surplus was obtained thanks to: *i)* reductions in prescription drug spending (the biggest saving item); *ii)* cost-control with contracted physicians; and *iii)* savings in technological devices and equipment. Going forward, the 2011 federal budget report mentions that additional savings will be achieved in: *i)* ambulatory care, *ii)* data centres and information technology, and *iii)* procurement and administrative costs. However, hospital costs, which generate 55% of total public health expenditure have not been included in the scheme.

The Federation of Sickness Funds recently emphasised this issue. According to the Federation, underlying spending dynamics in the health sector remain worrying: in 2013, additional spending of EUR 3.2 billion are projected (an increase of 10% over 2010), due mostly to additional hospital spending. The Federation suggested that more structural measures should be envisaged for the continuing implementation of the saving package, including: *i)* unifying the hospital law (which is fragmented into 9 different *Länder* laws); *ii)* merging federal and Sickness Fund resources presently earmarked for hospital funding and using them more effectively for efficiency gains; and *iii)* enhancing the transparency of spending in hospitals. The Federation said that if assertive measures are taken in these areas, bigger savings than the targets set in the 2009 saving package would be within reach.

1. The package covered the nine regional (*Länder*) funds, which together insure 80% of the Austrian population. The few smaller national branch funds did not participate.
2. Certain aspects of the package were criticized for not being fully transparent and equitable. First, subsidies were distributed according to size of membership (number of the insured in each Fund), without consideration to the specific risk structures and spending pressures faced by each fund. Second, they did not reward specific saving efforts, as they were not proportional to the cost containment delivered by each fund. Certain individual Sickness Funds challenged, on this ground, the fairness and even the constitutionality of the scheme (Upper Austria, Salzburg and Vorarlberg Funds were leading this opposition, because they were in surplus and had not accumulated debt to write-off). It was not clear however if the superior financial status of these regional funds was due to their higher efficiency and performance, or to their more favourable membership and risk structure.

Figure 2.8. **Cyclical sensitivity of health spending**



1. From 1990, health expenditure is calculated according to SHA (System of Health Account), for earlier reporting years only national accounts estimates are available. The break between 1989 and 1990 therefore occurs according to the change from SNA definitions to SHA definitions.
2. Correlation between 1990-98 not available for Germany.

Source: OECD Health Data 2010 and *OECD Economic Outlook Database*.

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of older cohorts with higher health spending); *ii)* technological progress which generates more costly medical treatments and products; and *iii)* increases in the relative prices of medical goods and services. All three factors play a particularly important role in Austria and call for policymakers' special attention. If these underlying trends are not fully taken into account, *ex post* spending cuts may become necessary when they hit, leading to suboptimal rationing and arbitrages in the health system.

Health cost impacts of ageing may grow more than in other countries

As everywhere, the pattern of cohort-specific public health expenditure rises with age in Austria. Per capita expenditure in the 85-89 years old cohort is, for example, five times higher than in the cohort 35-39. In 2010, 17.6% of the population was above 65, but will reach almost a quarter in 2030.[11] The impact on health spending of this shifting cohort structure is now well known and does not differ from other countries.[12] It is estimated that it will entail a relatively confined increase in the share of public health spending in GDP (Table 2.2 below).

Another factor will compound the impact of ageing on health care spending in Austria: The country's formal commitment to take responsibility for dependant old-age people's care needs in a broad sense, combining both healthcare and dependency help, and which should generate demand for new combinations of health and nursing services.

Austria has taken more comprehensive protection commitments *vis-à-vis* its elderly population than in most other OECD countries, irrespective of the financial means of beneficiaries. With the passing of the 1993 federal Long-Term Care Benefit Act, it reacted very early to the coming demographic changes. This Act offers, as a universal benefit to elderly people with disabilities, a combination of cash benefits and benefits in kind "which aim at making it possible for people requiring care to lead independent lives oriented towards their needs in spite of the restrictions they face". This is provided as a legally enforceable benefit, independent of income and assets. A benefits catalogue and quality standards *for outpatient and inpatient sectors* were set. The Law distinguished 7 different types of conditions that an elderly person may find him/herself in, calling for different care

services. Level 1 concerns people who do not need more than a relatively short visit per day; above level 3 people need 24 hours/stationary care; at levels 6 and 7 they need continuous day and night care. A monthly allowance is fixed for each level, from EUR 155 at level 1 to EUR 1 650 at level 7.[13]

Gauging the future distribution of dependency conditions is necessary to predict the future publicly funded care needs. Combinations of home-based, ambulatory, hospital and rehabilitation care will be needed. Their adequate combination will be important for both the quality and cost efficiency of care: a daily stay of an old-age person in a fully equipped hospital costs about EUR 800, while a stay in a more lightly equipped clinic declines to EUR 200. In more adapted settings, specially trained personnel may also provide better tailored services than high cost physicians.[14]

Projecting the care needs of dependant persons combines two alternative hypotheses in varying proportions (as with standard health spending projections): *compression of dependence* (i.e. chronic diseases come at higher ages, lifetime in dependence remaining constant) *versus expansion of dependence* (chronic diseases arising at constant age and lifetime in dependence increasing). Current nursing care need projections in Austria in co-operation with the European Commission include a *pure demographic* scenario (with constant dependency rates) and a *social change* scenario (with substitution of formal to informal care: 1% of those receiving informal care shifting to formal care each year). There are upward risks to these scenarios, as rising labour force participation by women could reduce available family care. Certain projections for nursing care places set for the year 2010 materialised several years earlier. The pace of shift from informal to formal care was identified by an early OECD analysis as a key upward risk on future spending projections (Oliveira Martins and de la Maisonneuve, 2006).[15]

Austria has however lower disability rates for its elderly population compared to Germany, Sweden, Denmark and the Netherlands. If this more favourable health status can be preserved and improved, it could exert a moderating impact on future care needs (Table 2.1).

Table 2.1. **Disability rates of the elderly**[1]

Age group	75-79		80-84		85-89		90+	
Gender	M	F	M	F	M	F	M	F
Austria	12	20	28	40	33	46	41	53
Germany	19	19	38	43	40	48	44	58
Sweden	18	12	29	40	34	48	41	54
Denmark	14	23	28	42	35	50	48	63
Netherlands	10	18	31	34	37	43	47	55

1. As defined in the *EU Share Database*: "the percentage of people with the prevalence of '1+' limitations with activities of daily living among men and women over 50 years of age".

Source: European Commission (2009).

Responsiveness to technological developments may create additional costs

Giving the entire population equal access to state-of-the-art technologies is an important principle of the Austrian health system. It was reiterated in the context of the renewal of the constitutional agreement on health policies between the federal

government and the *Länder* in 2008. It could put additional upward pressures on future public health expenditure, as a result of future technical innovations and change.

The balance between the costs and benefits of publicly funded health technologies – both treatments and pharmaceuticals – is in principle secured in Austria by applying Health Technology Assessment (HTA) (Ludwig Boltzmann Institute, 2009). HTA offers cost-benefit analyses for various treatments and services, and help policymakers decide on the coverage of the package. Still, HTA does not aim to cap public health spending, but to distinguish between cost-effective and cost-ineffective treatments. Austrian authorities intend to make more intensive use of HTA in the future but this will not necessarily reduce the impact of technological change on spending.

The utilization of HTA in pharmaceutical treatments gives an illustration of potentially limited impacts on volume of spending. HTA has been actively implemented in Austria for several years, with satisfactory results, and made the country highly receptive to efficient and high quality pharmaceutical innovations. A recent cross-country comparison on the diffusion of pharmaceutical innovations in Europe identified Austria as one of the most receptive European markets for pharmaceutical innovations (Richards, 2010). HTA appears to have contributed to a better-informed diffusion of new technologies. As long as adopting *efficient* state-of-the-art health technologies is a political goal, technological change should be expected to increase spending in the future.

Health inflation entails additional pressures

Recent international reviews of public health spending suggest that differences in countries' inflation rates in the health sector is a key factor of divergence of public health costs. Austria is *a priori* not favourably placed in this area. Cost and price increases in health are generally steeper than in other countries. If such inflation differentials persist, they are likely to put additional upward pressure on spending (Figure 2.9).

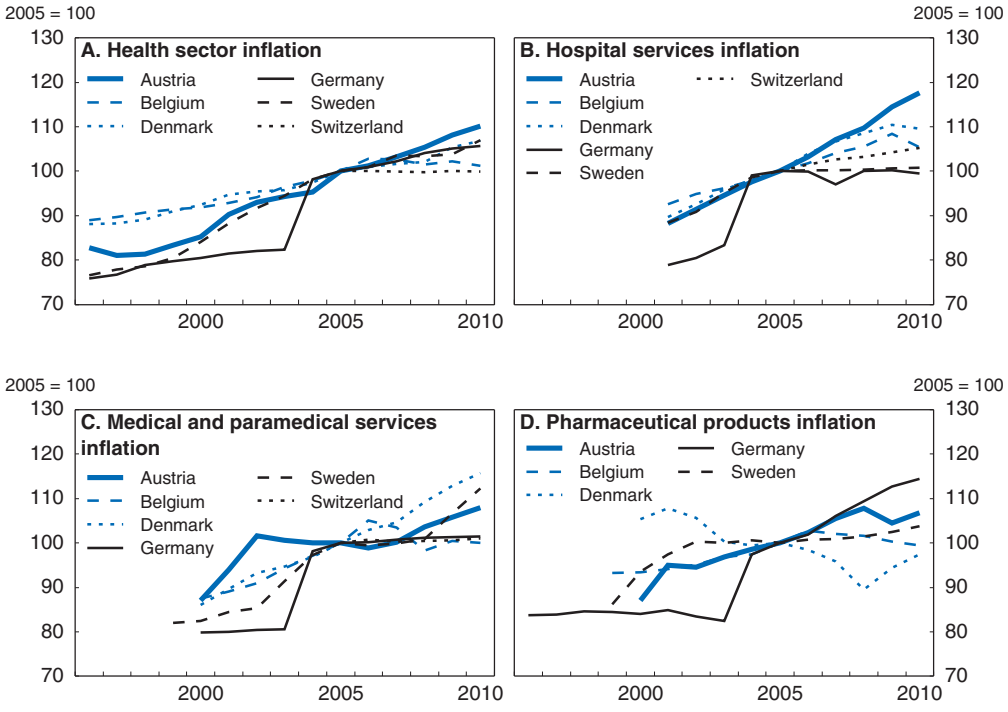
The 1997 *OECD Economic Survey of Austria* had already found that medical prices were 20% above EU levels. The largest differentials relative to EU averages were found in the ambulatory sector. The *Survey* observed that prices charged for the services of general practitioners, nurses and other practitioners, as well as for medical products and appliances, and for drugs and medicines were above EU average levels. The prices of specialist practitioners were found to be around the EU level.

Recent information confirms the persistence of these price pressures in Austria. For self-employed specialist physicians, the ratio of gross annual revenues to annual wages is now one of the highest in OECD, at about 4.8 times the average wage. For general practitioners, the ratio is also on the higher side, but closer to the international average at 2.9 times the average wage[16] (OECD, 2009).

