Liberalisation, privatisation and regulation in the Austrian healthcare sector/hospitals

Austrian Country Report

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INTRODUCTION

As in other areas of public services, liberalisation and privatisation processes are taking place in the health-care system. However, these are less related to official, uniform political strategies, but are taking place more indirectly and mainly without public discussion. Although the health system is exclusively under the jurisdiction of the member states, the European Union has a relatively large influence on health policies. The terms of the economic and monetary union in particular mean that public expenditure has had to be progressively reduced, which requires repeated rationalisation measures in the health sector. In addition, "modernisation", the restructuring of the welfare systems, is an essential component of the Lisbon competition strategy, which is being pushed forward as a Community task in the framework of the "Open Method of Coordination" (OMC) policy, and one on which the member states orient themselves.

A central survey object of this report is the liberalisation and privatisation tendencies in the health-care sector in Austria, in particular in the field of hospitals. Initially, an introductory overview of the fundamental characteristics of the Austrian health-care sector will be provided and then the role and structure of hospitals will be dealt with in greater detail. The focus of the description is on the aspects of regulation and funding of the health-care and hospital sector and the first tendencies towards privatisation in the sector. Finally, important components of the latest health reforms, the role of the government and other stakeholders, unresolved problems and remaining challenges will be explored.

1. BASIC CHARACTERISTICS OF THE AUSTRIAN HEALTH-CARE SECTOR

In comparison with other WHO countries in the year 2000, the high level of satisfaction and life expectancy, combined with a relatively high degree of fair distribution placed Austria among the top ten countries with the most efficient health-care system (WHO 2000). Satisfaction with the health-care system is generally very high and provision is good. However, the closure of hospitals and a limitation of medical provision are among the new "Austrian's fears for the future" (IMAS 2004).

1.1. Regulation

The safeguarding of health in Austria is a responsibility of government. The political agencies responsible are the various federal ministries – primarily the Ministry of Health and Women (BMGF) – the provinces, the municipalities and the social security institutions. The Austrian health system is shaped by the federal political structure of the country. The regulation of health care consists of a combination between the transfer

of sovereign responsibilities to the social insurance institutions and a regionalisation in the framework of the federal structure. This delegation of responsibilities is laid down in the constitution. Traditionally, the individual sectors of the health-care system, such as outpatient clinics or the inpatient field, are each characterised by different agencies, regulatory and financial mechanisms. However, in the last 15 years inter-sectoral structures, decision-making and funding routes have increasingly been introduced (Hofmacher/Rack 2006: XIV) (see chap. 4).

1.2. Financing, Health Insurance and Services

According to the figures for health-care expenditure under the international OECD standard, in 2004 Austria spent some € 23bn or 9.6% of its gross domestic product on the health-care sector (the average percentage in OECD countries is 8.4%, in the EU 7.5%) (WHO 2006). Without taking expenditure on long-term care into account, which accounted for 10% of total health-care expenditure, the ratio was 8.7% (Hofmacher/ Rack 2006: 105f.).

The financing of the health-care system comes from several sources, which results in a multitude of impenetrable sources of finance flows and forms, whose most important component is the contributions from the social security institutions as self-administered public funds. According to the *Statistics Austria* figures, in 2004 the social health insurance paid 45.3% of health expenditure, the federal government, provinces and municipalities covered 25%.[1] A further 25% of health expenditure in this year was privately funded through indirect coverage of costs (own contributions) and through direct coverage of costs (supplements) (Statistics Austria 2006, quoted in Hofmacher/ Rack 2006: 76).

Statutory health insurance

As in Germany, France and the Netherlands, Austria operates the so-called “Bismarck System”, a system of self-administering social security institutions. These are self-administered public funds and are coordinated by a central body, the Main Association of Austrian Social Security Institutions. The individual subgroups responsible for social insurance are formed by the provinces, professional groups or individual enterprises. Supervision of health and accident insurance institutions is the responsibility of the Ministry for Health and Women. There are currently 24 social insurance providers, 21 of them health-insurers (Hofmacher/Rack 2006: 77).

In Austria there is a statutory insurance obligation and there is no competition between the health boards. The introduction of competition has indeed been discussed, but as a whole and in the long term Austrian health policy operates on the basic consensus to regulate the health sector essentially through plans and service quantities, that is, supply

1 Although some 10% of which came from federal nursing benefit (“Pflegegeld”) which since 1993 has been paid to people in need of care.

oriented, and not on the basis of regulated competition between the health boards (Hofmacher 2006: 235). Social insurance includes health insurance, accident insurance and pension insurance. It is an insurance based on the solidarity principle which is linked to gainful employment. But there are also regulations for old-age pensioners and the unemployed and self-insurance for people not in employment or who are marginally employed is also possible (BMFG 2005: 103f.). The contributions to welfare and health insurance are related to the level of income. These are progressive up to a maximum threshold and then remain at the same level (ibid.). Insurance protection does not just cover the insured person themselves, but also family members such as children, spouses and partners, if these are not insured through their own contributions (BMFG 2005: 105ff.). Statutory health insurance covers approximately 95% of the population in compulsory insurance and a further 2% in private insurance. In 2003, of the remaining 3.1% of the population 0.7% had voluntary additional insurance and 2.4% were not insured. This concerned, for example, a section of the unemployed and asylum seekers (WHO 2004: 25). In principle, people with health insurance have a free choice of service providers in the out-patient sector, which consists of clinics, hospital clinics and largely of individual surgeries (Hofmacher/Rack 2006: XV).

On international comparisons the Austrian social insurance system has a high ratio of co-payment by the patient. Private co-payment is charged for a range of services. Some health boards, such as those for the civil servants and self-employed have a general co-payment rate of 20%. Others have co-payments for particular services. In the last 20 years there has been a significant shift of the financing burden to private households (BMGF 2005: 111).

