HiT summary

Austria

Introduction

Government and political background

Austria is a democratic republic and a federal state which is composed of nine states (*Länder*). The Länder have their legislative competencies and also participate in legislation at federal level in the *Bundesrat* (Upper House of Parliament). The Länder are subdivided into political districts (administrative units), which themselves are made up of local communities. As self-governing bodies, local communities have their own sphere of activity and carry out their financial affairs independently.

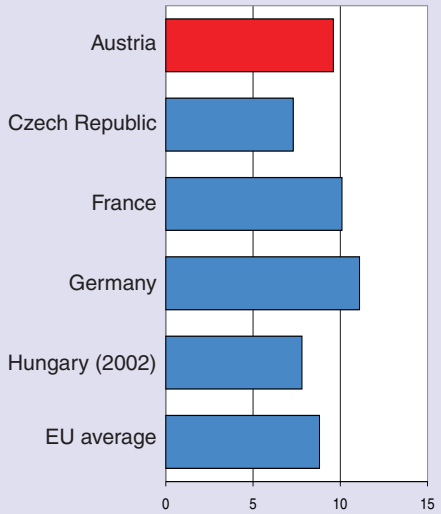
Population

Approximately 68% of the 8.1 million inhabitants lived in towns and cities in 2003. Since 1990, the population has grown by an average of 5% per year, which is above the average of the 25 countries which have been Member States of the European Union (EU) since May 2004. From 1990 to 2004, the proportion of those under the age of 15 fell from 17.4% to 16.2% of the population, whereas the proportion of those over 65 years rose from 14.9% to 15.7%. A further increase in the number of elderly people is expected in the coming decades.

Mean life expectancy

From 1990 to 2004, life expectancy at birth rose from an average of 76 years to 79.5 years and was thus above the EU average and that of the 15 countries that were already EU Member States before May 2004. In the same period, the mean life expectancy of women rose from 79.1 years to 82.2 years; that of men rose from 72.5 to 76.5 years.

Fig.1 Health care expenditure as a percentage of GDP in Austria, selected countries and EU average, 2004, WHO estimates



Sources: European Health for All database, June 2006; Austria: Statistik Austria, February 2006.

Main causes of death

Since 1990, almost all the indicators of morbidity, mortality and environment and lifestyle-related health risks have improved significantly. From 1990 to 2004, the age-standardized death rate fell from 8.1 to 6.2 per 1000 inhabitants, whereby a

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decrease of almost all types of illnesses could be observed. In 2004, it was below the average of the 15 countries that were already EU Member States before May 2004, in particular owing to a low mortality rate for cancer. However, mortality due to suicide and alcohol-related diseases was still disproportionately high in spite of a significant decrease.

The recent history of the health care system

Since the nationwide introduction of statutory mandatory health and accident insurance in 1887/1888, the proportion of insured people has steadily increased and now includes 97.6% of the population. The health care system has been characterized by significant increases in expenditure since around 1980. Since 1978, the Federal Government and the nine Länder have been concluding limited-period agreements on hospital financing according to Federal Constitution Article 15a. Since 2005, these agreements have also referred to the planning of other areas of health care provision and cross-sector financing approaches.

Reform trends

Health reforms have primarily dealt with cost-containment (by exploiting potential for more efficiency and increasing cost-sharing) and with structural reforms to improve the planning of capacities, the cooperation of stakeholders and the coordination of financing flows. Revenue has been continuously increased while maintaining the existing forms of financing. In the acute care sector, organizational tasks have been partly privatized. The reimbursement of services and medicines has been more strongly linked to health technology assessment. At the same time, new services (long-term care benefit, psychotherapy, prevention) and new structures for long-term care closer to patients' homes have been introduced. Contribution revenue has been increased and the contribution rates of some groups of the insured brought into line, but the revenue base has not been fundamentally changed. Quality assurance requirements have been raised and patients' rights have been strengthened by a charter and patients' ombudspersons.

Health care expenditure and GDP

Austria spent 9.6% of its gross domestic product (GDP) on health care in 2004 (Fig. 1), ranking above the EU average and that of the 15 Member States belonging to the EU before May 2004.

Overview

The Austrian health care system is characterized by the federalist structure of the country, the delegation of competencies to stakeholders in the social insurance system as well as by cross-stakeholder structures at federal and Länder levels which possess competencies in cooperative planning, coordination and financing. There has traditionally been regulated competition between service providers for patients and contracts with the social insurance institutions, but not between the health insurance funds themselves. The sectors of the health care system have customarily been characterized by different stakeholders and regulation and financing mechanisms. However, in recent years there have been increased efforts to introduce decision-making and financing flows which are effective across all sectors.

Organizational structure and management

Structure of the health care system

The *Nationalrat* (Lower House of Parliament), the *Bundesrat* (Upper House) and the Federal Ministry of Health and Women are the bodies primarily responsible for legislation in the health care system. The Ministry supervises the nationally active stakeholders in the social insurance system. It is partly supported in the execution of its statutory tasks (e.g. product safety, protection against infections, health

professions) by subordinate authorities such as the Austrian Health Institute and the Federal Office for Safety in the Health Care System (since 2006 the successor to the Federal Office for Medicines). Other ministries are also involved in parts of the health care system. For example, through its role in the financial adjustment process between the Government and the Länder, the Ministry of Finance is involved in decisions on the distribution of value-added tax (VAT) revenue.