These fee levels may partly result from the fragmented settlement of tariffs. For example, the Sickness Fund of the self-employed (SVA) recently suspended the contracting negotiations with the professional association of physicians, as they did not agree to lower tariffs to the level granted to *regional* Sickness Funds. An *ad hoc* arrangement was later found. More generally, higher fee levels for *national branch funds* increase doctors' income, while permitting to keep the fees paid by *regional* funds down. These differences call for more policy attention in the future.

To shed light on developments in health sector prices, Austria could participate in the new OECD project on Hospital Service Price Transparency. The objective of this exercise is

Figure 2.9. **Pressures from health inflation**



Source: Eurostat and OECD calculations.

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"to explore if differences across countries in per capita health expenditures are due to more services being consumed in some countries, or whether they reflect differences in the price level of services". It is planned to generate detailed comparisons of a wide range of hospital fees through time (OECD, 2010d).

The Austrian authorities started to map more precisely the future public funding needs of the health and long-term care systems. A working group was created under the co-ordination of the Federal Health Agency and has started work. In addition to standard projections produced in the framework of European Commission's Working Group on Ageing – which are summarized below – detailed national projections could concentrate on the time horizon 2020-30 which is critical from the point of view of fiscal strategy. A fuller set of factors bearing on both ongoing spending and new financing needs can be investigated. This work may also draw on a new project in the context of OECD's Health Committee to evaluate alternative models of health spending projections by member countries.

Current spending projections highlight these risks

The combined impact of the forces acting on public health spending start to be better understood at the international level. Internationally comparative medium-to-long term health spending projections start to be produced. Concerning Austria, three recent

projections have shed light on the national health spending outlook. All three gave insights on the magnitude of looming pressures:

- A pioneering OECD project in 2006 helped identify the key factors bearing on public health spending across OECD countries. It introduced detailed and integrated methodologies for projecting long-term spending for health *and* long-term care (Oliveira Martins and de la Maisonneuve, 2006). The exercise focused on the horizon 2050 and did not offer projections for the more medium-term future 2020-30. Nonetheless, it suggested that, under alternative assumptions, the share of public health spending in GDP in Austria may increase by 0.6 to 3.8 percentage points of GDP between 2005-50.
- The European Commission produced, in 2009, a full set of health spending scenarios for member countries for the period 2007-60 (EC, 2009). It included for each country eight different scenarios, with different hypotheses on the evolution of demand, prices and costs. One methodological shortcoming of this exercise was that cost pressures from technological change were not directly taken into account. Yet, technological factors were introduced in separate special scenarios and permitted to charter a broad spectrum of possible future spending paths (Table 2.1).[17]
- The IMF has undertaken a similar exercise in 2010, following a similar methodology (IMF 2010). The exercise included technological and other cost pressures. It has compounded demographic effects with long-term spending trends in each country. These additional factors on top of demographic effects have been termed *excess cost pressures*, and have been estimated individually for each country.[18]

Table 2.2 presents the spectrum of spending trends arising from these exercises concerning Austria. The breadth of projections is large, ranging from an increase of 0.5 to 2 percentage points of GDP of further spending by 2020, and 0.9 to 5 percentage points of further spending by 2030. In the light of the specific upward pressures in the Austrian context, policymakers may wish to pay special attention to the "high public cost" scenarios which may be more fully capturing the forces in play.

Table 2.2. **The spectrum of long-term health spending projections for Austria**[1]

As a % of GDP

	2007	2015	2020	2030	2040	Increase 2007-20 (pp)	Increase 2007-30 (pp)	Increase 2007-40 (pp)
EC baseline	6.5	6.8	7.0	7.4	7.8	0.5	0.9	1.3
EC "pure demographic"	6.5	6.8	7.0	7.5	7.9	0.5	1.0	1.4
EC "technology"[2]	6.5	6.9	8.5	10.1	11.6	2.0	3.6	5.1
IMF baseline	6.5	7.7	8.5	10.1	11.6	2.0	3.6	5.1
IMF optimistic	6.5			8.0			1.5	
IMF pessimistic	6.5			11.7			5.2	
[p.m. EC spending baseline for long-term care]	1.3	1.3	1.4	1.7	2.0	0.1	0.4	0.7

1. These projections concern only public health expenditure in a narrow sense, excluding public spending for long-term care.
2. Assuming the complete disappearance of the impact of technology by 2060.

Source: EC, IMF, OECD.

In this environment, forging a shared view of the medium-term fiscal outlook of the health sector between health policymakers and economic policymakers would be useful.

To this effect: *i)* the official health and long-term care spending projections (presently produced in the context of the European Commission) could be made more nationally visible; *ii)* the *healthcare* and *long-term care* components of scenarios be better integrated; *iii)* more detailed scenarios with the full range of hypotheses on the impact of technological change and future demands for new services could be developed; and *iv)* a medium-term (10-15 years) path for public health spending at general government level could be established. Also, in support of more immediate policies, the public health spending at general government level could be made a policy target associated with the multi-year budget framework which accompanies the annual budget law.

The efficiency of the system can be significantly improved, notably in the hospital sector

Recent research helped to document that existing services deliver good health outcomes, but do not aim for a high degree of economic efficiency. In particular, hospitals absorb much wider resources than in other countries and appear to suffer efficiency shortcomings. Three streams of information help document this state of affairs: *i)* microeconomic reviews of efficiency in the hospital sector; *ii)* comparisons of resource utilisation in regional health systems; and *iii)* aggregate assessments of national health system efficiencies in international comparison.

Hospitals' microeconomic efficiency can be improved

Hospital efficiency analyses have been well developed in Austria, on the basis of Data Envelopment Analysis (DEA) techniques. A 2005 study uncovered an average level of DEA inefficiency of 20% in a sample of hospitals (*i.e.* an *average* distance of 20% to the national efficiency frontier), suggesting that up to one fifth of hospital costs could be saved (Hofmarcher *et al.*, 2005). Additional recent research confirmed the existence of large efficiency gaps within the sector, but traced them more directly to the ownership structure of hospitals (Czypionka *et al.*, 2008). As also shown in the 2005 study, non-profit institutions owned by religious congregations appeared to operate at first sight more efficiently than public hospitals. Within the public sector, hospitals owned by the municipalities seemed to be more efficient than those belonging to the *Länder*.[19] The study reiterated, like the previous one, that the variation of efficiency *within* ownership groups is larger than *between* groups. This indicates that there is room for large productivity gains in all categories of hospitals.

There are however two caveats to these findings. *First*, a difference between *Länder*-owned hospitals and non-profit peers is that *Länder* hospitals are legally required to provide a high level of outpatient care activity (not required from private peers) which increases costs. *Secondly,* these measurements do not control for the quality of care and for the complexity of treatments. For example, the poor performance of accident hospitals may be partly due to the type of services that they provide (rehabilitation is a long and labour and capital intensive process). These caveats do however not rebuff the general conclusion on the presence of large efficiency reserves.

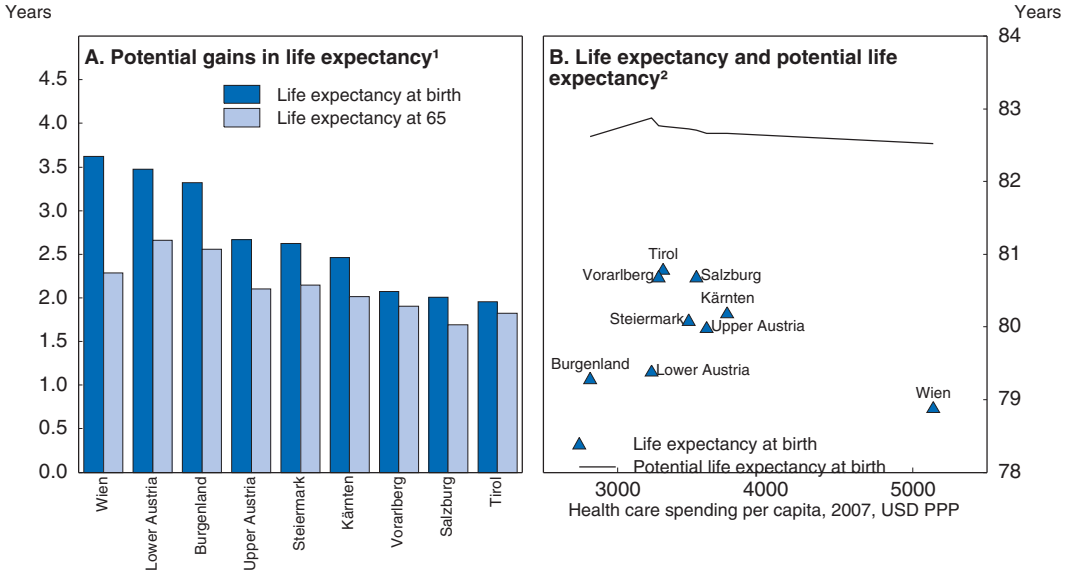
Insufficient technical specialization between hospitals is also a major present issue. Each Land has developed its own hospital system and this has made the specialization of hospitals difficult. *Länder* hospitals remain polyvalent and patients are not encouraged to travel to specialist institutions remote from living places – except in critical cases. It was simulated, for example in the area of breast cancer surgery, that 35 sites in Austria should

suffice to perform this treatment at the required degree of frequency, while around 110 sites currently offer this service. Lack of specialization undermines both the efficiency and quality of services.

Resource utilisation can be enhanced in several Länder

The OECD methodology utilised for the international comparisons of national health system efficiencies (section below) has been duplicated, for the purposes of this *Survey*, to compare economic efficiency levels in the nine Austrian *Länder*. The estimation suggests that the variation of efficiency levels is very high (Figure 2.10). Certain *Länder* achieve consistently better outcomes than others and, symmetrically, underperformers spend considerably more resources for given health outcomes. The exercise is subject to methodological caveats (notably because of cross-*Länder* movements of patients, in particular towards Vienna, undermines Vienna's estimated efficiency) but suggests that the room remaining for additional productivity gains is large.

Figure 2.10. **Comparisons between *Länder* suggest that there is large room for efficiency gains**



1. DEA efficiency calculations were performed with two inputs: health care spending per capita and a variable which is a composite indicator of the socio-economic environment (GDP per capita, educational attainment) and lifestyle factors (nitrogen oxide emissions, consumption of fruit and vegetables, lagged consumption of alcohol and tobacco – 1990 data).
2. Potential life expectancy represents the life expectancy level if the potential gains in life expectancy as obtained by DEA calculations were realised keeping the same amount of health care spending. It takes into account the experience of other OECD countries. The graph is a two-dimensional representation of a multi-dimensional computation (distances from efficiency frontier are not necessarily readable on a plan) while in this instance it does show the estimated potential for life year gains.

Source: OECD calculations based on *OECD Health Data 2010*.