Slightly more than a third of the Austrian population has private (additional) health insurance. According to the product, for these contributions the insured receive better hospital accommodation, the coverage of costs for the doctor of their choice, the payment of daily benefits in case of illness or the assumption of costs for complementary medical procedures. The number of people with private health insurance has decreased over the last ten years however (BMGF 2005: 110).

Service provision

As in almost all welfare-state countries, the Austrian health-care system is also characterised by a combination of public and private funding and service provision (Hofmacher/Rack 2006: 74). Hospital care[2] is publicly funded and essentially publicly provided. It accounts for approximately 48.6% of health expenditure. In the outpatient area there is a mixture of private and public service providers. Hospital outpatient departments are relatively important here and in recent years this importance has increased (Hofmacher/Rack 2006: 127). Hospital outpatient departments are an important interface in the Austrian health service. They are available sometimes on a 24-hour basis for emergency care and specialist acute care as well as for aftercare and screening, and can be chosen directly on presentation of a health insurance certificate (ibid.: 135).

2 Including hospital out-patient departments and clinics.

Part of the outpatient care, in particular general practitioners and specialists (private practice) is publicly funded but privately provided. This accounts for some 22% of health-service expenditure (ibid.). 21% of expenditure for services are paid for privately, but provided in public institutions. A ratio of 9% is privately funded and produced by private service-providers. This essentially includes services that are not in the list covered by health insurance.

Table 1: Public-private mix of funding and service provision, in per cent 2003[3]

	Expenditure		
Provision	public	private	total
public	48.6	20.7	69.4
private	21.5	9.2	30.6
Total provision	70.1	29.9	100.0

The Austrian health-care system is characterised by a high level of hospital visits, which is evident on the one hand in that a large part of expenditure goes to hospitals and on the other in the important role played by hospital clinics in outpatient treatment.

Employment

After the provision of company-related services, the health and social services sector is the area with the second highest contribution to employment growth in the EU. Austria is no exception in this respect. From 1995 to 2004 the health sector grew twice as strongly as the service sector and eight times as fast as employment growth in the economy as a whole. In 2004, 171,972 people, or 5.6% of the directly employed population were employed in the sector of health, veterinary and social services. This does not include those employed in the public administration of health care or in social insurance, so that the proportion of those employed in the health-care system is underestimated. In addition, the health and social services sector is an important labour market for women. Today, more than three quarters of those employed in this sector are women. In the economy as a whole, two fifths of employees are women (Hauptverband 2004/2005, IHS 2005 quoted in Hofmacher/Rack 2006: 158).

In 2003, 113,608 people were employed in the health-care system (that is 69% of the total economic field of health, veterinary and social services). Of these, 33% were doctors and 51.5% nursing staff. In the hospitals in 2003, 20.1% were doctors and just over 60% nursing staff. The strongest growth in people employed in hospitals in the period surveyed was among the medical-technical specialists (Statistics Austria 2005, IHS Health Econ 2005 quoted in Hofmacher/Rack 2006:159). More than 83.8% of all hospital staff are employed in the public hospitals (Statistics Austria 2003 quoted in

3 Sources: BMGF, Main Association of Austrian Social Security Institutions, 2004, IHS Health Econ calculations, 2005 (quoted in Hofmacher/Rack 2006: 74).

Hofmacher/Rack 2006: 141f.). Since 1970, there has been a continuous increase in medical personnel. The coverage density of doctors is rising and is around the EU average (ibid.: 159).

Measured against women's incomes as a whole, this occupational area offers above-average income opportunities. Gender discrimination, however, becomes clear in the fact that average incomes in the health services are lower than the general average income (Streissler 2003: 279). The incomes in the sector are 12% below median incomes and approximately at the level of incomes in retail trade, which are generally below average (Hofmacher/Rack 2006: 202).

1.3. Problems and Challenges

As a rule, expenditure in the health services is rising faster than incomes. This causes chronic financing problems for the system, which repeatedly requires reform. Fundamental changes in the health-care system in Austria are hard to implement. The constitutional requirement (a two thirds majority in parliament) means that they require a broad political consensus.

The developments in the income of health insurance in Austria are heavily dependent on the labour market, because they are linked to wages and salaries. While expenditures progress in parallel to GDP, the health-insurance contributions lag significantly behind economic growth (Streissler 2005: 122). This is due on the one hand to the falling wage ratio (wages and salaries are growing more slowly than GDP) and the spread of atypical forms of employment that are not subject to compulsory insurance.

Furthermore, health expenditure can be controlled only with difficulty. Despite their role as funders, the health boards can hardly intervene in the management of hospitals (Streissler 2004: 25). On the one hand this is a result of the specific features of Austrian regulation of health care. On the other hand it has to do with the general supply-driven demand in the health service in which doctors are essentially able to influence the quantity of medical services demanded of them (ibid.). In the hospital field, as a result of specialisation, this is even more the case than in general practice. Despite of this the highest expenditure growth rates are in the field of medicaments, owing to patent protection and the monopoly market structure (Streissler 2005: 123).

2. HOSPITALS

2.1. Structure and ownership of hospitals

Care in Austrian hospitals is overwhelmingly publicly organised and provided with the aid of private, non-profit owners, who sometimes also have rights in public law. As far as ownership structure is concerned, there are three types of hospitals: 1) state hospitals

(owners: municipalities, provinces or social insurance boards), 2) private, voluntary-sector, non-profit hospitals (owners: religious orders, charitable associations) and 3) private, profit-oriented hospitals (owners: private individuals, public and private limited companies). Furthermore, the Austrian hospital landscape is characterised by a multitude of small hospitals (BMFG 2005: 55).