According to federal framework laws and Länder laws, the nine Länder are responsible for the provision of hospitals and long-term care institutions and for maintaining their infrastructure. These tasks are partly delegated to local authorities. They are also responsible for the public health service, training institutions for non-academic health professions, the award of long-term care benefit and the ambulance service. Länder governments also supervise the regional physicians' chambers and regional health insurance funds.

The 21 social insurance institutions are organized in the Federation of Austrian Social Insurance Institutions together with five other social insurance institutions (for accident and pension insurance). The Federation coordinates, among other things, the administrative activities of the social insurance institutions (for example by means of model statutes). It also has the task of drawing up binding directives and concludes, after the health insurance funds' approval, general agreements at Länder level with the interest groups of outpatient service providers.

Membership of the relevant regional physicians' chambers is mandatory for all physicians. The chambers are organized in a holding; the Austrian Chamber of Physicians. As self-governing public bodies, the regional physicians' chambers are responsible for quality assurance and further and continuing education and training, and negotiate general agreements with the Federation for the provision of outpatient care by contracted physicians.

The Austrian Pharmacists' Association is the statutory representative body of pharmacists who work in public pharmacies or in hospitals. It is based on mandatory membership, and as a public body it takes on sovereign tasks. All practising midwives are members of the Austrian Midwives' Committee. Other health professions are organized in professional associations with voluntary membership, some of which are authorized to conclude collective agreements.

Caritas (a catholic welfare organization), Diakonie (a protestant welfare organization), the Red Cross, Volkshilfe and the Austrian Hilfswerk are organized in the Federal Working Group Free Welfare. The Association of Pharmaceutical Companies has 109 members. In 2000, the Austrian Generic Drugs Association was founded. The seven private health insurance funds are organized in the Association of Insurance Companies. There are currently well over 1000 self-help groups in the health and social sectors, some of which are organized in umbrella organizations.

Alongside the individual players, cross-stakeholder cooperative committees – and this is characteristic for the Austrian health care system – are increasingly being established at federal and Länder levels in order to better coordinate planning, regulation and financing flows, and to be able to intensify needs orientation and efficiency.

Planning, regulation and management

The distribution of responsibilities in legislature and implementation between the Federal Government, the Länder, local communities and social insurance is set out in the Federal Constitution Act and is regulated in more detail and in some cases elaborated in implementing laws at Länder level. Since 1956, the General Social Insurance Act has governed social health, accident and pension insurance for employees and acts as a reference law for the social insurance of the self-employed and other occupational groups. The Federal Government has delegated

competencies in the field of implementation to self-governing stakeholders in the social insurance system, particularly for outpatient services, the reimbursement and prescription of medicines and therapeutic aids, rehabilitation and cash benefits.

After obtaining the approval of the relevant health insurance funds, the Federation of Social Insurance Institutions concludes general agreements for the provision of outpatient services with the following bodies: the regional physicians' chambers, the Austrian Pharmacists' Association, the Austrian Midwives' Committee, the professional associations of other health workers which are entitled to conclude collective agreements, and the guilds of skilled tradespeople in the health sector. The general agreements regulate service amounts, fees and quality requirements.

The regional physicians' chambers additionally negotiate a capacity plan ("location plan") with the Federation of Social Insurance Institutions for outpatient care provision by contracted physicians, on the basis of which the health insurance funds selectively award individual contracts to a proportion of physicians in private practice. The remaining physicians in private practice do not have contracts with any health insurance fund. The cost of their services, however, can be partially reimbursed (80% of the fee usually charged by a contracted physician) by the funds upon application by the insured.

For services provided by other health professionals, the general agreements are valid for all people practising the respective profession; any fee demands which go beyond the negotiated "market price" have to be paid by the patients themselves.

As part of the negotiations on financial adjustment, the Federal Government and the nine Länder governments have concluded a special agreement (according to Federal Constitution Act Article 15a) on the organization and financing of the health care system for every legislative period since 1978. As a binding state treaty, this is published in the Federal Law Gazette. Health reform laws are often the result of these agreements between the Federal Government and the Länder. Until 2004, these agreements primarily affected acute inpatient care, which since 1999 has also included cross-sector planning for psychiatric care and major equipment in the inpatient and outpatient sectors. This was set out in the Austrian Hospitals and Major Equipment Plan for the whole country, representing a binding basis for capacity planning and financing flows at Länder level.

According to the 2005 Health Reform, this plan would be replaced from 2006 by the cross-sector Austrian Structural Plan for Health, with a time horizon reaching to 2010; the relevant negotiations, however, have not yet been completed. The new plan not only refers to acute inpatient, psychiatric and high-technology care, but also to the outpatient, day-care and rehabilitation sectors, to interfaces to long-term care and to prevention and health promotion. It is being developed by the Federal Health Agency (the successor to the Structural Fund since 2005), which should additionally draw up nationwide cross-sector quality specifications and reimbursement incentives as well as guidelines for the financial support of shifts in services between inpatient and outpatient care (by means of a so-called reform pool). The Federal Health Agency is managed by the Federal Health Commission (the successor to the Structural Commission since 2005), which is advised by the Federal Health Conference, in which the most important stakeholders in the health sector are represented; the Federal Government holds a majority.