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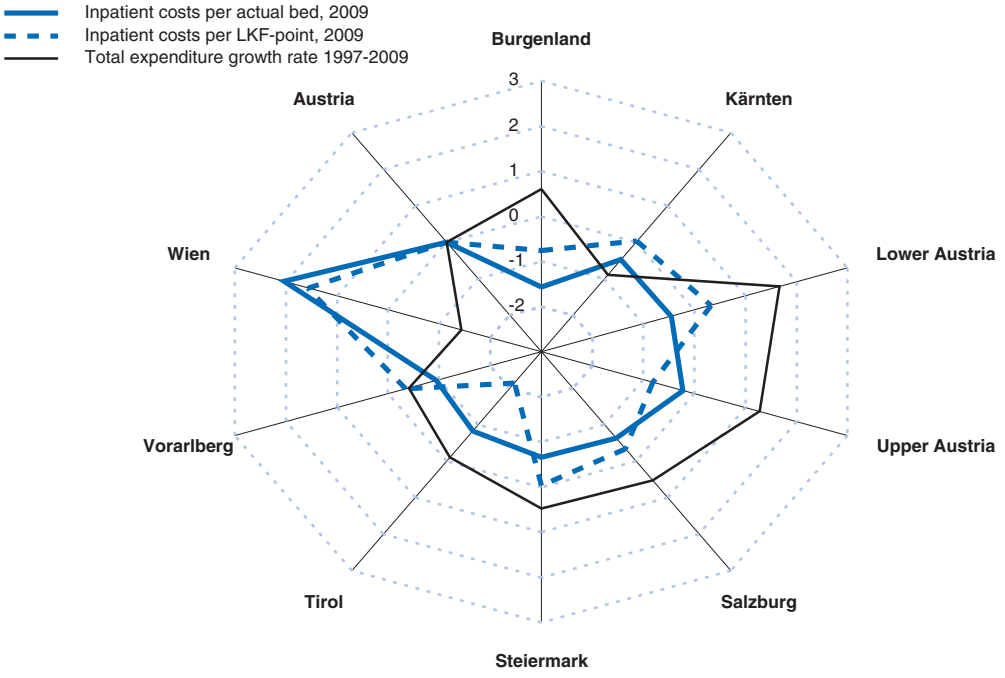
More detailed investigations comparing spending and cost structures across *Länder* confirm this finding. Austria's Court of Auditors undertook several such studies. They found important differences which seem to persist through time. For example, cost per activity point in "basic profile" hospitals in 2009 (calculated in detail for the DRG system,

Box 2.4 below) was EUR 1.25 in Lower Austria and EUR 0.85 in Tyrol, against a national average of EUR 1.12.[20] Similar differences were found in other hospital categories. Hospitals in Tyrol, Vorarlberg and Salzburg appeared more efficient than those in Lower and Upper Austria. Other work by the Court of Auditors revealed similar inter-*Länder* differences (Figure 2.11).

Figure 2.11. **Inter-*Länder* differences in health system costs**
(Standardised deviations from national level)



Source: Ministry of Health and Institute for Advances Studies, *HealthEcon 2011*.

StatLink http://dx.doi.org/10.1787/888932458710

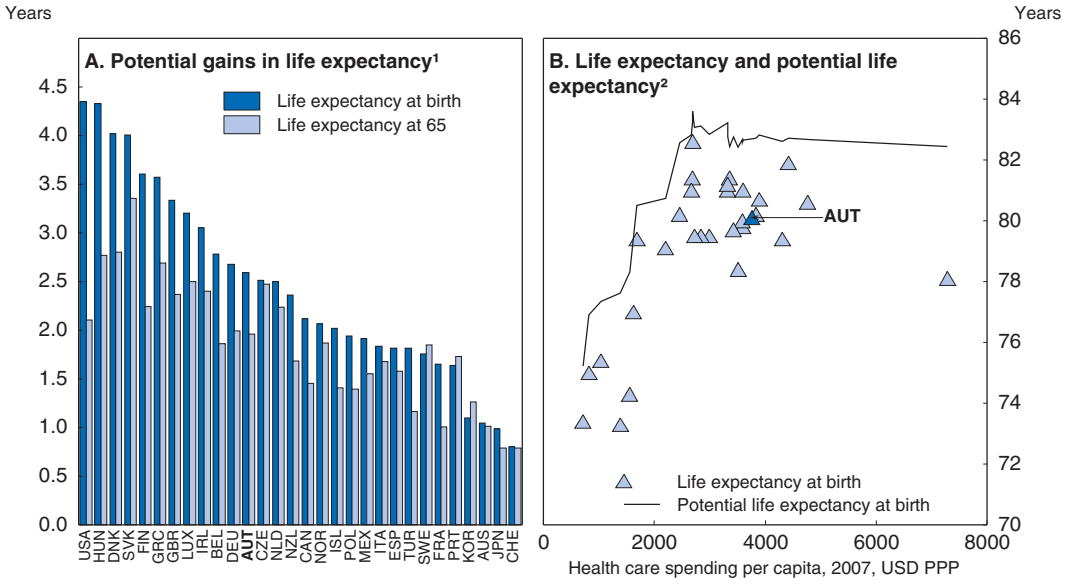
The aggregate efficiency of the system falls short of best practices

Recently, a large-scale OECD study has applied Data Envelopment Analysis Techniques to measure the economic efficiency of national health systems in 30 countries. It compared the average population health outcomes attained in each country (proxied by average life expectancy, which is an imperfect proxy but is reasonably well correlated with other indicators) with a set of inputs (such as health care resources per capita measured in monetary and physical terms, socio-economic inputs including education and pollution, and life-style factors including diet), and established how well each national system transforms these inputs into health status. Countries generating the highest life expectancy at given input levels, and those reaching given life expectancies at the lowest input costs, are said to form the international efficiency frontier (OECD, 2010a).

Results suggest that if Austria had used its current level of resources with the same efficiency as the best performing countries, it could improve the life expectancy of its population by two years and a half, roughly speaking half of the progress achieved in the past 40 years. They also implied, symmetrically, that if Austria's system was operating at

the frontier level of efficiency, spending could be reduced by 2 percentage points of GDP or one fourth of the current public expenditure for healthcare. With this level of estimated performance, Austria takes place in the lower half of the 30 countries – among those which have more life years to gain than average. These estimates confirm the existence of a large reserve for efficiency gains (Figure 2.12).

Figure 2.12. **A comprehensive international comparison reveals room for efficiency gains**



1. DEA efficiency calculations were performed with two inputs: health care spending per capita and a variable which is a composite indicator of the socio-economic environment (GDP per capita, educational attainment) and lifestyle factors (nitrogen oxide emissions, consumption of fruit and vegetables, lagged consumption of alcohol and tobacco – 1990 data).
2. Potential life expectancy represents the life expectancy level if the potential gains in life expectancy as obtained by DEA calculations were realised keeping the same amount of health care spending. See also footnote 2 of Figure 2.10.

Source: OECD (2010), *Health Care Systems: Efficiency and Policy Settings*.

StatLink http://dx.doi.org/10.1787/888932458729

A spending area where there is some recent, tentative and intriguing domestic research is the utilization of pharmaceuticals. A 2009 study by the University of Salzburg[21] suggested that 36% of the pharmaceuticals used in Austria by old-age persons appear to be dispensable, 30% of pharmaceuticals appear to have doubtful clinical relevance, and 23% are incorrectly dosed. The study observed that total pharmaceutical consumption increased by 90% over the past decade. Austria is indeed one of the OECD countries where pharmaceutical spending has increased most sharply (Figure 2.5 above).

Key shortcomings have started to be addressed but further action is needed

Addressing and reducing these efficiency shortcomings is now an agreed goal of Austrian policymakers. Successive vintages of health reform initiatives since 1997 aimed at lifting up the efficiency of the system. Action in four areas was prioritized: asserting stronger federal government influence on long-term capacity development (improving allocative efficiency); introducing payment systems emulating market disciplines and

helping catch-up with productivity benchmarks (technical efficiency); upgrading outputs by improving quality (increasing quality-adjusted output); and accelerating transition to lower cost *integrated care* via a better balanced combination of preventive, outpatient and inpatient services. Good results start to be obtained from these initiatives, but continuing action is needed to foster actual structural change.

Capacity planning should be consolidated

Since 2005, the Ministry of Health has reactivated efforts to direct capacity building in the national health system, in both inpatient and outpatient sectors. A new "National Capacity Plan" (*Österreichischer Strukturplan Gesundheit*, ÖSG) is intended as a central strategic instrument. Each *Land* is required by law to produce a regional plan in co-operation with its regional Sickness Fund (*Regionaler Strukturplan Gesundheit*, RSG), compatible with the national plan and targeted to put it in application. "Land Health Funds" and "Land Health Platforms" are created, consolidating resources from various federal and regional public sources, and required to contribute to the rationalisation of regional service supply structures.

ÖSG follows from an earlier *Österreichicher Krankenanstaltenplan* (ÖKAP, Austrian Plan on Hospitals), elaborated in consultation with the *Länder,* and dating from 1997. The *Länder* had had a strong influence on the elaboration of ÖKAP, and ÖKAP had not entailed any significant departure from existing and locally planned capacities. In contrast, ÖSG aimed at remaining less bound by existing capacities and asserting more influence on the actual development of capacities. Its first version was finalized in 2006, and its 2010 version outlined, on the basis of benchmarks by the National Planning and Research Institute – *Gesundheit Österreich GmbH* – inpatient and outpatient service needs for 2015 and 2020. The plan aims at reducing the gap between needs and capacity, and to improve both efficiency and resource allocation.

However, early experience with ÖSG has not been very conclusive, despite the amount of expectations and resources invested in the effort. Concerning the steering of hospital capacity, *Länder*'s continuing control of RSGs did not permit any significant deviations from existing and locally planned capacities, even if certain *Länder* tried to comply more with ÖSG objectives than others. Sickness Funds' "contracted physician networks" could also not be taken under the umbrella of the national plan: they continued to be shaped by negotiations between physicians' regional chambers and regional Sickness Funds, with limited connection with ÖSG so far. The goals of the plan have also been weakened by the concept of an "adjustment coefficient" in implementation, advocated by several *Länder*, implying that targets would be abided by only in some proportion ("the coefficient", for example by 25% below or above national goals). Sanctions legally available to discipline non-complying *Länder* could not be put in practice.

Against this background, a new strategic document[22] presented by the Federation of Sickness Funds in November 2010 judged the capacity targets of ÖSG, as not being guided by appropriate public health goals (Hauptverband, 2010). Hauptverband suggested that all key stakeholders (federal government, *Länder* and Sickness Funds) should develop together more ambitious targets. These targets should capture true service needs, including in the areas of public health and prevention. One illustrative suggestion was to decrease the number of projected foot amputations for patients with diabetes, thanks to much more effective preventive policies, rather than extrapolating historical trends. Hauptverband also proposed that planning should be done for broader areas than individual *Länder*,

arguing that the average population size of 1 million per *Land* falls short of minimum scale for effective planning. It suggested that planning objectives should be made compulsory and compliance be monitored independently. These suggestions are predicated on far-reaching changes in the institutional environment.