Table 2: Trends in the number and ownership of hospitals and hospital beds in Austria 1990-2003[4]

	1990		2003		Change	
	absolute	percentage	absolute	percentage	absolute	percentage
Hospitals						
Public	163	50.9	133	48.9	-30	-18.4
Social health insurance	43	13.4	40	14.7	-3	-7.0
Non-Profit	64	20.0	52	19.1	-12	-18.8
Private	50	15.6	47	17.2	-3	-6.0
Total	320	100.0	272	100.0	-48	-15.0
Beds						
Public	50153	68.3	45814	67.7	-4339	-8.7
Social health insurance	6138	8.4	5744	8.5	-394	-6.4
Non-Profit	13780	18.8	11863	17.5	-1917	-13.9
Private	3308	4.5	4287	6.3	979	29.6
Total	73379	100.0	67708	100.0	-5671	-7.7

In 2003, in-patient medical care in Austria was provided by a total of 272[5] hospitals which between them had 67,708 beds. In terms of the population there were thus 8.4 beds per 1,000 inhabitants (BMFG 2005; 54f.). 48.9% (133) of all Austrian hospitals are state-run. These, however, have more than two thirds (70.3%) of Austrian hospital beds. The social insurance institutions operate 40 hospitals, or 14.7% of all hospitals. In addition there are 47 private, charitable, non-profit-oriented hospitals, which represents 17.2% of all Austrian hospitals. 19.1%, or 52 hospitals, are private, profit-oriented hospitals. In comparison to 1990, in 2003 there were 48 fewer hospitals, a reduction of 15%. The reduction was particularly marked in hospital locations in public and non-

4 Sources: Statistics Austria, 1990 and 2003, IHS Health Econ calculations, 2005 (quoted in Hofmacher/ Rack 2006: 143).

5 The following data relate to 272 hospitals. These provided the data to the Ministry of Health and Women. The figures given are partly not immediately internationally comparable, as the following items are included in Austrian hospital statistics: day clinics, one-day care (therapies) semi-in-patient areas, some nursing homes and departments that do not necessarily have hospital status in other countries (this increases the total number of in-patient stays) (BMGF 2005: 54-56).

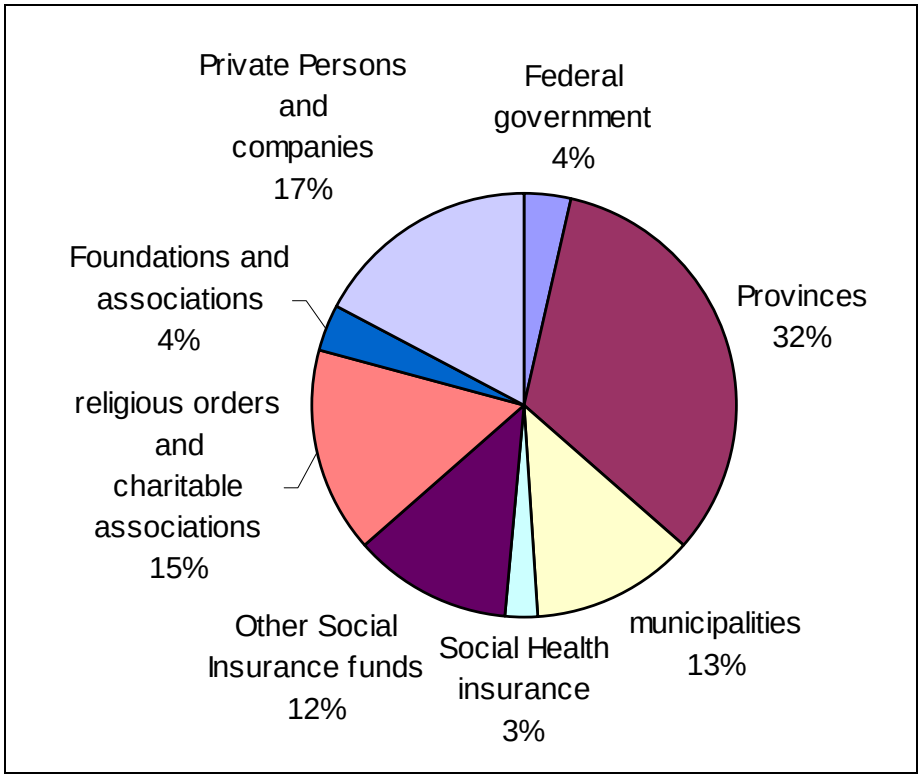
profit institutions, more so among the latter. In contrast to all the other providers, there are more beds in private hospitals than in 1990 (plus 30%, or 979 beds) (Table 2).

Table 3: Ownership structure in detail of Austrian hospitals [6]

	number of hospitals	percentage	number of beds	percentage
Owner				
Federal government	10	3.7	566	0.8
Provinces	89	32.7	35 404	52.3
municipalities	34	12.5	9844	14.5
Social Health insurance	7	2.6	1100	1.6
Other Social Insurance funds	33	12.1	4644	6.9
religious orders and charitable associations	42	15.4	10 873	16.1
Foundations and associations	10	3.7	990	1.5
Private Persons and companies	47	17.3	4287	6.3
Total	272	100.0	67 708	100.0

6 Source: Statistik Austria 2003, IHS Health Econ calculations 2005 (in Hofmacher/ Rack 2006: 141).

Figure 1: Pie chart of ownership structure of hospitals



2.2. Regulation

As laid down in the constitution (Art. 12 Federal Constitution Act) almost all areas of the health system in Austria are primarily under the competence of the government. The hospital system is an exception. Here the government is only responsible for legislating the basic principles. Implementation laws and the execution of them, including the guarantee of hospital care, is the responsibility of the provinces. The provinces and the municipalities are responsible for the provision of hospitals and the maintenance of the infrastructure. In this they are bound to the general framework legislation of the national government and thereby to the nationwide planning and standards (Hofmacher/Rack 2006: 59). The planning and regulatory competence of the social insurance in the hospitals, in contrast, is relatively limited (ibid: 230). Whereas a hospital is subject to public law and thereby to a statutory care and admissions law, private, profit-oriented hospitals can refuse admissions (ibid: 136).