The detailed planning and implementation of the Austrian Structural Plan for Health at Länder level is to be carried out by the nine Health Platforms, in which the most important players in the Länder (including patients' representatives) are represented. They are responsible for the State Health Funds (successors to the State Funds since 2005), in which the budgeted funding of the Federal Government, the Länder, local authorities

and social health insurance funds are pooled. This funding serves to finance acute inpatient care in public hospitals (fund hospitals) as well as the intersectoral reform pools.

Patients' rights are stipulated in numerous laws, and were summarized in the Patients' Charter agreed upon by the Federal Government and the Länder in 1999. In the meantime, patients' ombudsmen's offices have been embodied in regional laws in all the Länder. They provide information and advice, follow up complaints and can award compensation payments if necessary.

Decentralization

The Austrian health care system is traditionally characterized by decentralized structures as set out in the Federal Constitution, particularly the delegation of competencies to the Länder within the framework of federalism and the delegation of tasks to self-governing bodies in the social insurance system. Interlocking federalism at both legislative and executive levels requires a high level of joint decision-making between the Federal Government and the Länder (and local authorities), whereby there is a clear hierarchy in which the Federal Government takes precedence over the Länder. In recent decades, the Federal Government has increasingly exercised a controlling influence on the public health system. This has led to the creation of mainly cross-stakeholder cooperative bodies and funds at federal and Länder levels.

Since 2002, all the Länder (except Vienna) and many private non-profit-making owners have handed over the operation of their hospitals to companies organized according to private law. However, the (majority) owners usually act as a guarantor. These hospital operating companies are now hospital service providers, with the State Health Funds as their clients or purchasers of their services. The Austrian health care system has thus developed almost completely into a supply model which is based on decentralized contracts with service providers.

Health care financing and expenditure

Main source of financing: statutory health insurance

The financing of the health care system is pluralistic in accordance with the Federal Constitution and social insurance laws. The social health insurance system, which is the most important source of financing, provided a total of 45.3% of total health care funding in 2004.

In 2004, almost 98% of the population was covered by statutory health insurance, and the majority of the remaining inhabitants receive health care services via regional bodies (recipients of social assistance, asylum seekers, prisoners, etc.). Mandatory insurance is based on membership of an occupational group or place of residence; there is thus no competition between health insurance funds. It applies to almost all employees and the self-employed as well as pensioners, the unemployed and students in employment. Employees on low incomes can opt for voluntary insurance. Some self-employed professionals can choose not to have mandatory social insurance, since 2000. Children, household members who need a high level of care and spouses and partners who are not employed and look after children are co-insured free of charge. Other household members who are not in employment pay a reduced contribution, since 2002.

Contributions are not dependent on the state of health or the risk of expenditure of the insured person or her/his dependants, but are proportionate to the person's earnings – up to a ceiling on insurable earnings. The contribution rates are set annually by the Nationalrat. In 2005, they amounted to between 7.1% and 9.1% of the contribution base depending on the health insurance fund, whereby a respective ceiling on insurable earnings of €3630 and €4235 was set. Employees pay around half of the contribution amount; the other half is paid by their employer. The contributions are collected and administered

by the health insurance funds themselves. Services are financed according to a pay-as-you-go principle.

Since the mid-1980s at the latest, a gap started to develop between contribution revenue and the spending of the health insurance funds. In 2004, the health insurance funds together had a deficit of €253 million. The balances of the regional health insurance funds varied between levels of –6.6% and +0.4% of revenue; the nationally active funds usually have a surplus. Deficits can be balanced via a compensation fund established at the Federation of Austrian Social Insurance Institutions. In recent years, however, repeated reform measures have been necessary in order to compensate for deficits of social health insurance funds.

Health care benefits and rationing

In case of need, all those insured within the social health insurance system have a legal entitlement to benefits in kind and cash benefits within the framework of the specified range of services. The range of services is broad and includes outpatient medical treatment, dental treatment (without fixed dentures), psychotherapy, physiotherapy, ergotherapy and speech therapy, medicines and therapeutic aids, medical nursing care and rehabilitation as well as hospital treatment and stays at spas. In terms of cash benefits, social health insurance finances sick pay and maternity benefits.

Legislative decisions on the social health insurance funds' obligation to provide services are prepared in the discussions of the Supreme Health Board and the Länder health officers. Recommendations are, however, not binding for political decision-makers. Alongside the statutory obligatory services, health insurance funds also offer additional services or exemptions from cost-sharing according to their statutes.

Waiting times for medical treatment are rarely discussed in public and can be viewed as short in comparison to other countries, although there has been no precise evaluation of this.

Complementary sources of financing

Taxes

In 2004, 25% of health expenditure was borne by the Federal Government, the Länder and local authorities; of this, approximately 10% was accounted for by long-term nursing care.