Payment mechanisms should be refined

New performance-based payment mechanisms started to be introduced, designed to encourage service suppliers to catch-up with national productivity benchmarks. This was first introduced for the payment of hospital services, since 1997 and in successive steps, on the basis of a vast national co-operative project (Box 2.4).

The authorities consider extending the principles of the DRG system outside the hospital sector, toward outpatient care. If national cost benchmarks could be set for treatments in the outpatient sector, and fees were established on that basis, benefits

Box 2.4. **The Austrian DRG system: promises and setbacks**

Since 1997, 60% of the operating costs of hospitals are funded according to the treatments that they provide. The units of calculation are *points* allocated to each type of treatment, on the basis of *diagnosis related groups* (DRG). 982 different types of treatment are distinguished, and the number of points for each treatment are determined on the basis of around 500 000 inpatient stays in 20 reference hospitals. The system therefore pays each treatment according to a national cost benchmark, irrespective of the hospital's own costs. It therefore emulates a competitive pricing mechanism, giving hospitals incentives to converge with and overcome national productivity norms.

"Point values" are set retrospectively at the level of each Land, at the end of each accounting period, by dividing the *ex ante* hospital budget of the *Land* by the number of *ex post* points "gained" by the *Land*'s hospitals. The total budget for hospitals remains therefore fixed and is not affected by the total volume of points (services) provided. Upon inception, this feature was greeted by international health economists as a promising innovation for controlling hospital expenditure, while also preserving market-driven flexibility in the allocation of hospital budgets. It is available today only in a few countries operating DRG systems.*

The system includes also some additional discretionary options for each *Land*:

- In the so-called "Uniform Core Area" of the payment procedure, the points awarded for each type of treatment are based on national cost benchmarks.
- The second area of the payment procedure (the "*Land* Control Area") can be modified by each *Land*. It enables the *Land* to top up the national cost benchmark for each type of treatment with some preferred level of staffing, equipment, and other quality criteria.

Hospitals claim that the DRG system does not adequately reflect their outlays for outpatient services, while many of these services can be more efficiently provided by hospitals rather than independent physicians.

The fixed hospital budget of each *Land* is jointly financed by the federal government, *Land* government and Sickness Funds. It is consolidated in a "*Land* Health Fund" uniquely dedicated to DRG payments, and has an autonomous management structure. The Fund finances about 60% of the total operating costs of hospitals in the Land. The *Land* Health Fund was initially intended to fund 100% of the operating costs of hospitals, but was subsequently scaled down.

Box 2.4. **The Austrian DRG system: promises and setbacks** *(cont.)*

Actual experience with the DRG system in the first decade of implementation has been somewhat mixed. Despite important benefits in a range of areas, the system has not yet fulfilled its full promises:

- The expected efficiency gains from the new payment mechanism were initially achieved. The average length of stay in hospitals declined drastically, below OECD averages.
- Yet, hospitals tried to maintain their revenues by maximizing their number of points. The number of hospital admissions accelerated above trend.
- Two loopholes with respect to the basic philosophy of the DRG system continues to exist: payments under *Land Control Areas* above national cost standards, and financing made available beyond the DRG system: about 40% of the current costs of hospitals continue to be financed outside the system.
- Patients seeking outpatient care are frequently admitted for inpatient care, as hospitals have no other "medical home" for these types of services. This contributes to the expansion of hospital admissions.
- In sum, since the introduction of the DRG system the transparency of hospital activities has considerably improved for the authorities – the wealth of data arising from the DRG system has not been made public – but hospital costs have only slightly decelerated.

The DRG system continues to be refined on the basis of experience. The catalogue of nearly 1 000 cases is periodically revisited, and reference cost levels are updated. Still, as long as the built-in "loopholes" in the system persist, the expected benefits may be difficult to achieve.

The ancillary issue of private insurance funding for hospitals

In addition to the DRG system which governs the public funding of hospitals, private insurers reimburse these institutions for offering special amenities to privately insured people. This supplements the income of the hospital companies, managing doctors and their teams.

This procedure entails however one distortion: *Länder*'s hospital laws stipulate that in publicly funded hospitals, the number of beds for privately insured people should not exceed 25% of the bed capacity available for people who are covered only by Sickness Funds. This creates an incentive to keep bed capacity high, as bed cuts in "common wards" implies cutting back beds for "*Sonderklasse*" patients.

In an assessment of the issue in 2006, the Federal Audit Office recommended that funding from private insurers be made transparent, and that all stakeholders should receive an "appropriate" share of these fees. The Office recommended that a unified fee be charged to private insurers for each treatment, covering both the doctors' supplemental income and a charge for using hospital infrastructure.

The policy issue is admittedly complex. Any capping of private insurance contributions could have unintended consequences: First, public wage expenses for managing doctors may need to increase if they are unable to supplement their income. Second, giving doctors the option to supplement incomes with private insurance fees may be creating positive side-effects, because higher quality services are made available not only to privately insured patients, but also to public insurance patients.

* Beside Austria, Germany and certain Swedish regions appear to operate a form of a "cap and divide" technique in the valuation and funding of DRG points. See HOPE, 2006.

similar to the DRG system's may be anticipated. Ambulatory care provided for similar cases by independent physicians, the outpatient wards of hospitals and – gradually – polyvalent group practices could then be paid similar fees, and the most efficient care platforms can gain an edge. Part of the treatments could then shift to care settings where they are provided more efficiently and at a standard level of quality. Transiting to such a payment system in outpatient care would be a long process (the DRG system took several years to design and implement), entailing detailed case classification, quality normalization and cost benchmarking tasks. The authorities are nonetheless willing to engage in this direction.

The payment system for pharmaceuticals was also considerably modified. Drugs are classified into three categories, with different degrees of automaticity in their reimbursement – along international best practice. "Green box" medicines are readily reimbursed, "Yellow box" ones require authorization by social insurance chief physicians, and the "Red box" contains medicines for which a reimbursement policy is not established. The latter group of medicines are submitted to health technology assessment (HTA) to evaluate their cost-benefit balances, and are authorized or not on that basis. If this new payment mechanism is backed with additional measures in favour of generics (which still have a relatively limited share in the Austrian pharmaceuticals market[23]) it could deliver important savings.

Policymakers should continue to move to payment mechanisms fostering productivity gains: by financing services according to quality and cost criteria; by relying more on competition; and, when services are provided by national or local monopolies, notably when negotiating with medical chambers, by using as much as possible national cost benchmarks and yardstick competition.

Service quality should be better monitored

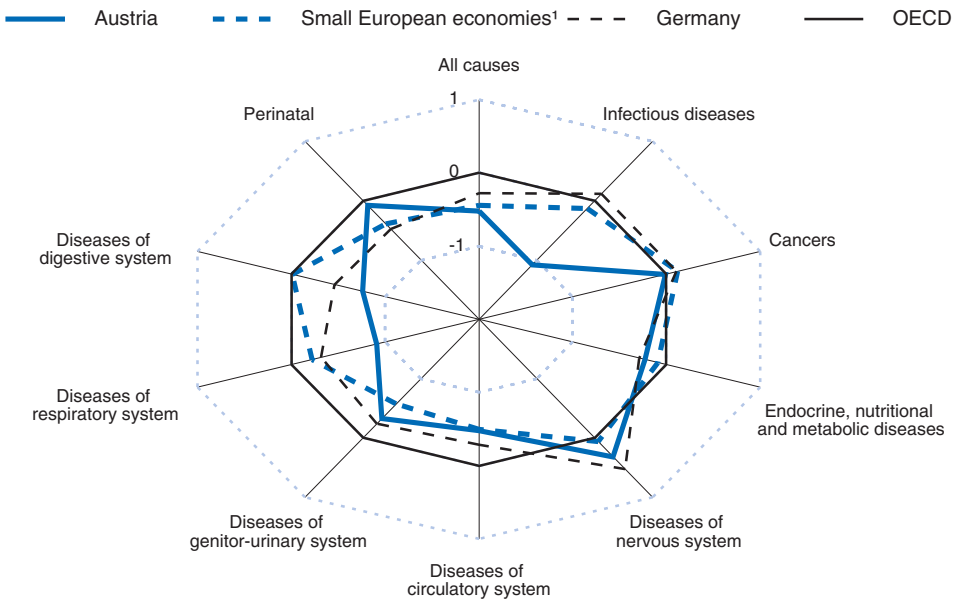
The quality of health services matters for the efficiency of the health system. It determines patients' health status, reduces need for follow-up care, and minimizes hospital re-admissions. There is a widely shared belief that health services are of a high quality in Austria, and that this quality is homogenous across the territory. Several national health experts observe however that this assertion is not backed by objective criteria or indicators. The Austrian system's operating without standard quality indicators is indeed one of its distinct characteristics. In a recent review Austria came out as being particularly poorly endowed with formal quality indicators (Paris *et al*., 2010).

Some internationally comparable indicators are nonetheless available to broadly evaluate quality outcomes (OECD, 2009a). The full range of indicators is not available for Austria (notably survival rates in certain health conditions such as cancers). Still, those that are available provide a preliminary comparative picture (Figure 2.13). They confirm that Austria 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.[24] In other areas, outcomes are similar to comparable countries.[25]

More specific indicators are also used to compare the quality of health services, such as "avoidable hospital admission" rates for specific diseases, and participation rates in public health programmes (OECD, 2011). These indicators suggest that there is room for improvement in these specific fields (Figure 2.14). The Austrian system is characterized for

Figure 2.13. **Some available indicators of quality of care**

Amenable mortality rates per 100 000 population



Note: Amenable mortality is defined as those deaths that were potentially preventable by timely and effective medical care. 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. Data represent the deviation from the OECD average and are expressed in number of standard deviations.

1. Arithmetic average of other small European high income economies: Denmark, the Netherlands and Sweden.

Source: OECD estimates based on Nolte and Mc Kee (2008), "Measuring the Health of Nations: Updating an Earlier Analysis", *Health Affairs*, January/February 2008.