National level

In the in-patient sector, the performance profile and the financing is regulated in the form of national cooperation instruments and the laws implementing these agreements. Since 1997 the government has assumed the role of a quasi-legally defined regulatory authority that promotes the agreement of standards for national in-patient care and can

apply sanctions if agencies do not adhere to the treaty (Hofmacher/Rack 2006: 230). Sanitary oversight of hospitals is a duty of the district administration authorities in the framework of the federal administration and is provided for by the medical health officers. Private hospitals and all institutions that have been approved as independent clinics are also subject to this oversight (ibid: 230).

An important instrument of health policy since 1997 is the Austrian Hospitals and Major Equipment Plan (Österreichischer Krankenanstalten und Großgeräteplan (ÖKAP/GGP) for publicly funded hospitals. This legally binding plan is continually updated and regulates the locations and capacity planning (beds, specialisation structures and technical equipment) for hospitals (BMGF 2005). These regulations are binding, and in cases of non-adherence the government can block payment of funds to the provinces for financing hospitals. (Hofmacher/Rack 2006: 198). The ÖKAP was replaced in 2006 by the Austrian Health Care Structural Plan (ÖSG), which includes a new planning method – "service-provision planning" – that establishes the minimum supply or minimum amount of medical services required on the basis of model and prognosis calculations. The ÖSG is a planning framework with a target date of 2010 and encompasses not only the hospital area but also the whole health-care structure and defines criteria for effective management at the interfaces between these areas of care. The emphasis is now on the development of an integrated system (BMGF 2005: 57f.).

Provincial and municipal level

In most cases the province is the majority shareholder of a hospital. The investment and running costs of the hospitals are borne by the owner or legal entity, the provinces (Hofmacher/Rack 2006: 192). At hospital level there is a separation between service provision and payment through the outsourcing of the management of public hospitals to private hospital-operating companies (ibid.: 61) (for more detail see 3.1). The hospital holdings are organised differently and now exist as providers of hospital services to the provincial health fund as the customer (ibid.: 192). Provinces and municipalities usually assume liability for any failures (ibid.: 192). Private hospital owners and private non-profit hospitals are increasingly formed in operating companies that to some extent are organised nationwide (ibid.).

Hospital level

The internal management of hospitals is usually carried out by a committee (collegial management). It consists of representatives of the doctors, the nursing and administrative staff. Usually there is also one representative of the technical staff present as well, according to the level of care. These committees are also responsible for the implementation of quality-control measures. All decisions concerning the running of the operation are to be taken cooperatively. The filling of the management positions is either undertaken by the hospital operating companies or the responsible authorities after public advertising of the posts (Hofmacher/Rack 2006: 62).

Table 4: Regulation actors and instruments of public hospitals

	Quantity of hospitals	Quality of hospitals
Federal government	location and capacity planning (ÖSG)	general framework legislation: nationwide planning, standard-setting and sanitary oversight (also for private hospitals)
Provinces		implementation: provision, maintenance of infrastructure, responsibility for investment and running costs
Hospitals		control-measures, management

2.3. Financing of hospitals

Hospitals are the most expensive area in health care. In-patient care consumes almost 38.9% of public expenditure. The expenditure on this area of care has risen by 2.4% since 1995. However, in this component there is also expenditure that falls to the hospital out-patient clinics Some 12% of the fund-hospital costs go on services in the hospital out-patient clinics (Statistics Austria 2004, BMGF, Hauptverband, IHS 2006 quoted in Hofmacher/Rack 2006: 111).

The public law governing hospitals includes legally prescribed subsidies of the public sector for the running costs (Hofmacher/Rack 2006: 136). Most public hospitals are so-called fund hospitals, which are financed by the provincial funds.[7] Non-profit hospitals, too, can have rights under public law and thereby the right to subsidy (ibid: XVII).

Whereas doctors in practice are paid exclusively from health insurance, for hospitals there is a mixed system. Some half of the costs of the hospital are financed from tax revenues. Alongside the provinces, the municipalities, the social insurance, private insurance and patients are involved in hospital funding (ibid: 70). These pay into the nine provincial funds. The largest proportion is assumed by the social insurance. The fund-hospital costs in 2004 were € 8.5bn; the social health insurance financed 40% of this, private insurance 7.4% (for accommodation in the special class) and private households through co-payments 3% (ibid: XVII). This system leads to the situation that provinces, municipalities and hospitals have a great interest in as many patients as possible being treated by general practitioners, because this does not incur any costs for them. Conversely, the insurers prefer it when patients are sent to hospital, as in that case their contribution is capped (Rümmele 2005: 77). The health insurance boards do indeed have to pay for a large part of the hospital financing, but they have hardly any right to a say in the hospitals that are run by the provinces and municipalities.

Since 1978, hospital financing has been governed by constitution-based, time-limited treaties[8] between the national government and the provinces. The funds are transferred

7 The classification “public” and “fund hospitals” is not quite identical. Some are public but not fund hospitals and others are fund hospitals but not public (Streissler 2004: 29).