Private households

In 2004, approximately 25% of health care expenditure was financed privately. Private households bore 13.5% of health care expenditure by means of indirect cost-sharing (services whose costs were fully borne by the insured) and 7.6% by means of direct cost-sharing (co-payments). In addition, 2.4% was financed by private insurance premiums, 1.4% by private non-profit-making organizations and 0.2% by employers (for the services of company physicians).

In 2004, 53% of indirect cost-sharing was accounted for by hospitals (mainly as private health insurance) and 30% by dental treatment. Direct cost-sharing has increased in recent years and affects almost every service provided by social health insurance; however, the outpatient clinics fee introduced in 2001 was withdrawn again in 2005 owing to the high costs involved in its implementation and the considerable resistance it had encountered. A large part of direct cost-sharing (47%) in 2004 was accounted for by the services of non-contracted physicians, prescription fees (19%) and therapeutic products (18%). Certain people in need of social protection and the chronically ill are exempted from the prescription fee. In addition, health insurance funds issue their own guidelines on exemptions in other service areas. A total of approximately 900 000 people or about 12% of the Austrian population are exempted from direct cost-sharing.

Private health insurance

Private health insurance financed approximately 10% of health expenditure in 2004, mainly in

the form of supplementary private insurance policies. The insurance companies' tariffs are risk-dependent and vary according to the Land in question. Their expenditure was predominantly related (82%) to inpatient care (mainly for more comfortable rooms and hospital per-diem fees), but also for outpatient care by non-contracted physicians (10%). Around a third of the population has private health insurance in addition to social health insurance.

Health care expenditure

In 2004, Austria spent approximately €23 billion on health care. This corresponded to 9.6% of its GDP (see Fig. 1). Without taking the expenditure for long-term care into consideration, which accounted for approximately 10% of total health care expenditure, the proportion was 8.7%. Owing to the current data revision (in accordance with the System of Health Accounts of the Organisation for Economic Co-operation and Development (OECD)), health care expenditure no longer appears to be below average in comparison with the countries belonging to the EU before May 2004, but rather above average.

When the public share of health care expenditure is considered, Austria is in the lower third of all EU countries, with approximately 70%. The proportion would be in the region of 73% if investments in so-called fund hospitals (public hospitals including private non-profit-making hospitals) were counted as public expenditure. Between 1995 and 2004, the proportion of total expenditure on hospitals, medicines and therapeutic aids rose, whereas the proportion of total expenditure on outpatient and nursing care services fell.

Health care delivery

The public health service, prevention and health promotion

The public health service is the responsibility of the Länder, which decentralize most of the relevant tasks to district administrations or to local authorities. It is in charge of health reporting, the prevention of epidemics and protection against infections, the supervisory activities of health inspectors and environmental medicine. In addition, the public health service is responsible for vaccinations (whereby the vaccines are partly financed by the health insurance funds). Within the EU, however, Austria has at 73.5% one of the lowest immunization rates against measles among infants. The measures taken by the public health service include the mother–child pass programme and care provided by school physicians; check-ups for young people and preventive check-ups for adults are financed by social health insurance. The proportion of participants increased to 14% of the adult population between 1990 and 2003.

Since 1992, health promotion has partly been an obligatory task of the health insurance system. In 1998, the Healthy Austria Fund was introduced to complement this work. It is financed from VAT revenue and promotes projects in setting-orientated health promotion and education.

Outpatient health care

People covered by social health insurance have freedom of choice in the outpatient sector between service providers in private practice (predominantly working in single practices), hospital outpatient departments and 836 outpatient clinics (mainly owned by individuals or the social insurance institutions).

As a part of the general agreements, a "location plan" is also negotiated at Länder level for outpatient care provision by contracted physicians, on the basis of which the health insurance funds selectively award individual contracts to a proportion of the physicians in private practice. It regulates the number and the geographical distribution of contracted physicians per specialty and is drawn up according to sociodemographic factors and existing hospital capacities in the catchment area. In 2003, 43% of the 19 209 self-employed physicians in private practice had a contractual relationship with one or more health insurance funds. Approximately 57%

worked as non-contracted physicians. Among dentists, the ratio was 72%:28%.