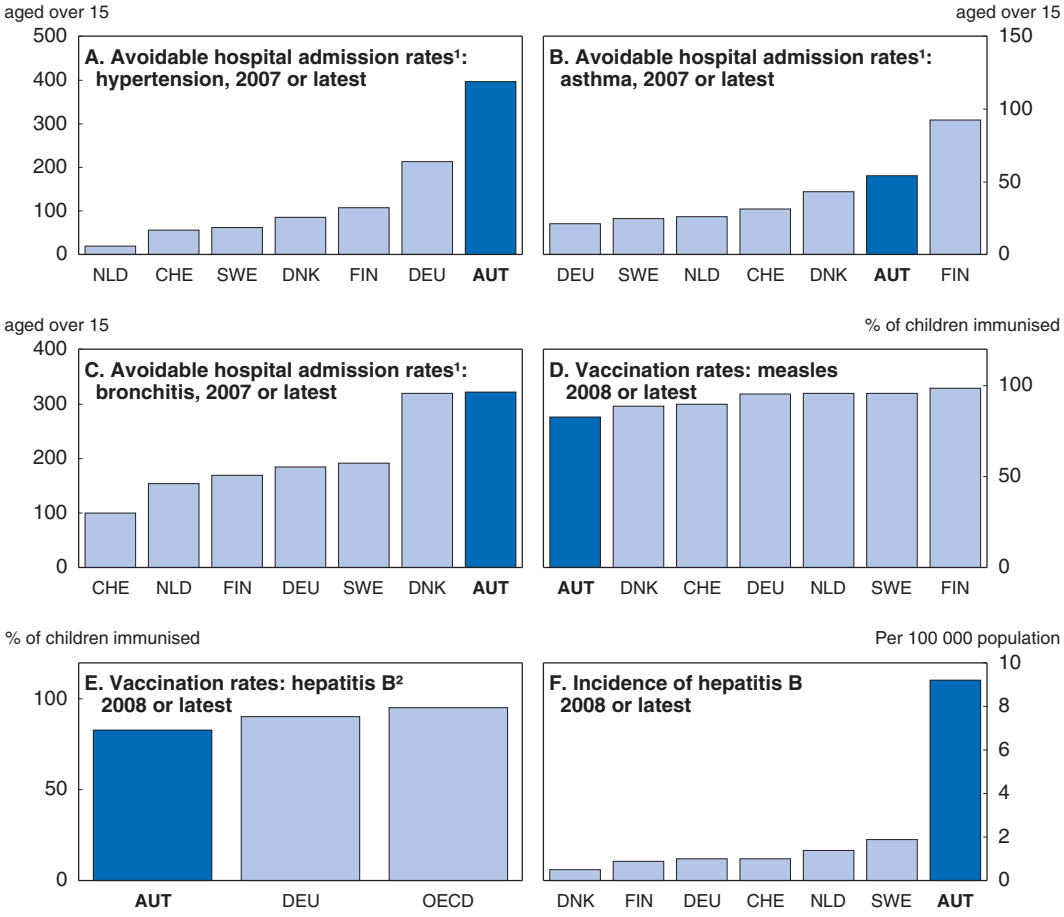
StatLink http://dx.doi.org/10.1787/888932458748

example by a comparatively limited outreach of certain important vaccination programmes.[26] As a result, the incidence of a serious disease such as hepatitis B is higher than in comparable countries. Such shortcomings in quality undermine the efficiency of the health system.

The authorities are aware of the need to reinforce the monitoring of quality. An "Austrian Quality Strategy" (*Österreichische Qualitätsstrategie*) was introduced by the Health Reform Act of 2005, which included a comprehensive federal quality strategy. A *Federal Institute for Quality in the Health Care System* (*Bundesinstitut für Qualität im Gesundheitwesen*) was created,[27] inspired by the system of quality indicators successfully put in place in Germany.[28] Quality reports were to be written on all sectors and professions according to uniform methods, for example in the area of antibiotics use, the use of blood components, microbiological diagnoses etc. However, implementation regulations could not yet be put in place, and quality reporting as requested by the law has not yet come through.

The Ministry of Health re-asserted the need to develop a quality monitoring system in the context of the saving package of 2009. A Critical Incident Reporting System was introduced in November 2009, as a mutual information tool between providers, on adverse events anonymously reported on a web-based system. It is expected to improve patient safety.[29] Partners such as the Medical Chamber and Sickness Funds were also asked to formulate measurable quality objectives, with a view to produce quality reports. However, this wider multi-stakeholder co-operation has not yet made progress.

Figure 2.14. **Other more specific indicators suggest room for improvements**



1. Defined as the number of hospital admissions of people aged 15 years and over per 100 000 population in that age group per year. The assumption behind this indicator is that, given today's treatment options to prevent acute exacerbations, no hospital admission should be necessary.
2. OECD average only includes countries with required or routine immunisation.

Source: *OECD Health Data 2010* and *OECD Health at a Glance 2009*.

StatLink http://dx.doi.org/10.1787/888932458767

In early 2011, the Minister of Health reiterated the importance of quality reporting and proposed a more binding federal quality law applicable to all services provided in the territory. A nationwide quality reporting system ("Health-Q-Reporting" programme) is projected to start in 2011. In this effort Austria could draw on a project starting in OECD's Health Committee to evaluate member countries' quality policies.

Transition to integrated care should be accelerated

Austrian system's excessive bias toward hospital services affects all dimensions of efficiency. This structure makes it difficult to reduce costs, and improve the quality of services through better complementarity between public health, prevention, outpatient, inpatient and rehabilitation programmes. Transition to such *integrated services* is considered today as an international best practice, as recently reiterated by the 2010 OECD Ministerial Conference on Health Policies (Box 2.5).

Box 2.5. **Transition to integrated care**

Transition to "integrated care" is recognized as a common policy priority across OECD countries. It emphasizes patient-centred care, and co-ordination of care between primary and secondary services. It may involve co-operation between specialists within medical teams, and between health and social service sectors. Transition to such integrated services becomes particularly necessary in response to the changing needs of an ageing society, the expansion of chronic diseases, and multi-morbidity (Leutz, 1999; Stein, 2009).

There are numerous models of integrated care being implemented in various countries: disease management programmes, selective integrated care contracts, integrated care groups and medical home models. These models are seen as means of promoting efficiency, and better patient outcomes, as well as addressing the problems of fragmented service delivery. There is an increasing need for new service design, promoting collaboration and co-operation between the different components of the health system.

In Austria, transition to integrated care is slow. As there is no gate keeping' function in the system, General Practitioners do not act as care managers. Different services have firewalls between them, such as clear boundaries between preventive, generalist, specialist, inpatient and rehabilitation services. This segmentation makes Austria's transition to integrated care more difficult, and generates efficiency and quality losses. There is some concern for example that the quality of the important national check-up scheme may have been seriously undermined by the absence of an integrated approach, and capture by special interests (Annex 2.A3).

Federal authorities and local health experts share this diagnosis. Many recent policy initiatives in Austria aimed at fostering new forms of integrated care. Promising results were obtained by certain of these efforts, but they have not altered the inpatient focus of the system. Austria's experience suggests that more systematic institutional changes are necessary to disseminate the new approach. Five recent experiences are worth reviewing:

- *The creation of* "*Land reform pools*". In 2005, a new instrument was created in each *Land* to stimulate greater patient flow between sectors. The Federal Health Agency was asked to draw up *guidelines for co-operation* between inpatient care, day care and outpatient activities. These guidelines were meant to give practical guidance to the reform pools in selecting new types of services to be funded. One per cent of federal health spending was re-directed immediately to these pools, and this share was to be increased to 2% by 2008.

  After a slow take-off in 2006, reform pool projects expanded in 2007, and then slowed again in 2008. The complex governance structure of programmes, which included *all* local stakeholders, limited the innovativeness of projects, and interest declined. An evaluation in 2009 suggested that less than 20% of the resources available in reform pools were actually used.

- *Disease Management Programmes (DMPs)*. These programmes have been the main gate of entry of integrated care in Austria (OECD, 2010 b). The idea was inspired by North American innovations, and was adapted to Austria by *embedding* the treatment of patients with chronic diseases into primary care.[30] This implies making additional payments to General Practitioners to co-ordinate care. Traditionally, GPs have had little incentives to prioritise prevention, or to co-ordinate care. In DMPs, they receive direct financial incentives, and clinical guidelines and technical support. This innovation was

introduced for Type 2 diabetes in 2007, and has developed rapidly. As of 2010, more than 400 physicians were participating. According to an early evaluation (effected in Salzburg, in a large randomized study) the programme has significantly reduced the average glucose concentration of participants, improved hypertension, and increased the uptake of preventive measures. The study will continue to follow patients and will provide information on the long-term effects of disease management.

- The government tried recently to foster "*group practices of physicians*" as an avenue for integrated care supply. Group practices were traditionally rare in Austria, and were confined to specific areas such as physical rehabilitation. In 2009 the government tried to legislate a new legal form for group practices ("Ärzte GmbH") "to better balance utilization and integration of inpatient and outpatient care". However, after strong opposition by interest groups, the proposal was amended in restrictive directions. "Ärzte GmbH" can now be created in single specialties (such as "radiology", "internal medicine", "general surgery"). Only physicians can be shareholders, and cannot employ salaried doctors.
- *Pilot experiments* could play an irreplaceable role in exposing the benefits of integration. Most recently, the Sickness Fund of the self-employed (SVA) started an integration experiment.[31] In agreement with its network of physicians, it launched new coaching and prevention services, inspired by the traditional role of a family doctor. Fund members are not obliged to use these services, but receive a financial incentive if they do so. SVA emphasized that the high education level of its membership is an asset in implementing this "revolutionary new orientation". 2011 will be the first year of implementation of this package.
- *Active, well-informed patients* can also be a driving force in promoting coherent, integrated care. In early 2010, the Ministry of Health launched the "Austria health portal", to help the population to become better informed users of services. The portal offers easy to retrieve information on prevention, diagnosis and treatment options. On the basis of individual tests, specific guidance can be provided. The portal includes also information on the safety records of various drugs. Early user rating of this service has been very encouraging. The authorities announce that in the final phase of its development, the entire population will be given access to their own Electronic Health Records, possibly in relation with preventive applications. Austria's expertise and lead in e-government (OECD 2009e) reinforce the project of putting in place an individual electronic health record infrastructure for the entire population, the ELGA system. ELGA offers the potential of providing the physical infrastructure of many integrated care innovations (Annex 2.A2).

Finally, an idea which has been aired in government circles in recent years, without being put in application, is to give the outpatient wards of hospitals a leading role in promoting integrated care. The 2007 government programme mentioned this possibility. These wards, which are densely available across the territory and enjoy the confidence of the population, could offer a platform for integrating prevention, gate-keeping and care management services. However, they lack their own management and budget structures at this point, and cannot develop into autonomous integrated service entities (they continue to be financed to a large extent from the inpatient budgets of hospitals).[32]

The experience of other OECD countries making good progress with integrated care suggests that both strategic guidance at the policy level, and an open and enabling

contracting environment at the microeconomic level are important for transition to integrated care. Financial incentives to innovative practices also play a role, by reducing the costs of innovation and demonstration (Box 2.6).

Box 2.6. **Open contracting and payment for integrated care: lessons from other OECD countries**

In the area of integrated care, Denmark, Germany and the Netherlands are front-runners. Administrative reforms in Denmark have shifted the focus towards more patient-centred care and a series of health reforms in Germany has paved the way for improved co-ordination of care. The Netherlands has been successful at implementing new chronic integrated care programmes. There are lessons that Austria could draw from these experiences.

In Denmark, a key ingredient was the leadership of the central government (Frølich *et al.*, 2008). A new National Board of Health created in 2007 issued several major health policy documents, including a national strategy on Chronic Disease Management. Eighteen health centres throughout the country were created with a focus on chronic care management and inter-sectoral co-operation.

The Ministry of Health and Prevention started a commission of primary care providers to develop recommendations for possible organisational changes in the primary care sector to support the new integrated care model. New initiatives were encouraged with financial support.