8 In the framework of the ”financial balancing negotiations”, the general negotiations on the federal distribution of the budget between the government and the provinces.

to nine "provincial funds" according to an agreed distribution pot and then passed on to the hospitals by the provinces. (Streissler 2004: 30). The provinces are responsible for ensuring the financing of the hospitals. There are considerable differences between the provinces with regard to the criteria for the disbursement of budgetary funds to the hospitals, the bed density and the level of investment as well as the costs for acute in-patient care. (Hofmacher/Rack 2006: 198). This causes considerable difficulties in presenting or checking the financial behaviour of the individual provincial funds or the hospital companies and hospitals (Streissler 2004: 31). In addition, in some provinces the hospital costs have been separated from the provincial budget by outsourced operating companies or through other methods (ibid: 14). If the costs for hospitals are not a component of the provincial budget they are also not subject to the Maastricht criteria.

Before 1997, financing took place in the form of undifferentiated daily flat rates. Since 1997, part of the operational running costs of hospitals has been billed on the basis of the "Leistungsorientiertes Krankenanstaltenfinanzierungssystem" (LKF), the DRG (Diagnosis-Related Groups). If this is insufficient to cover the costs of a clinic, the providers themselves (provinces and municipalities) are liable for the losses. The DRG system is a per-case flat-rate system which makes hospital financing possible on the basis of services actually rendered in the fund hospitals. The basis for the calculation is a points system, incorporating both medical, economic and statistical criteria, which is being continually revised (Hofmacher/Rack 2006: 192f.). The DRG control field can be adjusted according to province and makes it possible to take into account the structure-specific criteria of the provinces. (ibid.). 75% of fund-hospital expenditure is covered by DRG proceeds. The rest is covered by the provinces half each through supplements and benefits (affected by Maastricht criteria) and through loans and drawing on reserves (not affected by Maastricht criteria) (Streissler 2004: 60). Since 2002, private, for-profit hospitals and sanatoriums have also been financed according to the DRG system, and indeed from the funds of the Private Hospital Financing Fund ("Privatkranken-anstaltenfonds" – PRIKRAF). The PRIKRAF is the equalisation department for the services of private hospitals that are obliged to provide a service of the social health insurance. It is fed by area health boards and company health insurance as well as by special insurance companies and reimburses private for-profit hospitals' services to socially insured patients (BMGF 2005: 111).

Private co-payments

In-patients pay an additional fee of € 8 per day for a maximum of 28 days a year. In the course of the 2005 health reform, the possibility of raising this fee to a maximum € 10 was delegated to the provinces. This fee is collected directly by the hospitals. Here people who have already paid co-payments, people in need of social protection and particular insurance cases, such as maternity, organ donors, dialysis, etc, are exempt (BMGF 2005).

Patients' private health insurance is an important additional source of income for doctors working in public hospitals. Since payment in the public sector is seen as being relatively limited, these additional earnings are seen as an incentive to attract highly

qualified medial personnel to the public sector (Hofmacher/Rack 2006: 201). The number of special class beds for those with private insurance is legally not allowed to exceed 25% of total bed capacity. This condition entails an incentive for hospitals to keep the total number of beds high (ibid.).

2.4. Problems and challenges

The fragmentation of responsibilities in particular in the hospital field, and the accompanying "dual" financing have long been considered the most important structural problem in the Austrian health system (Hofmacher/Rack 2006: 232f.). A change in the mode of financing would require a change in the national constitution, which needs a two-thirds majority in parliament. In this connection the demand is often raised for a centralisation of competences. However, since 1997 ever-increasing decentralisation has been seen in the sense of the delegation of tasks (Hofmacher 2006: 232). In addition, the separation of service provision and financial responsibility is problematic, which not infrequently leads to an oversupply in hospitals and excessive capital intensity in treatments, as capital is quasi-free for the individual hospital (Streissler 2004: 38).

Furthermore the problem of the hospitals is not just in the rapidly rising costs but also in growing personnel shortages and the rising burden on doctors and nursing personnel as a result.

3. LIBERALISATION AND PRIVATISATION IN THE HEALTH SECTOR

In Austria, it is true, there is officially consensus that the market-economy provision of health services is incompatible with welfare-state objectives (Hofmacher/Rack 2006: 209). Nevertheless, an increasing economisation of the health system is taking place, and the first and growing privatisation tendencies can be observed. In the hospital sector, in particular in recent years, reforms have been drawn up in an essentially more market-driven form, relatively unnoticed by the general public. These developments are closely connected to the discussion of the funding crisis in the public health system, the growing interest of private providers in special areas of the attractive growth market of health care, and finally the efforts of the WTO and the EU, now to liberalise the health-care system alongside the other public services.

Liberalisation policies on the international level

In contrast to other public services, such as postal services or electricity, from the European Union there is no standardised or official liberalisation strategy with a route map and timetable. The efforts to liberalise the health-care sector are increasing, however, and taking place in a more indirect and less obvious way. This may also be

associated with the fact that the liberalisation of the health-care sector is still politically highly contentious.

Since 1995, the pressure for liberalisation has been coming in particular from the WTO in the framework of GATS (General Agreement on Trade in Services) for the worldwide liberalisation in trade in services. WTO member states can make lists of the areas that they would like to see liberalised in other treaty states. In 2001, the EU Commission drew up a list that included the field of health care. After massive public protest, part of the list – including health – had to be withdrawn (Rümmele 2005: 49).

The health-care and social-insurance systems are indeed the areas of social policy that are under the sole competence of the individual member states. However, EU competition and internal market policy has had massive effects on the social and health-care policies of the member states (Streissler 2005: 124). Initially, it is the Maastricht criteria of the economic and monetary union that permit the nation states ever less room for manoeuvre in public expenditure, a large proportion of which goes on health care. Furthermore, in the framework of the Lisbon strategy and the European Social Agenda, under the catchphrase "modernising social protection" the national systems were called on to consolidate their health-care systems. In addition, the basic freedoms of the internal market (free movement of people, goods, services and capital) increasingly became the subject of law suits at the European Court also over the health-care system. In recent years European Court verdicts on health have already led to some changes in the labour market, the pharmaceuticals market, in the field of health insurance and hospital investment (Streissler 2005: 124).