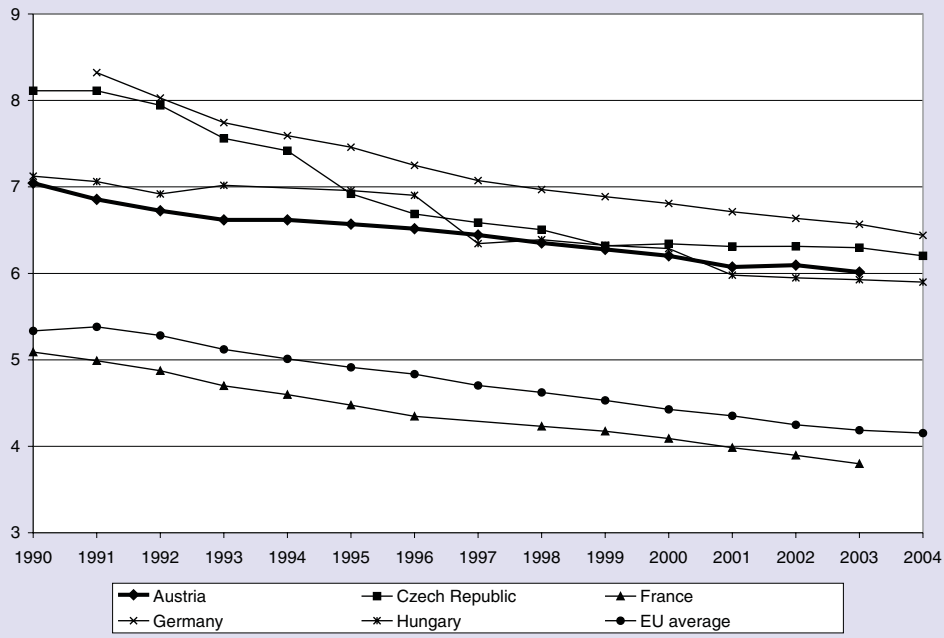
In 2004, the social insurance institutions financed an average of 5.5 cases with contracted physicians per insured person as benefits in kind, and 1.2 cases with non-contracted physicians by reimbursement of part of the costs. This rate of usage was approximately average for the EU (6.6 outpatient contacts with physicians in 2001). However, this does not include contacts with outpatient clinics or hospital outpatient clinics. During the accounting period (usually three months), the patient may only change from one contracted physician to another with the approval of the health insurance fund. There is no special gatekeeping function for general practitioners.

Inpatient health care

Inpatient health care is predominantly provided by public hospitals (49% of all hospitals with 68% of all hospital beds in 2003) as well as by hospitals owned by private non-profit-making organizations (19%/16%), social insurance institutions (19%/9%) and private profit-orientated owners (17%/6%). Of these, a total of 139 public or private non-profit-making hospitals (51%/73%) are required to provide care to all patients requiring it and receive public subsidies for investments and running costs (fund hospitals).

In the final analysis, 72% of hospital beds provided acute care in 2003. Between 1990 and 2003, the number of acute beds was reduced by 15%; the average figure for the EU, however, was 22% (Fig. 2). In 2003, the ratio of inhabitants to acute beds of 6 beds per 1000 people was clearly above the EU average of 4.2 per 1000 inhabitants. In addition, Austria had by far the highest admission rate (28.8 per 100 inhabitants), whereby a proportion of hospital outpatient cases are included in this figure. The average length of stay, on the other hand, was shorter than the EU average (6.4 compared with 6.9 days), while the

Fig. 2 **Number of hospital beds per 1000 inhabitants in acute hospitals in Austria, selected countries and EU average, 1990–2004**



Source: European Health for All database, January 2006.

Table 1 Acute hospital utilization and performance in Austria, selected countries and EU average, 2004 (or latest available year)

	Beds per 1000 inhabitants	Admissions per 100 inhabitants	Average length of stay (in days)	Occupancy rate (%)
Austria	6.0[a]	28.8[a]	6.4[a]	76.2[a]
Czech Republic	6.2	20.8	8.2	74.8
France	3.8[a]	16.6[a]	6.1[a]	84.0[a]
Germany	6.4	20.4	8.7	75.5
Hungary	5.9	23.5	6.5	76.6
EU average	4.2	17.5[a]	6.9[a]	77.5[a]

Source: European Health for All database, January 2006.

Note: [a] 2003.

utilization of bed capacity was slightly higher (76.2% compared with 77.5%) (Table 1).

Long-term care

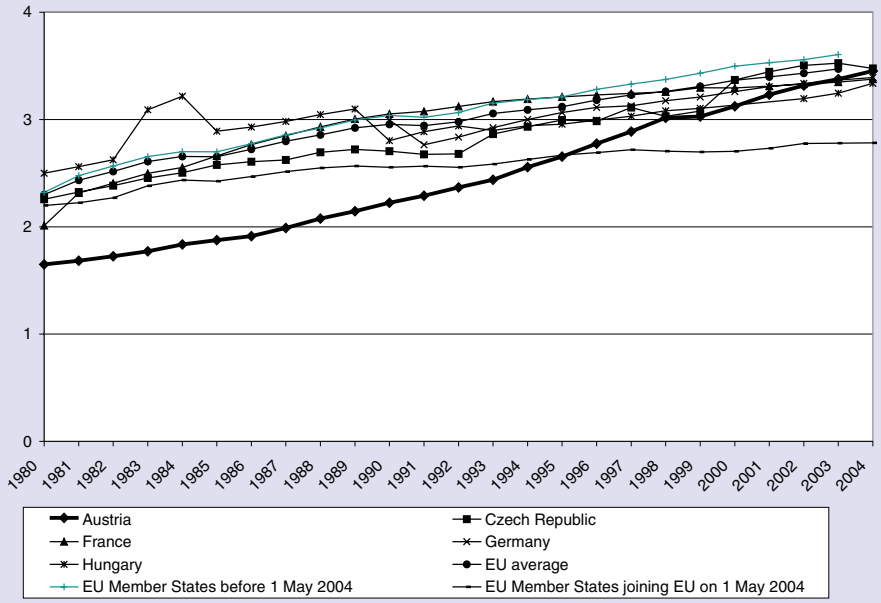
Depending on the group of the insured in question (or if there is a work-related cause), medical rehabilitation is financed by social health insurance, pension insurance or work-accident insurance. Until now, it has largely been provided in hospitals and institutional settings and partly in the insurance institutions' own facilities. As far as the care of the mentally ill is concerned, the number of hospital and institutional beds has been significantly reduced since 1980; others have been integrated into general hospitals and the average length of stay considerably reduced to 18 days (2003). The extension of facilities and services (providing residential and work-related support and day structure) close to the homes and lives of patients varies between the Länder and since 1999 has been an integral part of the nationwide psychiatry concept in the Hospitals and Major Equipment Plan.