In Germany, similar chronic care initiatives have been supported with federal financial incentives. They are provided to social insurers, care providers, and patients, and have contributed to the rapid diffusion of these programmes in the country.

There is a financial incentive for sickness funds to participate in DMPs. For each patient participating in a DMP, the Fund receives a flat fee. There are also financial incentives for patients (exemptions from standard co-payments) and physicians (a lump sum payment for co-ordination and documentation). In 2009, almost six million patients were enrolled in DMPs, and approximately 60-75% of eligible family physicians participated in such programmes.

Available evaluations indicate that German DMPs have significantly improved quality of care, with better clinical outcomes, and even reduced mortality. They are also cost-effective, as savings from avoided hospitalization are greater than other package costs (Borowitz *et al.*, 2010). The 2004 and 2007 Health Reform Acts in Germany also provided for 1% of contract costs of Sickness Funds to be allocated to integrated care programmes.

In the Netherlands, policies are explicitly supporting the integration between primary and secondary services since 1990s, under the concept of "transmural care". The 2006 Health insurance reform introduced an additional innovation, in form of bundled payment schemes for chronic disease management. Integrated care groups (such as diabetes care groups) allow GPs to enter in joint contracts with health insurers, on basis of such bundled payments. As of January 2010, additional funding for the same type of programmes was made available, termed "patient-oriented funding". This encouraged co-operation between ambulatory and hospital care providers in chronic care groups, by permitting joint payment by health insurers (Groenewegen, 2009).

Progress in all these avenues, including consolidation of capacity planning, utilisation of performance-based payment mechanisms, better monitoring and enforcement of quality standards, and fostering transition to integrated care require not only federal

government action, but also active co-operation and participation by the *Länder* governments and the Sickness Funds. The present institutional fragmentation of the system continues to make such strategic co-operation difficult, as in the past. In this environment, and taking into account the deeply-entrenched political and constitutional sources of fragmentation, all efforts should be made to consolidate public health resources around performance objectives. Performance, financing and spending responsibilities should be assigned more clearly than in the past. When such a clear division of responsibilities proves constitutionally impossible, "joint funds" ("fund pools") consolidating resources from different general government entities may be mobilised. For example, a "federal fund pool" can be created and utilised to help finance innovation and structural change in care supply, to better balance inpatient and outpatient services and to contain costs. In the longer term, a federal fund pool may also be put in charge of hospital investment across the territory, according to national plan objectives. A special fund can be put in charge of public health programmes. As a next step, after a fundamental change of financing structures, the operating costs of hospitals may also be fully paid by Sickness Funds, to which the tax resources (presently mobilised by federal and *Länder* governments for covering hospital costs) can be transferred. Overcoming the high fragmentation of the social insurance sector, by reducing the number of Sickness Funds, may also help. The Federation of Sickness Funds should also continue to centralize functions where there are economies of scale.

Health care policy should also be supported by improvements in lifestyles

Lifestyles are not sufficiently supportive of good health outcomes

The factors other than *access to health care*, but related to *health-relevant lifestyles* and *preventive behaviour* of the population are important determinants of national health outcomes – and costs. This is increasingly better understood (OECD, 2010c). For example, alcohol consumption, smoking, sugar, salt and fat in diet, and exercising, exert a key impact on health outcomes, and costs, via a range of intermediary determinants of health status (the so-called "proximal risk factors") such as overweight, blood pressure, cholesterol levels, blood glucose levels, etc.[33] For national policies aiming at enhancing the health status of the population, while keeping the cost of attaining these objectives under control, monitoring and improving these elements is crucial.

At first sight, standard health-related lifestyle elements in Austria do not differ significantly from OECD averages. They do not put Austria under a favourable light, but are not particularly deficient either. The incidence of overweight and obesity is, for example, slightly lower than OECD averages but higher for the 15 years-old. All in all, the net impact of these factors on life expectancy in Austria was estimated to be slightly negative – two to three months of lost life expectancy – reflecting principally above average alcohol consumption (Joumard *et al.*, 2008).

At closer examination however, there are important sources of concerns. Three problem areas are alcohol consumption, smoking, and diet. 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.[34] 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 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.

An important factor behind these unfavourable outcomes, and which does not herald rapid improvement, is the disappointing health-related behaviour of young generations: Austria's smoking rate among 15 years-old is the highest in OECD, both for girls (30%) and boys (24%). The drunkenness indicators for the same age group are the fourth highest in OECD.

Gaps in health-related lifestyles across social categories may become worrying

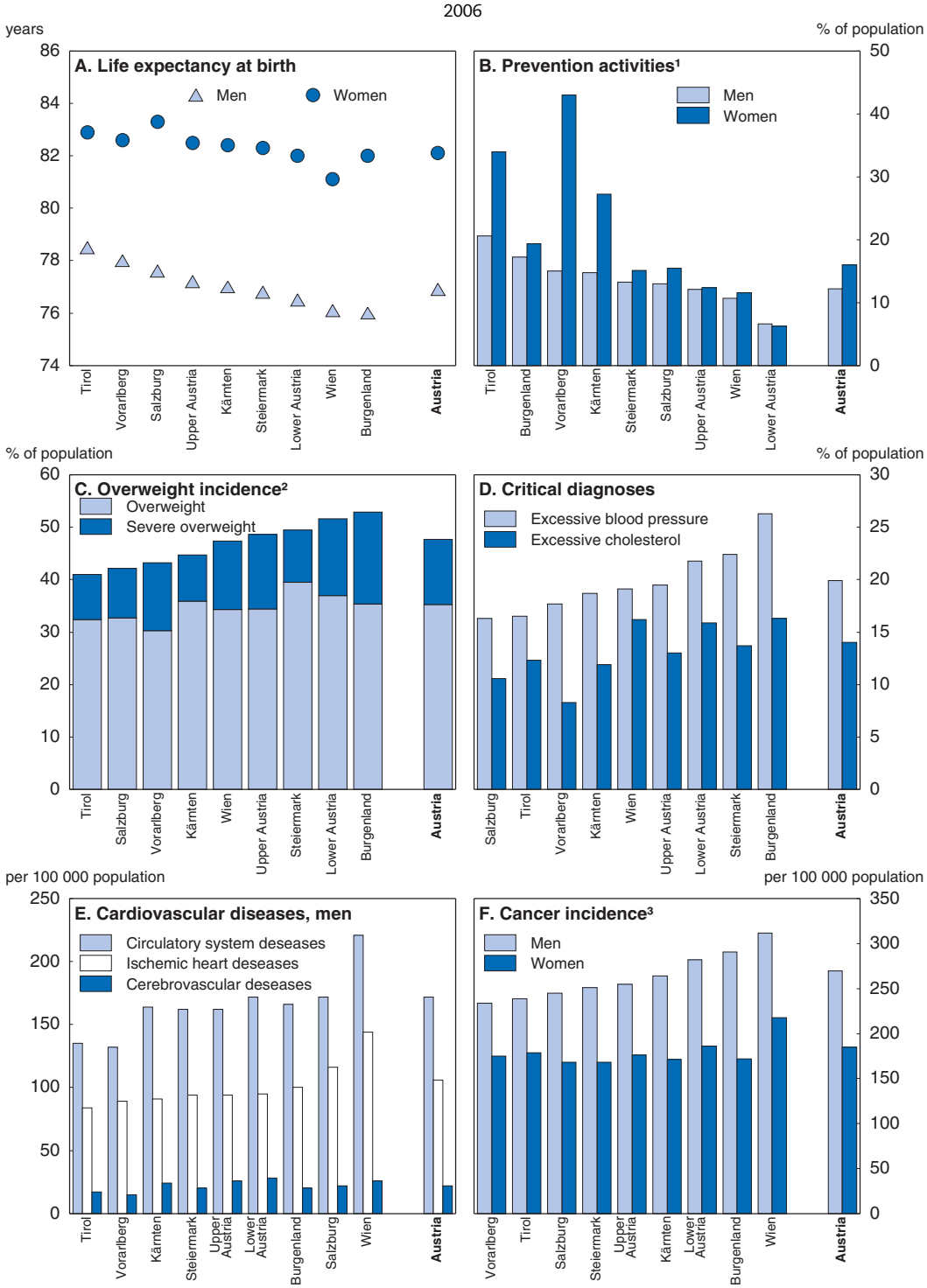
An additional source of concern is the large gap in health-relevant lifestyles between different groups in the population. For example, differences in preventive behaviour are intriguingly large between the nine *Länder* (Figure 2.15). With respect to overweight and obesity, Austria has one of the highest rates of differentiation between occupation-based groups. Also, the gaps experienced by immigrant communities with low average levels of education appear particularly deep (Figure 2.16). Whereas equity of access to the healthcare system is a major national priority, such severe differentiation in health-relevant lifestyles risk counteracting this effort and provoking a worrying divergence in health outcomes. They could also seriously increase the health costs of the population groups concerned.

Recent research showed that income-related health inequality has increased in Austria since 2005, while, in comparison to other countries, the level of this inequality has remained low (Eurostat, 2010). It is observed notably that while the educational background of the population as a whole has improved, and a larger proportion has shifted to lower-risk groups, the difference between the health expectancy of women with a low level of education and those with a medium level of education has significantly increased (Klotz, 2010). Other determinants of these divergences, such as income level, ethnical or cultural origin, and other personal factors have not yet been thoroughly researched. If these differences in preventive behavior and health-related lifestyles are not reduced, total health outcomes will fall short of potential, and the country will be unable to draw all the expected benefits from the high level of resources it is dedicating to the health system.

Such gaps may also have certain systemic implications in the future. Small proportions of individuals with particularly imprudent lifestyles risk generating disproportionally high health problems and costs. The Austrian system functions currently with unfailing social support to full risk pooling. It is estimated that in any given year, 1% of the population with the poorest health conditions receive 30% of total health insurance benefits; the 5% least healthy receive 60% of transfers, while the healthiest 50% consume 3% of total spending. Additional costs arising from unhealthy lifestyles should not undermine the valuable social consensus for risk pooling.