3.1. Privatisation in the hospital field

The liberalisation and privatisation as a rule happens in a rather hidden way and without a broader public discussion. The question and the problem of how to finance the hospitals are usually used to legitimise privatisation. Competition – according to the proponents of liberalisation – would lead to price reductions and private providers are more efficient and would also improve the quality of hospital care (Rümmele 2005:40).

In general the pressure on clinic operators to act increasingly as market-economy companies is rising; hospitals are then usually attempting to reduce services and to cash in on additional income (ibid.: 137f.). Savings and efficiency benefits (service areas are merged or completely outsourced, purchasing is bundled) are then primarily possible in hospitals if larger business units are formed. A public owner can also do this, a private one will do so in any case (ibid 2005: 81). For private providers it is in any case favourable if the public authorities have already created bigger units in the run-up to outsourcing and privatisation. In a privatisation, one then often takes over a regional monopoly (ibid: 81f.). The formation of large units of public hospitals can currently be observed above all in Austria and Germany. In Austria since the 1980s, hospital groups belonging to the province have emerged in almost every federal province. Many

municipalities have sold their hospitals to the provinces[9] and these have then incorporated them in larger units, in hospital companies or holding companies, such as *Kages* (Styria), the *Vorarlberger Krankenhausbetriebsgesellschaft* (Vorarlberg Hospital Company) or the *KAV* (Vienna Association of Hospitals). These are sometimes among the biggest employers in their provinces, even ahead of the major industrial companies. The bigger companies in Vienna or in Styria are already almost as large as private American or German clinic chains and they also act in a similar way (ibid: 82).

Public Private Partnerships

The most widespread variant of Privatisation in Austria is that of the *Public Private Partnerships (PPP)*, that is, cooperation between private companies and the public authorities, which can be organised in various forms. The most widespread PPP variant in Austria is the above-mentioned so-called *organisational privatisation*[10] of hospitals. As a result of this there is a separation between the provider of funds and the provider of services, and the hospital is economically but not organisationally independent. In the meantime, every province apart from Vienna is introducing companies organised according to private law for the running of public hospitals. The organisational forms of the companies differ, but they share the feature that the owners (the area bodies) usually assume responsibility for any failures. The private company thus assumes no risk for possible losses, the PPP contracts are time-limited and the public partner can also lay down standards for the running of the hospital (Rümmele 2005: 80). Private, non-profit hospitals that in part have public-law rights, have also increasingly formed themselves into operating companies (Hofmacher/Rack 2006: 136f.).

In the framework of the PPPs, private companies can also take over particular services that the hospital has outsourced, such as cooking, laundry, but also complete technical operations management. A hospital can also, for example, conclude a contract with an X-ray institute or a laboratory for a particular service. As a result of the outsourcing, personnel costs in particular are saved or there is a budget rededication to material costs (Rümmele 2005: 133).

Within PPPs, private companies are also being increasingly involved in the financing of investments. They take over the costs of building or renovating a hospital and receive payment for it (ibid: 36). At the end of the 1990s, *sale-and-lease-back deals* were widespread. Municipalities hoped for proceeds in the millions as a result. Here a gap in the US tax system was exploited. The government, provinces and municipalities sold canal networks, railway stations, railway stock, track networks and hospitals to US investors and leased them back from them on long-term leases. Both sides were able to make a small profit, but the actual effect of these deals will only be known after 15-20 years when the first contracts expire (ibid: 57).

9 Ever more frequently, financially weak municipalities negotiate with private clinic operators over the sale of hospitals, but overwhelmingly they nevertheless ultimately sell their hospitals to the provinces.

10 "Organisationsprivatisierungen", the separation between service provision and payment through the outsourcing of the management of public hospitals to private hospital-operating companies.

Sale of hospitals

In genuine privatisation, the public partner leaves completely and the private company can decide for itself what services it offers at what prices. This is limited, however, if it agrees service contracts with public or private insurers. Normally, these insurers will set standards concerning what it has to offer, or they buy services of a particularly defined quality. The room for manoeuvre for a private hospital is very dependent on the provincial legislation. Thus private hospitals may only be an additional option for wealthy or privately insured patients, which is partly the case in Austria. Private hospitals, however, may also be on an equal footing with public ones – they then assume a public care contract (Rümmele 2005: 81).

Examples of different forms of privatisation

Since 1999, two hospitals (Kitzbühl and Kapfenberg) have been sold to private companies (ibid.: 87). In two others (NRZ Rosenhügel and Neunkirchen) the management was transferred to a private company and five hospitals (Vöcklabruck, Steyr, Schladming, UKH Linz and Neunkirchen) were or are being renovated or newly built with private assistance (ibid.: 86f.) In addition, in 2003 the province of Styria attempted to transfer the management of all its 24 hospitals *(Kages)* to a private clinic operator. The attempt failed on the resistance of the doctors and the public as well as on the standards required by the province, where the interested parties saw too little room for manoeuvre (ibid.: 87). At the same time, privatisation discussions on the Hanusch hospital of the Vienna health insurance board broke out several times in 2002 and 2004. The hospital is run as a reference hospital and skills centre for all other health boards to study the running of a hospital and its procedures. The proponents of the sale, above all the government, see the hospital as an economic burden on the health insurance boards and as the main cause of the enormous deficit of the Vienna health insurance board (WGKK) (Rümmele 2005: 24).

3.2. Private providers

In Austria, too, the number of new companies and financially strong investors who would like to take over hospitals is rising. These are on the one hand international groups, such as the German *Sana* group or the German *Helios* clinics, and on the other hand Austrian providers.