In 1993, the Federal Long-Term Care Benefit Act and the nine largely identical Länder-level long-term care benefit acts were introduced, providing for long-term care benefit to which there is a legally enforceable entitlement if there is a need for care which will presumably last for at least six months. Its award is independent of the claimant's income and assets and the reason for their need for care. It is granted to all age groups in seven stages depending on the need for care (between €148 and €1562 per month in 2005). Long-term care benefit is financed from general tax revenue. In 2003, 4.5% of the population received long-term care benefit, 85% from the federal government budget and 15% from Länder budgets. In order to further develop long-term care in a nationally uniform way, the Federal Government and the Länder conclude an agreement according to Federal Constitution Article 15a for every legislative period. This deals with quality specifications and capacity planning for homes as well as mobile services and day clinics.

Health personnel and training

The number of employees in the health care sector is growing much faster than that of other service sectors. In 2004, the density of practising physicians was 3.5 per 1000 inhabitants and thus average for the EU (3.5). Compared to 1980, the number of practising physicians (Fig. 3) and dentists (0.5 in 2003) has increased at double the rate. The number of specialists has grown in particular, doubling between 1990 and 2003. The number of psychotherapists (0.65 in 2004) has increased fivefold compared to 1992. The number of nurses also doubled between 1980 and 2003 to 6 per 1000 inhabitants. However, it was still clearly below the EU average of 7.3 in 2003. The

Fig. 3 **Number of physicians per 1000 inhabitants in Austria, selected countries and EU average, 1980–2004**



Source: European Health for All database, January 2006.

density of health personnel varies considerably according to the Land in question.

Pharmaceuticals

Since 2006, medicines are licensed by the PharmMed Austria division of the Federal Office for Safety in the Health Care System (whereby certain time deadlines have had to be adhered to since 2004). The Federation of Austrian Social Insurance Institutions decides on the reimbursement of the costs of authorized pharmaceuticals, in which it is advised by the cross-stakeholder Medicines Evaluation Commission. Its decisions are scrutinized (upon application) by the Independent Medicines Commission.

Since 2004, every medicine is assigned to one of four "boxes", for which different rules apply for reimbursement and price regulations: all newly licensed medicines are assigned to the red box for a limited period; they are subject to authorization by supervising physicians and quantity controls by the health insurance funds. Subsequently, they are classified as medicines with an important additional therapeutic benefit (yellow box) with similar regulations, as medicines which can be freely prescribed (green box) or as medicines whose costs are not reimbursed, or are only reimbursed in exceptional cases (no box). The prices are set according to the average EU price (red box), or are subject to quantity discounts and price grades (yellow box) or percentage price reductions as well as promotional measures for generic drugs (green box).

The Federal Government sets degressive mark-ups for wholesalers and pharmacies. Retail pharmacies are highly regulated and are within the area of responsibility of the Federal Government. In 2003, 2221 pharmacies were licensed to dispense medicines to the public. Of these, 52% were public pharmacies, 1% were branches

of these pharmacies and 45% were in-house pharmacies in physicians' offices with a right to dispense drugs (particularly in rural areas). More than 50 hospital pharmacies are responsible for supplying medicines in hospitals.

The disproportionate rise in expenditure on medicines (from 1990) particularly affected health insurance funds (especially for patented medicines subject to the authorization of supervisory physicians), but also private households. The growth in expenditure slowed to 4% in 2004 and was thus within the agreed target range. Compared to other countries, only a small proportion of generic drugs are prescribed (less than 10%). The initiative "Medicines & Reason" (*Arznei & Vernunft*), which was jointly established by the social insurance institutions and the pharmaceuticals industry, and since 2003 has also included the Austrian Chamber of Physicians and the Pharmacists' Association, is to set binding evidence-based guidelines for the prescription, dispensing and use of medicines.

Health technology assessment and eHealth

Evidence-based health technology assessments are carried out by the Federation of Austrian Social Insurance Institutions (or the Medicines Evaluation Commission) for the admission of medicines to reimbursement categories and for authorization by head physicians in individual cases. They are also carried out by the Austrian Health Institute and the Institute for the Assessment of the Consequences of Technology.

Since 1997, major equipment planning has been integrated into hospitals planning and carried out on a cross-sector basis. Between 1998 and 2003, the number of major equipment units rose by around a quarter to 495 in acute hospitals and by more than a third to 181 in the outpatient and rehabilitation sectors. The density of such equipment is partly above the OECD average, in part slightly below.

Since 2006, the "e-card" has replaced paper vouchers of social health insurance funds (and for the time being is valid only in the outpatient sector). Employees with social health insurance pay an annual user fee of €10 via their employer. In the agreement according to Federal Constitution Article 15a for 2005–2008, the contracting parties decided to introduce electronic health files and e-prescriptions.