Austrian authorities are aware of the growing impact of the *non-healthcare* factors on health outcomes, and costs, and started to take related initiatives. The national prevention programme is being thoroughly re-assessed (see Annex 2.A3). A "Dialogue on Children's Health" (*Kindergesundheitsdialog*) focuses on vulnerable children. A National Action Plan diet (NAP.e) was launched in 2010, to help improve diet habits. The new *Tobacco Act* entered into force in January 2009, even if implementation seems to lag still behind. Similar campaigns in other countries delivered in many instances excellent results, which is encouraging for Austria.[35]

Figure 2.15. **Health conditions and outcomes differ across *Länder***

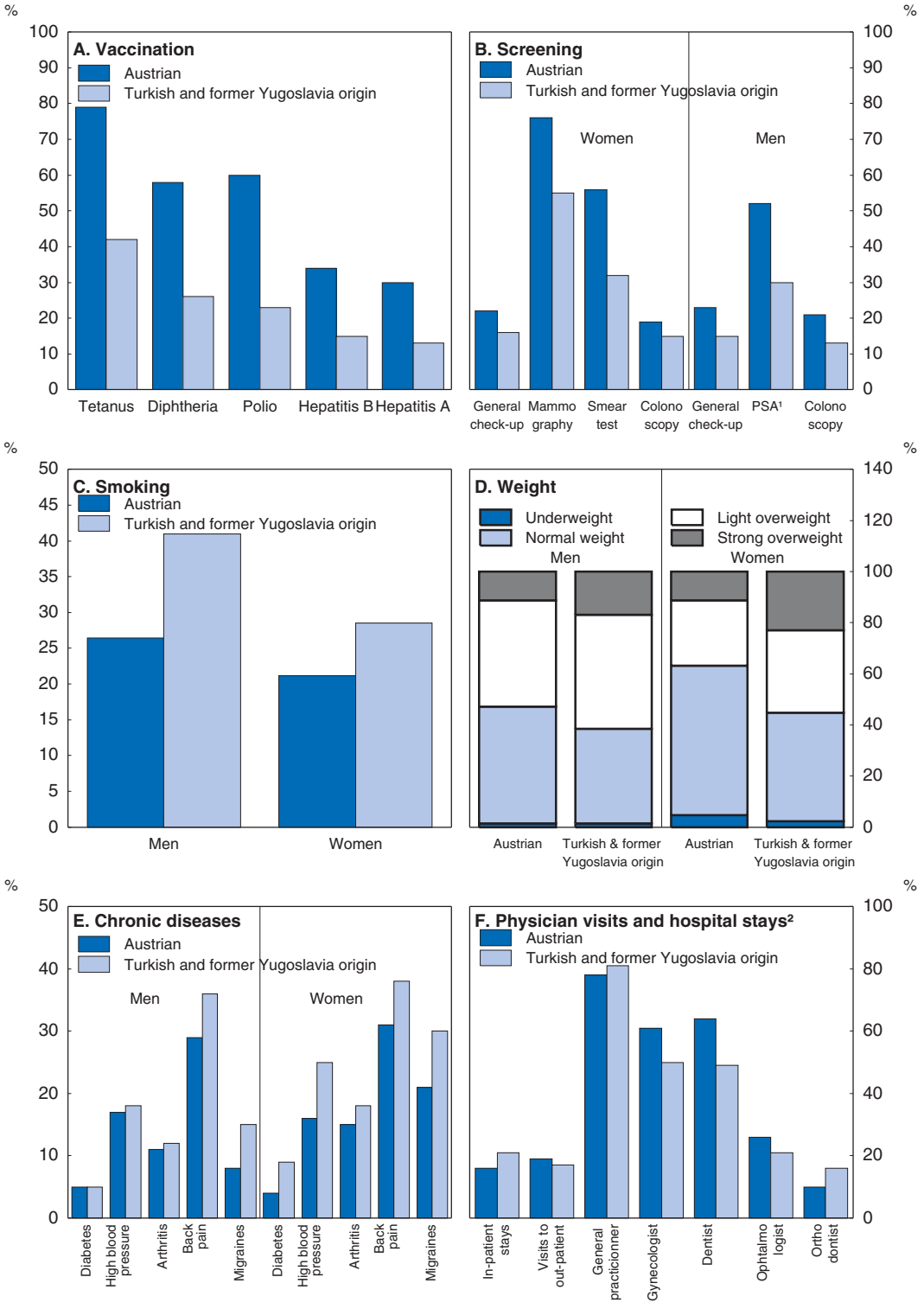


1. Percentage of population which participated each year in the voluntary national check-up programme between 2002-06.
2. Overweight is assessed by the body-mass-index (BMI). A BMI exceeding 25 but less than 30 refers to overweight and more than 30 to severe overweight.
3. All new cases of cancer per 100 000 population.

Source: Verfasst von der Gesudheit Österrich GmbH/Geschäftscbereich ÖBIG, "*Monitoring 2007 zum Gesundheistsbericht Österreich 2004*".

StatLink http://dx.doi.org/10.1787/888932458786

Figure 2.16. **Health-related behaviour differ between native and immigrant groups**



1. PSA – testicular cancer screening.
2. In the last 12 months.

Source: Statistics Austria, "*Sozio-demographische und sozio-ökonomische von Gesundheit*", 2006/2007.

StatLink http://dx.doi.org/10.1787/888932458805

To achieve progress with health-relevant lifestyle factors, at the national level as well as for specific disadvantaged groups, quantitative "health goals" such as target rates of smoking, alcohol consumption, diet, etc., as well as in terms of "intermediary risk factors" such as body mass, blood pressure, blood glucose, cholesterol, etc., levels could be defined as benchmarks and targets for health policy. Monitoring them closely at national and regional level, as well as for specific groups, may usefully inform policy.

Policy recommendations

The policy recommendations of this Chapter are summarized in Box 2.7.

Box 2.7. **Policy recommendations**

Tighten the institutional design of the health system

- Public resources dedicated to health should be further consolidated and be given clear objectives, *i.e.* performance, financing and spending responsibilities should be much more clearly assigned in the national health system.
- The national capacity plan for publicly-funded inpatient and outpatient care should be optimized and enforced, under federal government authority, with the support of the *Länder* governments and Sickness Funds.
- In areas where a clear division of responsibilities between general government entities is constitutionally impossible, consolidate resources in "fund pools", and allocate them according to policy objectives. "Federal fund pools" helping re-balance care supply structures and contain costs, and to steer hospital investment across the territory would be examples.
- To increase policy leverage, the high fragmentation of Sickness Funds should be overcome. One possible step is to reduce the number of funds by merging them.
- The Federation of Sickness Funds (*Hauptverband*) should continue to centralize functions where there are economies of scale. It should continue to co-ordinate the participation of the social insurance sector to reform efforts.

Mobilize performance-based payment mechanisms to improve productivity

- Eliminate the firewalls between physicians' services and hospitals' outpatient wards and contract with both for ambulatory care, in order to trigger more user choice and competition.
- Base fee negotiations with all ambulatory care providers on more innovative cost-saving techniques, to help make converge fees with benchmark cost levels. Aim at gradually expanding the cost based hospital payment system DRG into outpatient care.
- Fully implement the DRG system on all inpatient services and close the loopholes which permit deviations of DRG payments from national cost benchmarks. As a next step – after a fundamental change of financing structures –, make Sickness Funds pay the full costs of inpatient care (on the basis of a transfer to the Sickness Funds of the tax resources currently allocated by federal and *Länder* governments to hospital costs).
- Increase competition in the pharmaceutical market by submitting not only new but also the existing stock' of drugs to health technology assessment, and by authorizing additional generic products when possible.

Box 2.7. **Policy recommendations** *(cont.)*

Emphasise national health and quality goals

- Set national health goals, such as quantified targets for obesity and overweight rates, blood glucose levels and cholesterol levels. Pursue them by a better balance between lifestyle improvement, prevention and curative care.
- Implement more effective public health programmes with respect to nutrition, smoking and alcohol consumption.
- Continue to develop "children's health" programmes which have positive life-long impacts.
- Develop special programmes for vulnerable groups which lag behind in lifestyles and prevention, notably low education immigrant and resident groups.
- Implement fully the national quality strategy in the entire range of health services, if necessary on a stronger legal and regulatory basis.

Promote better balanced integrated care

- Continue to back disease management programmes (DMPs) and diffuse best practices in all chronic care areas.
- Remove legal restrictions for group practices, and for the outpatient departments of hospitals which could become autonomous entities. Do not restrict the ownership structures and employment practices of these operations.
- Authorise Sickness Funds to enter into managed care agreements with polyvalent group practices and outpatient clinics.
- Continue to give high priority to the development of the individual electronic health record-based ELGA system.

Make the medium-term fiscal outlook of the system more prominent

- Focus the post-crisis spending saving measures on structural areas, notably in the hospital sector.
- Make the official health and long-term care spending projections (presently produced in the context of the European Commission) more nationally visible.
- Integrate better the "health care" and "long-term care" components of projections, to better take into account growing demand for disability care.
- Produce national spending scenarios, with a full range of hypotheses on the impact of technological change and future demands for new services.
- Set a medium-term (10-15 years) path for public health spending at general government level.
- Consider making the public health spending at general government level a policy target associated with the multi-year budget framework which accompanies the annual budget law.

Notes

1. The Constitution stipulates that responsibilities for almost all areas of the health care system – with a few exceptions in legislation and implementation - lie with the Federal government. Responsibility for enacting legislation and implementation lies with the nine provinces (*Länder*), while the sanitary supervision of the hospital sector remains the responsibility of the Federal government.
2. "Land Health Funds" financing local hospitals were set up in each *Land* as part of health care reforms in 2005.
3. As termed in the social security law.
4. Reimbursement rates in all ten standard functions of public health packages are each the relatively highest in the OECD (acute in-patient care, outpatient primary care, outpatient specialist care, clinical laboratory tests, diagnostic imaging, physiotherapist services, pharmaceuticals, eyeglasses and contact lenses, dental care and dental prostheses) (Paris *et al.*, 2010).
5. These figures follow the convention taken in all OECD work on health and includes spending for long-term care, as reflected in the *OECD Health Database*.
6. In Austria, the number of magnetic resonance imaging devices (MRIs) increased from 7 per million population in 1996 to 18 in 2008. Well above the OECD average of 12.6. Only Japan, US, Iceland and Italy have higher figures.
7. At 3.4% per year between 2000-09, against 3.3% in Denmark, 3% in Sweden, 2.9% in Germany and 1.1% in Switzerland.
8. There are certain indications that this high degree of accessibility came under pressure in the recent period. Imbalances between demand and supply have emerged in certain parts of the health system. They show in "queues" for certain publicly-funded treatments. There are indications that patients with private insurance can circumvent them, sometime in non-transparent ways. A recent review by Transparency International-Austria reported: *i*) pent-up demand for certain restrained drugs and implants; *ii*) evidence of under-the-table payments to professionals controlling access to these resources; and *iii*) pressure faced by many patients to purchase for-fee services as a way to get access to publicly funded services (quoted by Sanofi-Aventis, 2010).
9. As of early 2009, Regional Sickness Funds had accumulated a total debt of about EUR 1.2 billion.
10. The share of "generics and original drugs priced at generic level" increased from 27% of all prescriptions in 2003, to 46% in 2010.
11. The demographic change will accelerate in the decade 2020-30: the baby-boom generation of the 1960s will then reach the age of 65, and the share of the population above 65 will increase by 4.3 percentage points per year, attaining 24% in 2030.
12. Standard assumptions help outline the impact of ageing on spending. Projections start from two alternative assumptions that they combine in varying proportions: *i*) a *pure demographic hypothesis* (based on stable age-specific disease rates, with longer life leading to longer periods of morbidity and costlier disease treatment), and a *healthy ageing hypothesis* (with the number of years spent in bad health staying constant and remaining concentrated in the latest years in life, with limited impacts on costs). Various combinations of these hypotheses permit to chart the bracket of spending paths.
13. Nine largely identical *Länder* acts followed. Two important agreements between the Federal Government and *Länder* shaped public commitments. A first agreement in 1993 recognised long-term care services as a responsibility of the nine *Länder*, under minimum service standards to be issued by the *Länder* themselves. A second agreement, in 2008, regulated public funding for "24-hour care", a specific type of support where helpers live in the dependent's home and are employed as private household staff. These persons were to be adequately trained. Some *Länder* adopted additional laws on specific types of care services, including for nursing homes.
14. The creation of "acute geriatric" departments in hospitals was a response to this need in the presence of excess capacity in acute care beds. Since 2000, hospitals have charged a flat rate per case for "geriatric medicine". They also pursue research, which can lead to new forms of treatment in age-related diseases such as Alzheimer, Parkinson and complex diabete cases. Well-designed palliative care is also a crucial and sensitive function, essential for the well-being of patients and families. There are innovative case management programmes in this area in certain Austrian hospitals, such as in the University Hospital of Graz.