Austrian private health insurers jointly own a hospital company, *Humanomed*. This operates sanatoriums, private clinics, outpatient clinics, old-peoples' homes, spa homes, thermal spas and a consulting company, which according to its own definition has specialised in the breaking up of publicly administered hospitals into private legal forms (Rümmele 2005: 88). In 2003 it tendered for the management of the Styrian *Kages* together with the German *Sana* group (a German private health insurer).

In addition, the major construction companies in Austria cooperate with hospital specialists and thus attempt to use PPP models to get into business from construction to

operating management of hospitals, which so far only one company has succeeded in doing however. At present, therefore, they are mainly investing abroad, in Germany and eastern Europe (Rümmele 81). The most important partnerships are *HCC Krabag* (Health Care Company Krankenhaus Betriebsführung AG (owners: Haselsteiner family private foundation), the *Raiffeisen Holding NÖ-Wien* and a Carinthian private hospital operator.

The great role model for these companies is *Vamed AG*, which is so far the only one active in the Austrian market. This emerged around the public construction scandal of the Vienna General Hospital (AKH), completed the construction of the AKH and is today responsible for managing its technical operation. The company is under majority ownership of the German medical technology group *Fresensius*, which also runs hospitals in Germany through a subsidiary company. Apart from this, *Siemens Health Management GmbH* is tendering for hospitals, radiotherapy, construction and house technology and financing, in the hope of being able to work in the eastern European market alongside the Austrian (Rümmele 90f).

3.3. Open questions and challenges

In the health-care sector too, there is a tendency for private providers to engage in cherry picking. They tend towards patient selection, picking out the easier, and lower-risk cases. The data of the Austrian DRG system also show this (Streissler 2005: 128). Private companies usually limit themselves to standardisable, and therefore lucrative treatments. Risky treatments and expensive acute capacities still have to be paid for by the general public (Rümmele 2005: 15). Furthermore, the private operators use the public infrastructure inasmuch as they locate themselves in the vicinity of the best public hospitals. Thus today the greatest number of health institutions is in the vicinity of the AKH (Vienna General Hospital), as in emergency the best hospital in Austria is nearby and there is a high level of specialist skills coordination (ibid.: 29). Many AKH doctors have practices in private clinics around the AKH or are involved in private institutes (ibid.: 30).

Private operators can indeed operate to some extent more cheaply, because they usually save on personnel. Thus they usually employ their staff on worse collective agreements or work predominantly with agency workers (Streissler 2005: 127). In addition, they do not train staff themselves (ibid.).

The outsourcing of special services in the framework of the PPPs often leads to a growing concentration on the part of the private suppliers. They can then for their part increase the (price) pressure on the hospitals (Rümmele 2005: 133). If public hospitals are part-privatised in the framework of the PPPs, then the question arises of at what point a hospital is considered to be a private enterprise, and is thus subject to competition law under which the public subsidies become actionable as an infringement of competition law.

4. HEALTH-CARE REFORMS

In recent years there were two reform periods (1996-2000 and 2000-2005) and in 2005 a renewed health-care reform. European Union policy has played an important role in the objectives of all health-care reforms in the last 15 years. With the accession to the economic and monetary union in 1998, Austria also assumed the resulting obligations to strive for and implement a practical zero budget deficit. On the other hand, there is the orientation on the Lisbon competition strategy and the called-for modernisation of the European social model that it entails. In a 2001 report of the Commission it was stated that health-care provision and long-term care in the EU face the challenge of meeting three objectives simultaneously: comprehensive access to services, high quality and long-term financing (COM 2002).

Health-care reforms in the last 15 years have been primarily concerned with reducing expenditure by opening up economically exploitable reserves and increasing charges, as well as with structural reforms for better planning of capacities, cooperation between the players and coordination of financial flows (Hofmacher/Rack 2006: XVIII). Revenues have been continually raised and equalised among the insured groups, but the revenue basis has not fundamentally changed (ibid.). To finance the contributions, co-payments, prescription charges and diverse charges, e.g. for glasses, have been raised, as has tobacco tax (Hofmacher 2006: 233). The reimbursement of services and medicaments has been increasingly linked to health-technology assessment, and at the same time new benefits such as national care benefit, psychotherapeutic care and screening measures have been introduced as well as new structures in long-term local care (ibid.). The quality-control requirements have been raised and patient rights have been strengthened through a charter and “patient advocates” (ibid.).

Since 1997 there is a strengthened role for the federal government as a central coordinator for structural policy measures, which develops and establishes standards for in-patient care in agreement with the provinces and which can apply sanctions if players do not adhere to agreements (Hofmacher/Rack 2006: 210). Here the emphasis has above all been on the planning of in-patient care and top-quality medical care and the standards for the hospitals derived from them. After 20 years of preparatory work, in 1997 the diagnosis-related group (DRG) system of financing was agreed. Associated with this, for the first time a compulsory hospitals and major equipment plan as a structural policy instrument was established by mutual agreement (ibid.: 225).

The latest health-care reform, of 2005, also follows the well-known path of consolidation and structural reform in hospital care, even if some new accents have been set on making the coordination between the funding providers and the service providers more cooperative. A main aim of the 2005 reform was greater integration of care. The instrument for this is the Austrian Structural Plan for Health, which was planned by the federal government and is to be implemented by the area authorities (Hofmacher/Rack 2006:234). In 2005, the Federal Health Agency was set up for organisation and financing of health care, charged with the further development of the hospital financing system (BMGF 2005: 112f.). The most important reform at

provincial level is the establishment of *Provincial Health Platforms* as organs of the respective provincial health fund. The provincial health funds replace the provincial funds that had existed since 1997. The provincial health funds can also be formed on an inter-regional basis. The health platforms now envisage the participation of all service providers and leave decision-making in the distribution of funds to the service areas to the voluntary commitment of the players. The province, the social insurer and the federal government are equally represented in the health platforms. Apart from this, other players, such as representatives of the Chamber of Doctors, towns and cities, municipalities, patients' representatives and operators of hospitals financed by the provincial health funds, also belong to it. The structure is intended to improve cooperation between the social insurers and the provinces (Hofmacher/Rack 2006:60). What is new is a stipulation that the district authorities and the social insurer share overall responsibility for health care (Hofmacher 2006: 231).