Financial resource allocation

Third-party budget setting and the allocation of resources

There are a multitude of financing flows and forms of financing, reflecting the plurality of financing and service provision. They differ according to the sector in question and are usually bound up with joint planning and steering competencies. The use of resources in the outpatient sector is mainly controlled via general agreements and by selective agreements with contracted physicians. Doctors' prescriptions are checked (and partly approved) by supervisory physicians employed by the health insurance funds.

In the inpatient sector, budgets are set for funding from public sources in accordance with the negotiations on financial adjustment, and are linked to VAT revenue. The Federal Government sets a part of this aside for transplants, structural measures and special planning activities, while the remainder flows into State Health Funds at Länder level where public funding is pooled with budgeted funding from the social health insurance system. According to the 2005 health reform, the "cooperation area" or "reform pool" is also to be set up in the State Health Funds. This should enable funding for the shifts in services planned in the Austrian Structural Plan for Health to be made available to other (mostly outpatient) sectors, as well as for integrated forms of care provision. A total of 1% (by 2008 up to 2%) of the money in the funds is to be brought into the reform pool.

Payment of hospitals

The Länder (and local authorities) are not only responsible for investment and maintenance costs, but also contribute towards the running costs of public hospitals in accordance with federal and Länder hospitals laws. Public hospitals are owned by public or private non-profit-making bodies, are listed in the hospitals plans at Länder level, are subject to public law and are financed from State Health Funds (these replaced the State Funds in 2005).

In 2004, the total cost of public hospitals amounted to €8.5 billion. Approximately 10% of this came from private sources (7% from private supplementary insurance and 3% from direct or indirect cost-sharing by private households) and 50% from the State Health Funds. The funds are mainly financed by budgeting funding from the social health insurance system (around 80%), supplemented by budgeted funding from the Federal Government (7.1%), the Länder (1.9%) and local authorities (1.3%). This is raised from VAT revenue in accordance with the financial adjustment negotiations between the Federal Government and the Länder. Around half of the costs are financed by the hospital owners (Länder and private non-profit-making organizations). This funding mainly flows directly to public hospitals. Since 1997, the Federal Government has had the possibility of withholding funding for hospitals, particularly if the Länder do not implement planning and quality specifications. This amount translates into approximately 2% of the total costs of public hospitals. Until now, this sanctioning mechanism has not been used.

The reimbursement of the inpatient services of public hospitals has been carried out on the basis of a modified diagnosis-related groups (DRGs) payment system since 1997. The Austrian DRG model consists of a core component of nationally uniform procedure- and diagnosis-orientated case groups and a fund control area which takes the special characteristics of hospitals into account and differs according to the Land in question. The DRG system is updated annually and included a total of 883 procedure- and diagnosis-orientated case groups in 2005. A length of stay is assigned to each DRG; if this is exceeded or the stay is shorter, points are added or subtracted degressively from the DRG flat rate. Given the financial situation in the acute inpatient sector with partial budget setting, the procedure- and diagnosis-orientated reimbursement system with points per DRG has led to a reduction of lengths of stay and an increase in technical efficiency, but also to an increase in admissions.

In public hospitals, the inpatient area accounted for 88% of costs and hospital outpatient clinics for 12% in 2004. The services of the latter are currently being reimbursed with special flat rates per case; in future they are to be integrated into the DRG system in order to promote a shift of inpatient services into the outpatient sector.

Private profit-orientated hospitals are financed by direct payments from private households and from private supplementary insurance. In addition, 45 of the 47 establishments currently have contracts with individual social health insurance institutions, whose capped funding is pooled in the Private Hospitals Financing Fund founded since 2002, and paid out according to criteria of the Austrian DRG model.

Payment of physicians

Outpatient medical and dental services are financed from contributions to social health insurance. The services of non-contracted physicians and dentists are reimbursed up to a level of 80% of the fee which a contracted physician would charge for the same service; all other fees are paid directly by private households or by private supplementary insurance. The fees of non-contracted physicians are usually significantly higher than the fees negotiated for contracted physicians. The payment of physicians in private practice is set so that operating costs and investments for the practice can be amortized.

Health insurance funds conclude individual contracts selectively with a proportion of physicians and dentists in private practice (43% and 72% respectively in 2005). These contracts

are largely determined by the general agreements. According to these, contracted physicians receive a mixture of payments per patient for basic services and per individual service for items which go beyond the scope of basic services. The distribution of these payment elements varies according to specialty, Land and partly owing to the type of health insurance fund. In some Länder there are limitations on service amounts with degressive payments for physicians' services.

Health care reforms

From 1978, health reforms mostly had the aim of stabilizing expenditure growth and modernizing the structures of the health care system. Furthermore, the range of services is to be even more geared to the needs of the population and quality and patient orientation are to be improved. Since the mid-1990s, ensuring the financial feasibility of the health care system has been increasingly and more explicitly formulated as a key objective. Specific national health goals were formulated in the 2005 health reform.