15. As of 2007, Austria had an estimated 270 000 dependant persons without counting those taken care of by their families. 63 000 of these persons were taken care of in nursing homes, 122 000 received daily visits, and 83 000 received informal care – generally by self-employed immigrants organised by non-profit associations.

16. Fee levels of independent physicians could be expected to interact with the wage levels of health professionals. Similar data is not available for salaried physicians and nurses, but wage premia for young hospital interns and nurses – who do not have sectoral representation through professional chambers – appear to be low. Revenue levels of higher level hospital doctors ("managing doctors") is difficult to monitor because of their multiple remuneration elements, including fees for treating private patients (including private insurance patients) which may be dwarfing their official wages. Reported physician wages differ also across *Länder*. Annual labour cost per physician was EUR 103 000 in Carinthia in 2009, against EUR 85 000 in Tirol, EUR 91 000 in Wien and EUR 94 000 as a national average.

17. The Commission considered that the influence of technological progress on future costs was impossible to predict. Instead, it produced two additional *technology scenarios* on a stand-alone basis, with purely exogenous assumptions. One of these two scenarios will be referred to here as the "EU technology scenario".

18. The IMF considered that these trends are rooted in the structural fundamentals of each country. Alternative assumptions on the size of the impact underpinned one "optimistic" and one "pessimistic" scenario.

19. In recent years, hospitals owned by the municipalities were increasingly taken over by the *Länder*.

20. The study covered 132 "general public" hospitals classified into five groups: "basic profile" hospitals (64), "extended basic profile" hospitals (31), "high profile" hospitals (5), "university hospitals" (3) and "specialty hospitals" (30).

21. Quoted by K. Langbein, 2009.

22. Masterplan Gesundheit, 2010.

23. See above footnote 10.

24. Notably from infectious diseases, and from the diseases of the digestive and respiratory system.

25. Such as the diseases of the circulatory and genitor-urinary systems, and cancers.

26. There are some concerns however that available vaccination data in the Austrian context could be incomplete and may underestimate actiual vaccination rates.

27. Under the auspices of *Gesundheit Österreich GmbH*, the research arm of the Ministry of Health.

28. Germany also initially lacked a satisfactory health service quality monitoring system. An assertive transparency quality policy was put in place in the 2000s, with the creation of the German Institute of Health Quality Standards. The set of indicators developed and monitored by this Institute are considered today as international benchmarks.

29. Hofmarcher, 2009.

30. Austrian and German Disease Management Programs have a similar design. They differ from the original US innovation which embedded this function in integrated service organisations.

31. The Social Security Institution for Trade and Industry (SVA) is the Sickness Fund of entrepreneurs and liberal professions. It has about 700 000 members, composed of 340 000 professionally active, 230 000 dependant family members and 130 000 pensioners.

32. Outpatient clinics could create competition for physicians in private practice, and have in the past stirred opposition from professional organisations. The so-called "outpatient clinic debate" in the 1970s had inspired a verdict by the Constitutional Court that before a permit is granted to an outpatient clinic, agreement is needed from regional medical associations.

33. For instance, obese persons (with a body mass index between 30-35) experience much higher rates of cardiovascular diseases, diabetes and cancers. They incur health care expenditures at least 25% higher than normal weight persons. They also live two to four years less on average.

34. Smoking rates among adults in AUT in 2006 stood at 23.2%, almost equal to the 2008 OECD average of 23.3% - while proactive countries such as the United States and Sweden managed to reduce it below 17%.

35. Such as the *Finnish Coronary Heart Disease Program* centered on dietary change which helped divide mortality rates from coronary diseases by four between 1971-95.

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ANNEX 2.A1

The future of the health system in the national policy agenda

The Austrian population displays a strong attachment to the health institutions, and is concerned about their future fate. A large Europe-wide survey in 2007 (*Eurobarometer 2007*) has reiterated the strong support of the population to the system.

The survey reveals that: *i)* in terms of perceived ease of access Austria ranks number one in Europe: 92% of the population find having easy access; *ii)* in terms of satisfaction Austria is ranked 2nd: 92% of the population think that their system is very good or fairly good; *iii)* in terms of the affordability of the hospital care, Austria is in the top four group: 89% think that it is affordable; *iv)* concerning the quality of family doctors Austria is also among the top four, with 93% thinking it is good, accessible and affordable; *v)* on the quality of medical and surgical specialists Austria is 3rd, with 87% thinking the quality is very good or fairly good.

Perceptions are equally positive concerning the quality of long-term care, but mitigated concerning its availability and affordability. 41% find that long-term care services are not fully available, 56% think that they are not affordable. When asked if they will be provided with the necessary long-term care in the future, Austrians become the 8th most pessimistic in Europe: 30% think that the needed services will not be available.

The latest *Eurobarometer 2010* poll, which was a shorter update of the more comprehensive 2007 survey reiterated the same perceptions: In the area of the overall quality of health care Austria was ranked 2nd, with 95% of the population supportive. The *Euro Health Consumer Index* produced by Sweden's *Health Consumer Powerhouse* also confirmed the positive readings for existing health services. This index measures the user-friendliness of the national health systems – uniquely from a patient point of view.* 38 criteria are applied. Austria had the 1st place in 2007, and the 4th in 2009, after the Netherlands, Denmark and Iceland. The relative weakening in 2009 was due to a missing *unified* benefit catalogue across the territory. The manager of the survey indicated that if such a catalogue was available Austria would regain its top position in Europe (Sanofi, 2009).

All in all, the Austrian population shows very strong support to the existing health services, but also appears to realize that the high concentration of public means in

* The technical basis of this ranking has been criticized, as in other opinion and satisfaction surveys which are not based on objective quality criteria. See Pilchbauer, 2007.

maintaining this system may make responding to new needs relatively difficult. In certain national surveys, more than 80% of respondents suggested that maintaining the quality of the public health system is today's most important national challenge. A majority indicated their readiness to contribute financially more to an effective public insurance system, rather than changing the balance between public and private coverage.

ANNEX 2.A2

Austria's progress with e-health technologies

Austria is building up an important information technology infrastructure for the health system.

First, in 2005, electronic billing was phased-in with the e-card. About 8 million people have an e-card, which is used as identification with providers. In addition to the billing function, the e-card is also used for authorization of certain services, mainly drugs. Total investment outlays for the roll-out of the e-card were in the order of EUR 110 million.

Second, the government made progress in implementing individual electronic health records (the ELGA system). Considering that market failures in the health sector could prevent patient-oriented e-health solutions from emerging, the authorities decided in 2006 that ELGA would be developed as a publicly financed infrastructure, encompassing all providers and patients. For this purpose, EUR 30 million for investment were made available.

While new policy initiatives to better integrate care have often disappointed in recent years, the government´s e-health approach appears promising. It is strategically designed, and, in comparison to what other countries have achieved so far, appears comprehensive and inclusive.* ELGA aims to support integrated provision of care across providers by documenting health related information of patients in a variety of data repositories. Data and information can be retrieved both by providers and by patients. This system will facilitate timely access to patient information by each provider, irrespective of where the provider is located. This will make health-related information centrally available, make it easier for patients to navigate the system, and ultimately has the potential to improve communication and co-ordination of care between sectors. It may also aid better targeting of vulnerable groups such as chronically ill patients. The e-card will be the electronic key to access patient information, and by 2012 it will be used to access relevant health-related information in various repositories. Patient access to their individual data will be possible via a web platform which was launched in 2010 (*Austria Health Portal*, see the main text).

In November 2009, a limited liability company (ELGA GmbH) was founded by all stakeholders. This organisation co-ordinates, builds and monitors the creation of all components necessary to run electronic exchanges across providers, and for access of patients. It is collaborating with European projects in this area.

* A particularly effective e-health record system, permitting to monitor individual health conditions, and adapt prevention and care strategies on an individual basis, is in use in California's *Kaiser-Permanente* health maintenance system (Feachem *et al*., 2002). ELGA has similar objectives.

In 2011, the first ELGA application will be run by using e-medication as a pilot. E-medication permits patients to have their doctors and pharmacists cross-check their medication record, on the basis of information stored on the e-card. The goal is to make drug therapy more effective and safe, by identifying interacting drugs or harmful dosages.

ANNEX 2.A3

Some challenges with the national check-up programme

A risk of loss of quality arising from firewalls between care segments has been pointed out by Austrian health experts in the operation of the ambitious national check-up system.*

Austria is the only OECD country where free medical check-ups every three years are available for the entire population (about 40% of the population take advantage). In 2009, Austria-wide, about 970 000 women and men (12% of the population) participated in this screening program. A comprehensive study by LSE carried out in 2010 for the Federation of Sickness Funds (*Hauptverband*) pointed to deficiencies in the design and implementation of this prevention package: according to this analysis the programme has a limited budget and a large part of this limited budget is spent on poorly-adapted procedures which do not target specific risk groups. The programme risks becoming a supply-pushed non-evaluated scheme, subject to risk of capture by special provider interests.

An illustrative problem is mentioned in the provision of one crucial function in check-ups: mammography screening for women. In this area, the Federation of Sickness Funds (*Hauptverband*) advocated and secured the principle of "double diagnoses", *i.e.* each mammography being followed by an ultra-sound examination in case of uncertainty of diagnosis. This practice may be in accordance with the EC guidelines. The EC, however, only recommends "second readings" of mammograms in case of uncertainty, before recourse to more strict and costly ultrasounds, and some Sickness Funds seem to differ in their interpretation of "uncertainty". Critical observers argue that present arrangements in Austria generate an unduly high proportion of false-positive mammograms, requiring far too many further investigations at excessive costs: 88% of all mammograms are accompanied by ultrasound examinations. They suggest that the designer of the prevention package (Federal Health Agency) did not decide on the basis of evidence-based medical merit, but under unilateral recommendations by service suppliers. They suggest that meeting quality standards in screening would save money for the Sickness Funds. Under the auspices of the *Hauptverband*, a new federal-wide programme is under construction.

* LSE (2010) and testimony by Austrian health experts.

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