With the 2005 reform, the regulatory competence of the federal government was on the one hand strengthened and on the other weakened. On the one hand with the health platforms the preconditions were created for comprehensive involvement in the organisation of regional health care; on the other hand, it could become weaker as a result of the comprehensive, nationwide planning and quality standards (Hofmacher/ Rack 2006: 59).

4.1. The role of the government and other stakeholders

Since the year 2000, with the change of government from a grand coalition between the Social-Democratic Party (SPÖ) and the People's Party (ÖVP) to a right-wing conservative government between the ÖVP and the Freedom Party (FPÖ) / Movement for Austria's Future (BZÖ), the health-care policy discourse has been marked by more conflicts, as the reforms that have taken place since then were openly linked to the claim to be reconstructing the system. This reconstruction begins at several levels and was guided by the basic idea that how much health costs and who is "socially needy" should be transparent (key words: co-payment and exemption conditions) (Hofmacher 2006: 235). The planned increase in co-payment and an additional outpatient charge were highly controversial and the outpatient charge ultimately had to be rescinded in 2005 as a result of vehement protests.

In the search for cost reduction, the right-wing conservative government has recently undertaken repeated attempts to change the organisational structures of the social insurance bodies, achieving a weakening of the trade-union-dominated self administration. Unofficially, this concerned breaking the power of the unions; officially the argumentation was that the dominance of the unions hindered the entrepreneurial behaviour and thereby also European policy objectives (Hofmacher 2006: 235). In terms of power balance the health reform also resulted in a certain strengthening of the provinces, the majority of which in Austria are ruled by the ÖVP.

The biggest ideological differences between the parties consist in relation to the guaranteeing of the income basis of the health-care system. Whereas the right-wing conservative government is traditionally in favour of more co-payment, the Social Democrats, Greens and the Chamber of Labour demand an extension of the insurance contribution base or an increase in the highest contribution base for all those insured; in this way the funding crisis in health care is to be dealt with in a solidaristic way. The idea behind it is to extend the income base of health insurance by incorporating income from capital and profits; as a result of the current system, working people would carry a greater burden than companies and the well off.

As far as privatisation is concerned, the official position is very reserved. However, with certain measures and argumentation this is being indirectly promoted by the government. PPPs in particular are hailed as opportunities to relieve pressure on budgets, by the Social Democrats as well (Streissler 2005: 128). To some extent there are close interconnections between politics and private providers in almost all parties; some politicians and ex-politicians are owners of private companies. Owing to the existing privatisation tendencies in the hospital and health insurance sector and the extension of co-payments in the social insurance system, in the recent election campaign Social Democrats and Greens warned against the development of a two-tier medical system and spoke out against it.

4.2. Unsolved problems and remaining challenges

It has not been possible to sustainably consolidate the health-care system either on the income or on the expenditure side. It has not been possible to achieve a long-term guarantee of the income basis. Unemployment and atypical employment are still and increasingly weakening the income basis of social health insurance.

The aim of the 1997 reform was to better integrate service provision in the in-patient field with that in the out-patient sector at regional level and through the improvement of interface management to raise economic efficiency reserves and make the structures more transparent for patients. Owing to the separation of service provision and financial responsibility, and the lack of integration of the out-patient and in-patient field, however, there is as before uneconomic use of funds; for the individual hospital, capital is practically free (Streissler 2005: 122). Previously, the basic problem of guaranteeing the financing and in particular that of the hospitals “from one source” was avoided (Hofmacher 2006: 236). Part of the problems arising from this are to be solved by the newly created health-care platforms; their effects will only be evaluated in 2007.

The DRG has indeed led to savings, but productivity improvements have hardly been possible (Streissler 2005: 122). There was a reduction in beds, an increase in in-patient stays, a reduction in lengths of stay and a brake was put on the growth of personnel costs (ibid.: 36). In Austria, a reshuffling rather than a reduction of beds was needed; reallocations were to be planned and coordinated nationwide in order to guarantee accessible basic care everywhere (ibid.: 131). Special treatments, on the other hand may

be concentrated in particular skill centres, as a result of which the quality of rare operations should rise (ibid.). A simple but rather problematic cost-cutting variant is to reduce core staffing levels. Personnel numbers in hospitals have been growing significantly more slowly in recent years. In Vienna there have even been reductions, which has resulted in the existing nursing staff complaining of overwork (Streissler 2005: 122).

CONCLUSIONS

Liberalisation and privatisation tendencies in the health-care sector in Austria are relatively limited. However, private providers are very interested in this lucrative growth market, but owing to the current regulatory structure the investment opportunities are still rather modest.

Officially, there is a broad political consensus against liberalisation and privatisation in this area. However, there are the first privatisation tendencies – supported by the political side – in particular in the field of hospitals, which in recent years have been organised on a more market-oriented basis through diverse forms of public-private partnerships. The funding crisis in the health-care system is increasingly being used to legitimate privatisation. More competition would lead to more "efficiency" and falling prices, according to the argumentations of its proponents. However, these ignore the tendencies of private providers likewise to strive for monopoly positions and only to deal with the lucrative areas of the market (cherry-picking), and are therefore unable to contribute to the solution of the problems in the health-care area – a sustainable guarantee of the provision and funding of health services.

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