The consolidation of public finances became increasingly significant from 1980 onwards, particularly owing to rising expenditure in the public health system, a slowing down of economic growth and as a result of the EU stability requirements for the introduction of the euro. The introduction of budget setting for health insurance funding for hospitals in 1997 directly linked annual expenditure to the development of contribution revenue. Budgets are also set for the payments from the Federal Government, the Länder and local authorities, although the Länder and local authorities as the owners of public hospitals increasingly provide additional funding.

Further cost-containment measures included the introduction of procedure- and diagnosis-based reimbursement in the inpatient sector (1997), the repeated increase of co-payments, and selective contracting with physicians in private practice. In the pharmaceuticals sector, recent years have seen price regulations, a lowering of the degressive mark-ups for wholesalers and pharmacies, quantity discounts for health insurance funds and measures to increase the low levels of generic drugs prescribed and reduce the number of refundable medicines. In 2005, the categories for reimbursement and pricing were fundamentally revised.

To ensure sufficient financing, cost-sharing by private households, the funding from Länder and local authorities as well as contributions and ceilings on insurable earnings in social health insurance were increased, particularly the (reduced) contribution for pensioners (2003, 2005). The contributions of wage and salary earners were aligned in 2003.

The 1997 structural reforms were accompanied by a reorganization of financing flows and decision-making flows. Transforming the hospitals financing fund into a structural fund at federal level and nine Länder funds was intended to provide better integration of inpatient and outpatient service provision at Länder level and interface management was to raise the potential for greater efficiency. In addition, major equipment planning (1997) and psychiatry planning (1999) were integrated into (acute) hospital planning, made binding and extended to include the outpatient sector.

The 2005 health reform created organizational opportunities for cross-sector planning, quality assurance and financial incentives. In the currently valid agreement according to Federal Constitution Article 15a (2005–2008) the Federal Government's competency for planning and regulation is fundamentally strengthened and extended to all areas of care. The Austrian Structural Plan for Health, the nationwide quality specifications and the "reform pool" are of great significance in this context. The social health insurance institutions' ability to exercise an influence on cross-sector planning at Länder level was increased by the introduction of the Health Platforms, which govern the State Health Funds. An increase in mergers, specialization and rationalization measures is expected to ensue from the organizational privatizations of public hospitals since 2002.

The Health Reform Act 2005 is a comprehensive federal law to ensure the quality of health services, to focus fragmented quality assurance activities and to realize nationwide specifications for the provision of services in all sectors and for all health professions. Specifically for physicians in private practice, the Austrian Chamber of Physicians established an organization to develop binding standards for quality assurance and quality management in medicine.

Conclusions

In the past 25 years, the stakeholders in the Austrian health care system have succeeded – characteristically by means of cooperative agreements and planning – in ensuring almost universal health care provision with an extensive catalogue of services, in spite of considerable increases in expenditure and continuing cost-containment measures. Waiting times for medical treatment are rarely discussed in public and have to be viewed as short in comparison to other countries, although there has been no precise evaluation of this. However, the structure of offers is characterized by inequalities between the Länder and also between urban and rural areas. Altogether, life expectancy and most of the documented health indicators have improved markedly since the early 1990s. The level of satisfaction of the population with the health care system continues to be high in an international comparison.

Cost-containment measures have contributed to a consolidation of the growth in health expenditure, but have not been able to avoid an increase in expenditure above the level of economic growth. They have also not been able to prevent deficits in the health insurance funds and to spare the Federal Government the task of raising contribution revenue and thus non-wage labour costs. In spite of a reduction in acute beds, Austria has an above-average level of inpatient capacity in comparison to other EU countries. The exceedingly high admission rates are partly owing to the procedure and diagnosis-based inpatient reimbursement system and to a lack of incentives to shift services to outpatient settings.

Sectoral fragmentation, which also creates the bias towards hospitals, is a long-standing weakness of the Austrian health care system. In spite of numerous efforts, it has until now not been possible to allow funding to follow the services provided across the sectoral borders caused by administrative and financial factors, and to structure the supply chain in a needs-orientated way. The planning, structures and funds introduced since 2005 permit for the first time the cross-sectoral control of capacities and financing flows as well as incentives for improved interface management and integrated forms of care. However, the degree to which these measures have been implemented is still unclear. Further health policy challenges exist in the expected increase of the number of elderly people, a partial increase in demand, and the integration of technological innovations into the range of services of publicly financed health care.

Future reforms should pursue the following priorities: first, to ensure a financial basis in order to be able to continue to guarantee the needs-orientated utilization of health services and to finance it according to individuals' ability to pay; second, the productivity of health care workers in the public health system should be further improved; and third, it should be ensured that the increased use of funding really leads to health-relevant benefits. This can only be guaranteed if investment decisions are increasingly based on technology assessment methods and if quality assurance determines health care practices.

HiT summary

Austria

The Health Systems in Transition (HiT) profile on Austria was compiled by Maria M. Hofmarcher (Institute for Advanced Studies, Vienna) and Herta M. Rack (Federal Ministry of Health and Women, with the collaboration of Gerald Röhrling (IHS, Vienna). Gerald Röhrling not only researched and compiled data tirelessly; he also made an important contribution to Chapter 4 on the health care delivery system. This HiT was edited by Annette Riesberg (Technical University Berlin) and the research director was Reinhard Busse (European Observatory on Health Systems and Policies, Technical University Berlin).

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